Updated January 2018

United Airlines Consolidated Welfare Benefit Plan

Frequently Asked Questions

These Frequently Asked Questions ("FAQs") are intended to provide you with additional information regarding the various Benefit Programs under the United Airlines Consolidated Welfare Benefit Plan (the "Plan"), sponsored by United Airlines, Inc. ("United" or the "Company").

Detailed information regarding the benefits available to you under the Plan can be found by reviewing the following resources available on Your Benefits Resources (YBR):

- The Summary Plan Description (SPD) and the SPD Addendum
- Schedule of Benefits pertinent to your medical plan
- Contact Information Sheet, which shows the phone numbers, websites, and other information for the Plan's claims administrators, insurance companies, and the United Airlines Benefits Center (UABC)

For questions related to anything noted in this FAQ document, contact the United Airlines Benefits Center (UABC) at 1-800-651-1007, Monday-Friday, 7a.m.-7p.m. Central Time.

Note: Some of the benefit programs offered under the Plan are provided under one or more insurance policies issued by the insurance company(ies) identified in the Contact Information Sheet. If there is ever a conflict between these FAQs and the insurance policies, the insurance policies will always govern.

General Information FAQs

Q1: Are there special rules for "team" employees under the Benefit Programs?

A1: Yes. If you and your spouse/qualified domestic partner are both United employees, you are referred to as a "team" and special eligibility and coverage provisions apply to you under the Medical and Dental programs. Contact the UABC for more information.

Q2: Are there special rules relating to coverage of a child under a Qualified Medical Child Support Order ("QMCSO")?

A2: Yes. If you are enrolled in an HMO Option and/or DHMO Option and a QMCSO requires the medical program and/or dental program to provide coverage to a child who lives outside of the provider's service area, then your membership in the HMO may be terminated and you may be required to elect a coverage option that covers the area where the child lives. Contact the UABC for more information.

Q3: What should I do if I become eligible for Medicare while I am covered under the Plan?

A3: Under current law, you and your dependents generally become eligible for Medicare at age 65 (or earlier for certain qualifying disabilities and in other special cases). Special coordination rules may apply which limit your benefits under the Plan. Please notify the UABC once you start Medicare benefits.

Q4: I am a domestic employee on international assignment. Are there alternative coverage options that apply to me?

A4: Yes. Those plans which are available to you are outlined on Your Benefits Resources (YBR) during Annual Enrollment. You can contact the UABC for additional information, including if your international assignment begins mid-year and you wish to change your benefit elections for the remainder of the year.

Q5: I am a union employee. A provision in my Collective Bargaining Agreement (CBA) is not described in the SPD that I received. Does it still apply?

A5: Yes. Due to variations between collectively bargained workgroups, the SPDs cannot cover all workgroup specific rules. The provisions of your Collective Bargaining Agreement apply even if not mentioned in the SPD that you received.

Medical Program FAQs

Q1: What are some key terms that I should keep in mind as I evaluate my coverage options under the Medical Program?

A1: You should remember the following key terms

- **"Health care deductible": Refers to the amount of covered expenses that you must pay each plan year before the Plan pays anything.** Your deductible varies depending on the coverage option that you are enrolled in. Full details for all coverage options you are eligible for, including deductible amounts, are available on YBR during Annual Enrollment. There are two types of health care deductibles if you are enrolled in a family plan: embedded and aggregate.
    - In an embedded deductible, co-insurance begins for the individual when the individual deductible is met. When two individual deductibles are met, the family deductible is satisfied. This plan design applies to the following plans with Blue Cross Blue Shield or Aetna: $350 PPO, $750 PPO, $1,250 PPO, Traditional PPO, Bronze EPO, Core EPO, Core PPO, and Build Your Own EPO Options.
    - In an aggregate deductible, one deductible applies to all covered family members. Once the combined expenses for any family members meet the deductible, the deductible is met. The aggregate deductible plan design applies to the Healthy Rewards PPO, Core HDHP, and Healthy Advantage HSA plans.
        - Note: The Healthy Advantage HSA plan has an aggregate deductible, but an embedded out-of-pocket max. In this instance, when an individual meets the individual out-of-pocket max, then the plan will pay 100% of the covered expenses for just that one person for the remainder of the year. When two individuals meet the individual out-of-pocket max, the family out-of-pocket max is met.
- **"Coinsurance": Refers to the percentage of covered expenses the Plan will pay after you have satisfied the individual or family deductible, as applicable.** The coinsurance percentage varies by coverage option, and can also vary depending on whether you receive services from a provider in the EPO or PPO network or outside of the EPO or PPO network. The applicable coinsurance percentages are

provided in the SPD Addendum.

- **"Copayment or Co-pay": Refers to the flat fee charged at the time a covered individual receives medical services,** such as office visits (including all services performed in the office during an office visit) and prescription medications. Often, any service which is covered by a copayment will not be subject to a medical deductible. Exact plan design and co-pay amounts vary by coverage option.
- **"Out-of-pocket maximum": Refers to the maximum amount you must pay towards your covered expenses for the year (including your deductible and coinsurance).** There are two types of out-of-pocket limits that may apply: an individual out-of-pocket limit and a family out-of-pocket limit. Once you reach your individual out-of-pocket limit, the Plan generally pays 100% of the amount of most covered expenses for the remainder of the year. In a family plan, just like with your deductible, your out-of-pocket maximum can be either embedded or aggregate.
    - With an embedded out-of-pocket maximum, when an individual meets the individual out-of-pocket maximum, the plan will pay 100% of the covered expenses for just that one person the rest of the year. Once two individuals reach the individual out-of-pocket maximum, the family out-of-pocket maximum is satisfied. This plan design applies to the following plans with Blue Cross Blue Shield or Aetna: $350 PPO, $750 PPO, $1,250 PPO, Traditional PPO, Bronze EPO, Core EPO, Core PPO, Healthy Advantage HSA, and Build Your Own EPO Options.
    - An aggregate out-of-pocket maximum is when one out-of-pocket maximum applies to all covered family members. Once combined expenses reach the out-of-pocket maximum, the plan will pay 100% of the covered expenses for all covered family members for the rest of the year. The aggregate out-of-pocket maximum plan design applies to the Healthy Rewards PPO and Core HDHP.

Prescription Drug FAQs

Q1: Who should I contact if I have questions regarding my prescription drug coverage?

A1: Your prescription drug coverage varies depending upon which medical coverage option you are enrolled in. If enrolled in one of the following medical plans through Blue Cross Blue Shield or Aetna, your pharmacy coverage is through CVS/caremark: $350 PPO, $750 PPO, $1,250 PPO, Traditional PPO, Bronze EPO, Core EPO, Core PPO, Core HDHP, Healthy Advantage HSA, Healthy Rewards PPO, and Build Your Own EPO Options.

If enrolled in any other medical plan with United, contact your medical carrier directly to determine who administers the pharmacy benefits for your medical plan. The Contact Information Sheet on Your Benefits Resources (YBR) includes contact information for your specific medical carrier.

Dental Program FAQs

Q1: How do I submit a claim for reimbursement of covered dental expenses?

A1: Your dental claims administrator varies depending upon which dental coverage option you are enrolled in. In most cases, your dentist will electronically submit your dental claim on your behalf. If the dentist does not submit a claim on your behalf, you may request a dental claim form from the applicable claims administrator listed below. All relevant sections of the claim form must be filled out completely by you. Your dental claims administrator will advise you of any additional information needed to complete the claim.

If your benefits under the Dental Program are considered secondary to other dental coverage that you have (e.g., through your spouse or domestic partner's coverage), you must submit the "Explanation of Benefits" or other statement from the primary plan along with the itemized bill.

U.S. benefits claim: A claim for U.S. dental benefits must be sent to the applicable claims administrator at:

Dental PPO Plan:

MetLife Dental Claims

PO Box 981282

El Paso, TX

79998-1282

888-UAL-DENT (825-3368) or www.metlife.com/mybenefits

Dental DHMO Plan:

Aetna

800-843-3661 or www.aetnavigator.com

Cigna

800-244-6224 or www.myCigna.com (frozen to current CO enrolled participants only)

International claims: A claim for international dental benefits must be sent to the designated claims administrator. Contact the UABC for more information.

Q2: How can I locate a MetLife in-network dentist?

A2: Significant claim savings are available to you by using a MetLife PDP network dentist. Negotiated fees typically range from 15-45% less than the average charges in a dentist's community for similar services. Login to your account at www.metlife.com/mybenefits and use the "Find a Dentist" link or call 888-UAL-DENT (825-3368) to receive a list.

If searching the internet without logging in, please note that only the "PDP" network dentists for MetLife are considered in-network under United's Dental Program. A dentist's statement that he/she accepts MetLife dental insurance does not mean he/she is considered in-network under United's Dental Program.

Q3: What is a "pretreatment estimate" and when should I request one?

A3: A "pretreatment estimate" is a request by you or your dentist for your insurer to provide an estimate of how much the Plan will pay in benefits that you may obtain before you get dental care. This is not the same as an estimate that your dentist may give you. Your general dentist or specialist sends MetLife a plan for your care and asks for an estimate of benefits. Although you may request a pretreatment estimate for any services, we particularly recommend that you or your dentist request a pretreatment estimate for any service or combination of services your dentists estimates will cost at least $300. This often applies to services such as crowns, bridges, inlays and periodontics.

To get an estimate, simply ask your dentist to submit a request online at www.metlife.com or call 877-MET-DDS9 (638-3379). You and/or your dentist will receive a benefit estimate - online and by mail - detailing what the plan will cover. Actual payments may vary depending upon plan maximums, deductibles, frequency limits, and other conditions at time of payment.

Vision Program FAQs

Q1: How do I submit a claim for vision benefits?

A1: To request a vision claim reimbursement form, please contact the applicable claims administrator listed below. All relevant sections of the claim form must be filled out completely by you.

Vision Care Options

Vision Service Plan (VSP)

800-877-7195 or www.vsp.com

Superior Vision

800- 507-3800 or www.superiorvision.com

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Flexible Spending Programs FAQs

Q1: How do I request a claim form for Flexible Spending Account (FSA) reimbursements?

A1: To request or submit a claim form for your FSA, please contact your claims administrator, Your Spending Account (YSA), online or by phone.

Access YSA online through *Flying Together: Flying Together > Employee Services > Health and Insurance (YBR) > Your Spending Accounts*.

Access YSA by phone by calling the UABC at 800-651-1007.

Q2: Does the IRS limit my annual contributions to the Healthcare FSA?

A2: Yes. Each year, the IRS evaluates the contribution limits for the Healthcare FSA. For 2018, the annual contribution limit for the Healthcare FSA is $2,650.

Q3: What are the general tax considerations regarding expense reimbursements under the Health Care FSA?

A3: If you have health care expenses that are tax deductible, keep in mind that if you receive reimbursement for such health care expenses under the Health Care FSA, you may not take a tax deduction for the same items on your income tax return.

Q4: What are the general tax considerations regarding expense reimbursements under the Dependent Care FSA?

A4: A percentage of eligible dependent care expenses can be claimed as a tax credit on your federal tax return. However, dependent care expenses reimbursed from your Dependent Care FSA are not available for tax credit on your income tax return. If you pay expenses through the Dependent Care FSA, you save not only federal income taxes but state and local income taxes (in most areas) and Social Security taxes (if you are below the wage base) as well. Reimbursements (in the year paid) from the Dependent Care FSA are tax-free unless they exceed your earned income or, if less, your spouse's

earned income for that year. (For this purpose, earned income is defined as taxable wages and other compensation). Whether it is more advantageous to use the Dependent Care FSA depends on your income level and on the amount of your dependent care expenses. If you want to claim a tax credit for your eligible dependent care expenses, you must obtain and report on your federal income tax return your care provider's name, address, and taxpayer identification number and the amount of dependent care benefits you received from the Dependent Care FSA.

Q5: How do I determine whether an expense is covered under the Dependent Care FSA?

A5: To determine if an expense is covered under the Dependent Care FSA, reference Your Benefits Resources (YBR), or reach out to YSA directly. There is a full listing of eligible expenses available on YBR under the "Explore your plan options" tile.