Health Care Benefits Summary Plan Description

For Salaried Employees and Same as Salaried Bargaining Employees of Alcoa USA Corporation

Effective January 1, 2021

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PLAN OVERVIEW

Alcoa USA's health care program is designed to offer medical, prescription drug, dental and vision benefits, and to protect you from catastrophic health care bills.

There are two medical options (each includes prescription drug coverage), one dental option and one vision option. When you and any eligible dependents enroll in medical coverage, you automatically are enrolled for prescription drug coverage. If you elect to opt out of medical/prescription drug coverage, you may still enroll for dental and/or vision benefits.

This booklet provides information about medical, prescription drug, dental and vision benefits available to you.

Who Is Eligible

You are eligible for Alcoa USA's health care benefits if you are an active full-time or part-time salaried employee or an employee covered by a collective bargaining contract with the International Brotherhood of Electrical Workers (IBEW).

The following are **not** eligible: temporary, agency, leased or contract employees, and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

Dependents eligible for coverage under the plan include the following. Proof of dependent eligibility is required (see "Proof of Dependent Eligibility").

- Your legal spouse of the same or opposite gender (as determined by federal law) or domestic partner (see "Coverage for a Domestic Partner");
- Your children under age 26; and
- Your unmarried child over age 26 who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous and who is principally supported by you.

"Principally supported by you" means that the child:

- Is dependent on you for more than one-half of his or her support, as defined by the U.S. Internal Revenue Code; and

- Was reported as a dependent on your most recent federal income tax return.

In addition, a spouse or domestic partner who lives outside the U.S., Canada or Mexico cannot be covered as your dependent, unless he or she lives with you.

For purposes of the plan, children include:

- Your biological children;
- Legally adopted children (including children living with you
- Stepchildren;
- The children of a certified domestic partner;
- A child for whom you are the legal guardian;
- A grandchild, defined as any child born to your son or daughter while he or she is covered under the plan; provided they are principally supported by you as defined above; and
- Eligible children for whom coverage by the employee is required by a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

If your dependent no longer meets these eligibility requirements, you must call 1-844-31ALCOA (1-844-312-5262) to report the status change (see “Status Changes”).

Proof of Dependent Eligibility

You must provide proof that your dependent is eligible for coverage under the plan. Such proof is required when you enroll a new dependent for coverage under the plan or report a change in a dependent child’s status, such as disability status.

From time to time, you also may be required to verify that your dependent(s) are still eligible for coverage. You will receive a notice describing the documents that you must submit to prove your dependent’s eligibility for coverage. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated period. If you fail to do so, coverage for your dependent will end retroactive to the date specified in the notice. For a complete list of required documentation, call 1-844-31ALCOA (1-844-312-5262) or go to the UPoint website.

Coverage for a Domestic Partner

When you enroll a domestic partner, you will be required to provide proof that your partner meets the Company's eligibility guidelines. You will need to submit a Declaration of Domestic Partner Affidavit and proof that you satisfy certain conditions, which includes, but is not limited to:

- Documentation that proves that your relationship has existed for at least 12 months and that you and your partner are financially interdependent;
- Documentation showing that you both reside at the same address; and
- Two other forms of proof, such as a lease or deed in the names of both parties which describes the parties as joint tenants or tenants by the entirety or proof of a joint checking, savings or credit card account.

For a complete list of required documentation, call 1-844-31ALCOA (1-844-312-5262) or go to the UPoint website.

Under current law, you are required to be taxed on health benefits provided to a domestic partner who does not qualify as a dependent under Internal Revenue Code Section 152(d). Because it is administratively difficult to determine if your domestic partner qualifies as a dependent under the Code, Alcoa USA will treat all domestic partner benefits the same regarding tax. The value of a domestic partner's coverage will be taxable to you and treated as "imputed income." This will also apply to coverage provided to the children of a domestic partner. Imputed income is the term that the IRS applies to the value of any benefit or service that is considered income for the purposes of calculating your federal taxes. The full value of coverage will be included in your pay as taxable wages (even though you do not receive the cash) and will appear as a separate line item on your pay stub. Also, federal income tax, FICA, state and other applicable payroll taxes will be withheld. The additional taxable income will not be included when calculating other benefits, such as pension and savings plans. Consult with your tax advisor if you have questions regarding your specific tax situation.

Who Pays the Cost

You and the Company share the cost of your health care benefits. You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. You may receive credits and/or cash incentives as described in this section.

Credits or Cash Incentives

You can receive credits or cash incentives based on your participation in and/or your completion of wellness-related programs:

- **Credits**—Any credits you receive may be used to help pay for pre-tax benefit coverage that you elect during enrollment; you will receive remaining credits, if any, as taxable cash in your pay throughout the year.
- **Cash Incentives**—Any cash incentives you receive will be paid to you as taxable cash.

Your enrollment materials will provide details on the credit and/or cash incentives that you may be eligible for and will provide program participation and completion requirements.

Working Spouse Contribution

If you elect to cover your spouse or domestic partner under the Alcoa medical plan, you will pay an additional monthly pre-tax contribution. The monthly contribution is $100 in 2021, but, subject to change in future years.

The contribution will not apply if your spouse/domestic partner is:

- not employed, or
- employed but not eligible for or offered medical coverage through their employer, or
- an Alcoa employee

During enrollment, when you elect to cover your spouse/domestic partner under the medical plan, you will be asked to verify that your spouse/domestic partner meets one of these three criteria and if they do not, you will pay the contribution. If you do not make an active election, but cover your spouse, you will pay the contribution. Your domestic partner is eligible to be covered by the plan when you submit a signed Declaration of Domestic Partnership Affidavit and other documentation that proves cohabitation and financial interdependence. Additional information is on UPoint.

Tobacco Free-Credits

Employee Tobacco-Free Credit

Employees who enroll in medical and prescription drug coverage may qualify for a tobacco-free credit. The amount of the credit may vary from year-to-year and will be referenced in your enrollment materials. In order to qualify for the tobacco-free credit, an employee must declare that he or she is tobacco-free.

"Tobacco-Free" means that you do not use tobacco in any form—cigarettes, e-cigarettes, cigars, pipes, snuff or chewing tobacco. To be considered a non-tobacco user and eligible for the tobacco-free credit you must:

- Not have used any type of tobacco product for a period of 30 days before the date you elect medical/prescription drug coverage (or for a period of 30 days before the date that you apply during the year for the credit); and
- Pledge to remain tobacco-free.

Using tobacco on one occasion is considered using tobacco. If you have done this within 30 days of enrollment, you will not be eligible for the tobacco-free credit.

If it is unreasonably difficult (due to a medical condition) or medically inadvisable for you to stop using tobacco products, you may still qualify for the tobacco-free credit by having your physician complete a Tobacco Use Certification Form, which is available by calling 1-844-31ALCOA (1-844-312-5262).

Providing false information related to the tobacco-free credit could result in disciplinary action up to and including termination.

Dependent Tobacco-Free Credit

If you enroll your dependent(s) in medical and prescription drug benefits, and you declare that all of your covered dependents are tobacco free, a credit separate from the Employee Tobacco-Free Credit will be available to offset the cost of your Company-provided medical/prescription drug benefits. The credit is the same regardless of how many dependents you enroll—as long as they are all tobacco-free. The amount of the credit may vary from year-to-year and will be referenced in your enrollment materials.

Your dependents are eligible for this credit even if you are not eligible for the Employee Tobacco-Free Credit (you use tobacco but your dependents do not). See your enrollment materials for more information about tobacco-free credits.

If it is unreasonably difficult (due to a medical condition) or medically inadvisable for your dependent to stop using tobacco products, your dependent may still qualify for the tobacco-free credit by having the physician complete a Tobacco Use Certification Form, which is available by calling 1-844-31ALCOA (1-844-312-5262).

Providing false information about your dependent related to the tobacco-free credit could result in disciplinary action up to and including your termination.

Coverage Categories

The following coverage categories are available for health care benefits:

- You only;
- You + spouse or domestic partner;
- You + dependent child(ren); and
- You + family (you + spouse or domestic partner + dependent children).
- You must elect coverage for yourself in order to cover your eligible dependents.

Enrollment

New Hire Enrollment

As a newly eligible employee, you receive information and instructions about how to enroll for your benefits through the UPoint website or by calling 1-844-31ALCOA (1-844-312-5262). You must make your initial enrollment election by the deadline shown in your enrollment materials. Your elections remain in effect until December 31 of that year, unless you have a status change as described under "Changing Your Coverage". After that, you will enroll during annual enrollment.

Annual Enrollment

Each year during annual enrollment, you must enroll for health care coverage for the upcoming year, as described in your enrollment materials. This rule applies even if you are not actively at work during annual enrollment. The elections you make will take effect on January 1 and stay in effect through December 31, unless you have a status change as described under "Changing Your Coverage".

If You Opt Out of Coverage or Do Not Enroll

If you opt out of medical/prescription drug coverage, you will not be covered under the plan for the upcoming year. However, you remain eligible to enroll in other benefits, such as dental, vision, disability, life insurance, etc.

If you fail to enroll for coverage by the deadline, you and your eligible dependents will be assigned coverage as described in the enrollment materials.

If you decide to opt out or if you fail to enroll for coverage, you will not be able to change your coverage until the next annual enrollment, unless you have a status change as described under "Changing Your Coverage".

If you are a retiree and covered under Alcoa's retiree medical plan and you opt out of Alcoa sponsored coverage, you will not be permitted back into the coverage at any time in the future.

Enrolling New Dependents

If you have a newly eligible dependent (due to marriage, birth, adoption, etc.), you may enroll him or her for coverage under the plan by calling 1-844-31ALCOA (1-844-312-5262) or via the UPoint website. For coverage to begin on the date a new dependent first became eligible, you must enroll him or her in the plan within 31 days of that date (see “When Coverage Begins” for more information). For a newborn, you must enroll him or her for coverage under the plan within 31 days after the date of birth. If you fail to do so, any charges incurred after this 31-day period will not be covered, and coverage will not become effective until the enrollment is processed.

You are required to submit proof of your new dependent’s eligibility for coverage under the plan (see “Proof of Dependent Eligibility”). You will receive a notice describing the documents that you must submit to prove your dependent’s eligibility. If you fail to submit the required proof within the designated 45-day period, coverage for your dependent will end retroactive to the date specified in the notice. If you submit the required proof after this 45-day period, coverage for your dependent will begin on the date the documentation is approved and the enrollment is processed. If your new dependent is your domestic partner, he or she can be enrolled at any time during the year, if he or she meets the eligibility requirements.

HMO Enrollment

Instead of the plan, you may choose an HMO if one is offered at your location. Each year, your enrollment materials will list any available HMOs. You enroll in the HMO through the Company, but information about HMO coverage is provided by the HMO.

If you elect an HMO, your medical and prescription drug coverage is provided through the HMO. However, you are eligible to elect other types of coverage, such as dental and vision, offered under the plan.

If You Are Married to Another Company Employee/Retiree

If your spouse is a Company employee or a Company retiree who is eligible for the Company’s health care benefits, the following rules apply for your enrollment.

- Each of you may elect your own coverage, based on your eligibility for benefits, but only one of you may cover eligible dependent children; or
- One of you may enroll as a dependent under the other’s coverage, as long as the person enrolling as a dependent is eligible to opt out of his or her own plan. If you choose to be covered as a dependent, you still must make individual elections for other benefits, such as disability and life insurance.

You may not be covered as both an employee and a dependent through the Company.

If Your Domestic Partner Is Another Company Employee

If your domestic partner is a Company employee who is eligible for the Company's health care benefits, the same rules presented above apply. Because of special tax rules, before enrolling for domestic partner coverage, you may want to consult a tax advisor.

When Coverage Begins

For You

Your health care coverage begins on the first day you are actively at work. If your location has a probationary period that impacts these benefits, coverage will begin upon successful completion of the probationary period. However, a probationary period can be no longer than 90 calendar days.

For Your Dependents

If you enroll eligible dependents within 31 days of your initial eligibility, their coverage starts at the same time as yours.

Coverage for new eligible dependents will begin on the date they became a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you wait longer than 31 days, coverage will begin on the date the enrollment is processed. You are required to provide proof that your dependent is eligible for coverage under the plan (see "Proof of Dependent Eligibility").

If your new dependent is your domestic partner, he or she can be enrolled at any time during the year, if he or she meets the eligibility requirements.

Changing Your Coverage

You may change the dependents covered under the plan only under the following circumstances:

- Once a year during annual enrollment; or
- Within 31 days of a status change, as described below, or on the date your enrollment is processed if the change is made after 31 days. If you do not have a status change, you must wait until annual enrollment to make any coverage changes.

Status Changes

If you experience a change in certain family or employment circumstances, that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual enrollment period. Any changes must be consistent with the status change.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- Your marriage;
- The birth, adoption or placement for adoption of a child;
- Your divorce, annulment or legal separation;
- A change in a dependent child's eligibility due to age or marital status;
- Your death or the death of your spouse/domestic partner or other eligible dependent;
- A change in employment status for you or your spouse or domestic partner that affects benefits (including termination or commencement of employment, strike or lockout or commencement of or return from an unpaid leave of absence);
- A change in your Company work location or home address that changes your overall benefit options and/or prices;
- A significant change in coverage or the cost of coverage;
- A reduction or loss of your or a dependent's coverage under this or another plan; or
- A court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 31 days, after the event occurs. You also must report any change in your domestic partner relationship within 31 days. To report a status change, call 1-844-31ALCOA (1-844-312-5262).

In addition, if you or an eligible dependent loses health care coverage under Medicaid or the Children's Health Insurance Program (CHIP) or if you become eligible for premium assistance under Medicaid or CHIP, you and/or your eligible dependent may enroll in the health care plan. To change coverage, you must call 1-844-31ALCOA (1-844-312-5262) within 60 days of the event.

For changes due to your marriage or divorce or the birth or adoption of a child, you may go to the UPoint website to report the change.

Coverage While Not at Work

In certain situations, health care coverage may continue for you and/or your dependents when you are not at work. This benefit extension begins at the end of the last day you are actively at work and ends based on your status as described in the following sections. The benefit extension period is considered part of any COBRA coverage for which you may be eligible and runs concurrently with COBRA.

During the benefit extension period, your cost for this coverage is the same as it was as an active employee, but it is paid on an after-tax basis. You will be billed directly for payment. You must pay the entire amount due for your health care coverage (including medical, prescription drug, dental, vision, and optional life insurance) on the date payment is due. If you fail to do so, all of your health care coverage will end on the last day of the month for which full payment is made.

If you do not return to work for the Company at the end of the benefit extension period, you may be eligible to continue coverage under COBRA by paying the full cost for health care coverage under COBRA plus an administrative fee of two percent.

For information about COBRA coverage and how benefit extensions work with COBRA, see “Continuing Health Care Coverage through COBRA”.

If You Are Laid Off or Permanently Separated

If you are laid off or permanently separated, your health care coverage may continue as determined by your location’s benefit extension policy.

If You Are Disabled

If you are eligible to receive short-term disability (STD) benefits, you may continue health care coverage for up to six months. When the initial six-month disability period ends, if you are eligible to receive long-term disability (LTD) or workers’ compensation benefits, you may continue health care coverage under the benefit extension for an additional 18 months, up to a maximum of 24 months.

If you are not eligible for long-term disability (LTD) or workers' compensation benefits, you may continue health care coverage through COBRA (see "Continuing Health Care Coverage through COBRA").

If You Take a Personal or Educational Leave of Absence

If you take an approved personal or educational leave of absence, health care coverage may continue for at least 31 days, starting on the date your leave begins and ending on the 31st day or at the end of the month in which the 31st day occurs, if later.

If you take an approved leave under the Family and Medical Leave Act (FMLA), coverage may continue during the leave. See the Work & Personal Life Benefit Programs booklet for information about FMLA.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins. For the first 12 months, you will be covered under the active employee plan and you will pay the same rate as an active employee pays for coverage, but it is paid on an after-tax basis. For the next 12 months, you will be covered under COBRA and will pay the full premium rate plus a two percent administrative fee for coverage.

If the benefit provided by your location is greater than the initial 12-month period described above, your coverage may continue for the greater period at the same rate as an active employee pays. For the remaining months, up to a maximum of 24, you will be covered under COBRA and you will pay the full premium rate plus a two percent administrative fee. You will be notified if this situation applies to you.

If You Die

If you die while you are a covered employee, health care coverage for your surviving spouse or domestic partner and/or dependent children may continue under the employee plan at the active employee rate for up to six months after your death. After this six-month period ends, your eligible dependents may elect COBRA coverage (see "Continuing Health Care Coverage through COBRA"). A domestic partner is not entitled to COBRA coverage under current law. However, he or she may be eligible to continue coverage under the plan (see "Continuing Coverage for a Domestic Partner").

However, if you are a covered employee, vested in the Alcoa retirement plan (Pension Plan for Certain Salaried Employees of Alcoa USA Corp and or Pension Plan for Certain Hourly Employees of Alcoa USA Corp) and hired prior to January 1, 2002, and you and your spouse were married at least one year prior to your death, your spouse may be offered retire healthcare if it is available.

If retiree health care is not offered, your eligible surviving spouse and dependents may elect COBRA coverage.) as described above.

If You Retire

If you were hired prior to January 1, 2002, and are eligible for retiree medical because you are eligible for an immediate pension (not including a lump sum distribution), then you are eligible for access to healthcare coverage that Alcoa provides, but beginning January 1, 2021, Alcoa will not contribute to the cost of coverage. If you are Pre-Medicare upon retirement, you will be offered healthcare coverage that is the same as active employees, except that Alcoa will not contribute to any portion of coverage, including the Health Savings Account. If you are Medicare eligible, you will be provided information about purchasing individual coverage on a Medicare Exchange.

If you opt out of healthcare coverage when you are first eligible (including first eligible following a period of coverage under COBRA), you will not be able to enroll in the future.

When Coverage Ends

Your health care coverage ends on your last day of active work, unless you are laid off or permanently separated, disabled, take a leave of absence or you retire and you are not eligible for retiree medical coverage. You are not eligible for retiree medical coverage if your hire date is after December 31, 2001. Additionally, beginning on January 1, 2021, Alcoa will not provide any contribution to the cost of retiree coverage, regardless of the date you retire.

Coverage for your spouse or domestic partner and dependent child(ren) ends when your coverage ends or when the spouse, domestic partner and/or child is no longer eligible. For a dependent child, coverage ends on the last day of the month in which the child reaches age 26; coverage for an unmarried child over age 26 who is not capable of self-support due to a physical or mental disability may be able to continue (see “Eligible Dependents”). In the event of your death, spouse, domestic partner and/or dependent child coverage may continue, as described under “Coverage While Not at Work

MEDICAL BENEFITS

How the Plan Works

The plan offers two medical options (as described below) for you and your eligible dependents; each option:

- Covers the same services;
- Includes the same prescription drug plan. When you enroll yourself and your eligible dependents in one of the medical options, you automatically are enrolled for prescription drug coverage;
- Has different deductibles, coinsurance amounts and annual out-of-pocket maximums; and
- Has different payroll contributions as shown in your enrollment materials.

The medical options are as follows.

- **PPO**—This option offers coverage without a deductible for routine in-network preventive care and office visits.

- **High Deductible Health Plan, or HDHP**—In addition to medical coverage, this option provides a Health Savings Account to which both you and the Company may contribute, providing that you meet government requirements.

Any contributions into the account are yours, and they are controlled by you. If you ever leave the Company, you take the entire account—whether contributed by the Company or you—with you. Also, under this option, both your medical and prescription drug expenses apply toward your deductible, and an integrated out-of-pocket maximum.

You must meet your annual deductible before the plan starts to pay any medical or prescription drug expenses. If you cover two or more people, the employee-only deductible and out-of-pocket maximum work differently. There is an embedded individual out-of-pocket maximum within the family out-of-pocket maximum. This means that if one individual covered within a family plan meets the maximum out-of-pocket expenses as determined annually by the IRS, then their claims will be covered at 100% for the remainder of the plan year, even if the combined family out-of-pocket maximum has not been reached (see "Health Savings Account (HSA) under the HDHP Medical Option").

The charts at the end of this section show detailed information about each of these options. Always refer to the summary charts on UPoint for information on your healthcare and other benefits.

Instead of one of the above options, you may select an HMO if offered at your location. Each year, your enrollment materials will list any available HMOs. You enroll in the HMO through the Company, but information about HMO coverage is provided by the HMO. In addition, coverage is determined by the HMO.

Preferred Provider Organization (PPO) and HDHP

Under both plan options, your medical benefits are delivered through a Preferred Provider Organization (PPO). A PPO is a type of managed care plan in which a network of participating doctors, hospitals, laboratories, home health care agencies and other health care providers have agreed to provide services for a negotiated fee.

When you enroll in a PPO, you are not required to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist.
A PPO gives you the flexibility to choose providers inside or outside the network each time you need care.

If you use in-network providers, the plan pays a higher percentage of covered expenses (after you meet any applicable deductible) and there are no claim forms to complete. For a list of in-network providers, contact the appropriate claim administrator at the telephone number or website shown on your medical ID card. We encourage you to check whether a provider is in-network whenever you use a new provider.

If you receive in-network services and an ancillary part of the services are provided by an out-of-network provider without your knowledge, such services will be paid at the in-network benefit level. For example, if you have an operation performed by an in-network surgeon at an in-network hospital and the anesthesiologist selected by the surgeon is not an in-network provider, the anesthesiologist charge will be payable at the in-network benefit level.

If you use out-of-network providers, the plan pays a lower percentage of covered expenses (after you meet the applicable deductible), up to the reasonable and customary (R&C) limit. You are responsible for charges in excess of the R&C limit and this excess amount does not apply to your deductible or out-of-pocket maximum. You also pay a higher deductible and out-of-pocket maximum and must file claim forms to be reimbursed for covered expenses. **Please note that you may incur significantly greater financial responsibility for the use of an out-of-network provider than you would have incurred if you had used an in-network provider for the same service.**

The same medical services, except for certain preventive care benefits, are covered whether you use in-network or out-of-network providers (see "Covered Medical Expenses").

Your Deductible

A deductible is money you must pay for covered expenses before the plan pays benefits. The amount of your deductible depends on which medical option you choose and whether you use in-network or out-of-network providers. Under the PPO option, there is a separate individual and family medical deductible and a separate prescription drug deductible. Under the HDHP option, the deductibles for medical and prescription drug expenses are combined. If you enroll two or more people in HDHP, you must meet this combined deductible before the plan starts to pay for eligible medical and prescription drug expenses. Deductibles for each option are shown in the following charts.

Your medical deductible does not include:

- Any coinsurance you pay;
- Amounts in excess of reasonable and customary (R&C) limits;
- Any prescription drug plan (unless you enroll in the HDHP option), dental plan and vision plan expenses; and
- Any expenses not covered under the plan.

If you use both in-network and out-of-network providers, your expenses are subject to separate deductibles—the in-network deductible and the out-of-network deductible. In addition, in-network expenses do not apply toward the out-of-network deductible and out-of-network expenses do not apply toward the in-network deductible.

Inpatient Facility Deductible per Admission

The inpatient facility deductible per admission is the additional amount of deductible expense you must pay for medically necessary and appropriate health care you receive during an admission to a facility. The inpatient facility deductible must be met before the program begins to pay all or part of the remaining expenses. This inpatient facility deductible amount may not be applied toward the satisfaction of any other deductible required by your program. However, any inpatient facility deductible amounts paid will apply to the satisfaction of your annual out-of-pocket maximum.

The inpatient facility deductible per admission will apply to confinements in a hospital, rehabilitation facility, psychiatric hospital facility, skilled nursing facility, hospice facility, birthing center or substance abuse treatment facility. A new inpatient facility deductible will be taken for each covered admission; however, confinements separated by less than 30 days may not require that more than one inpatient deductible be satisfied.

The amount of your inpatient facility deductible per admission is specified in the "Medical Options under the Plan" chart.

Your Coinsurance

Once you meet your deductible, the plan pays a certain portion of covered medical expenses and you are responsible to pay a portion. The portion you must pay is a coinsurance. Coinsurance amounts are shown in the following charts.

Coinsurance Levels

For the PPO medical options, the coinsurance amount for a provider and/or service depends on the type of provider you see, where you receive services and how you are billed for these services; this difference does not apply to the HDHP option. The following charts show the following coinsurance levels for each medical option:

PCP Office Care—Services performed by a primary care physician (PCP) in his or her office and billed through that office. A PCP is defined as a family practitioner, general practitioner, internist or pediatrician.

Specialist's Office/Emergency Room Care—Services performed by any other physician or health care provider (for example, a cardiologist, allergist, gynecologist or physical therapist) in his or her office or in an emergency room and billed through that facility.

Other Services—A partial list of services includes hospitalization and durable medical equipment. It also includes surgery, laboratory services and X-rays, if these services are not performed in or billed by a PCP's or specialist's office. If you have a question about a covered service or need more information, call your medical claim administrator at the number on your medical ID card.

Your Out-of-Pocket Maximums under the PPO Medical Option

The PPO medical option has separate out-of-pocket maximums for medical and prescription drug expenses. The medical out-of-pocket maximum (see below) applies to covered medical expenses and the prescription drug out-of-pocket maximum applies to covered prescription drug expenses. The medical out-of-pocket maximum limits the amount you pay each year for covered medical expenses. When your share of covered medical expenses (including your deductible and coinsurance amounts) reaches the medical out-of-pocket maximum, the plan pays 100% of your covered medical expenses for the rest of the calendar year. There are separate individual and family out-of-pocket maximums, as shown in the following charts.

The medical out-of-pocket maximum for the family can be met when covered medical services are used by multiple members, even when no single family member meets the per-person maximum. Also, when the family meets the medical out-of-pocket maximum for covered medical services provided to two or more individuals, there is no need for each covered person in the family to meet the individual medical out-of-pocket maximum.

The medical out-of-pocket maximum does not include:

- Prescription drug plan (unless you enroll in the HDHP option), dental plan and vision plan expenses;
- Amounts in excess of the reasonable and customary (R&C) limit (see details in the following section); and
- Expenses not covered under the plan.

If you use both in-network and out-of-network providers under the PPO option, your covered expenses are subject to separate out-of-pocket maximums—the in-network maximum and the out-of-network maximum. In addition, in-network expenses do not apply toward the out-of-network maximum and out-of-network expenses do not apply toward the in-network maximum.

Your Out-of-Pocket Maximum under the HDHP Medical Option

Under the HDHP option, covered out-of-pocket expenses for both medical and prescription drug are combined toward one integrated out-of-pocket maximum. Once you reach the HDHP out-of-pocket maximum, the plan pays 100% of your covered medical and prescription drug expenses for the rest of the calendar year.

If you cover two or more people under the HDHP option, the annual out-of-pocket maximum works differently. An individual covered within a family plan can meet an embedded out-of-pocket maximum (for 2018, this amount is $7,350, however this amount is indexed annually) and the plan will begin paying at 100% for that individual. Once other members of the family meet the remainder of the total family out-of-pocket maximum, then the plan will begin to pay at 100% for all family members.

The HDHP out-of-pocket maximum does not include:

- Dental plan and vision plan expenses;
- Amounts in excess of the reasonable and customary (R&C) limit (see next page);
- Any amounts that do not apply to the prescription drug Maximum Coinsurance Amount;
- Drugs purchased at out-of-network pharmacies; and
- Expenses not covered under the medical plan and/or prescription drug plan.

If you use both in-network and out-of-network providers, your covered expenses are subject to separate out-of-pocket maximums—the in-network maximum and the out-of-network maximum. In addition, in-network expenses do not apply toward the out-of-network maximum and out-of-network expenses do not apply toward the in-network maximum.

Maximum Plan Benefits

There are no annual or lifetime maximums for medical benefits under the plan.

Reasonable and Customary (R&C) Limit

If you use out-of-network providers, covered medical expenses are subject to the R&C limit, and you are responsible for paying any charges above this limit. The R&C limit is the amount determined by the claim administrator to be the prevailing charge for a covered service or supply. **The R&C limit may be significantly lower than amounts covered by the plan for in-network services.** Determination of the prevailing charge by the plan is final and conclusive and is based on the:

- Complexity of the service;

- Range of services provided; and
- Prevailing charge level in the geographic area where the provider is located and other geographic areas with similar medical cost experience.

Covered Medical Expenses

Covered medical expenses are medically necessary services and supplies, as determined by the claim administrator, that are provided by an eligible provider.

Under each medical option, covered expenses are the same but deductibles, coinsurance amounts and out-of-pocket maximums. Charts provided in the following pages show the benefits paid by each option for covered medical expenses.

Medical Benefits Under the Plan		
	PPO	**HDHP**
Annual Health Savings Account Contribution*	Not Applicable	Alcoa provides: $400 employee only $800 two or more people You may contribute the difference between the IRS maximum for that year and the Alcoa contribution.* If you are age 55 or older, you may contribute an additional $1,000*
** Per IRS, total maximum contributions to an HSA are $3,600/$7,200 for 2021, combined for company and employee. Individuals age 55 and older can make up an additional $1,000 in "catch-up" contributions in 2021. This may change annually. ** Under IRS regulations, all covered services must apply to the HDHP deductible. For Teladoc, HDHP participants pay $40 for each visit until deductible is met and $8 each visit after the deductible is met. *** If you cover two or more people under the HDHP option, the annual out-of-pocket maximum works differently. An individual covered within a family plan can meet an embedded out-of-pocket maximum, and the Plan will begin paying at 100% for that individual. Once other members of the family meet the total out-of-pocket maximum, then the Plan will begin to pay at 100% for all family members. For 2019, the individual out-of-pocket maximum within a family is $7,900.*		

In-Network Medical Benefits subject to deductible unless otherwise noted		
	PPO	**HDHP**
Your Annual deductible	$1,000 per person $2,000 per family (Medical only)	$2,000 employee only $4,000 two or more people (Includes Medical and Prescription)
Inpatient Facility Deductible per Admission	$250	Not Applicable
Coinsurance Routine Preventive Care	Plan pays 100%, no deductible	Plan pays 100%, no deductible
Coinsurance PCP Office Visits Specialist Office Visits	Plan pays 70%, no deductible	Plan pays 80%
Coinsurance Emergency Room Care Other Services	Plan pays 70%	Plan pays 80%
Coinsurance Teladoc Consultation	$8 with no deductible	$40 before deductible is met, $8 after deductible is met**

In-Network Medical Benefits
subject to deductible unless otherwise noted

	PPO	**HDHP**
Annual Medical Out-of-Pocket Maximum	$3,000 per person $6,000 per family	$4,250 employee only $8,500 two or more*** (Includes Medical <u>and</u> Prescription)
Annual Prescription Drug Out-of-Pocket Maximum	$3,000 per person $6,000 per family	
Allergy Injections, Serum, Testing and Treatment Performed in and billed by PCP or Specialist's office	Plan pays 70%, no deductible	Plan pays 80%
Ambulance Transportation Only	Plan pays 70%	Plan pays 80%
Ambulatory Surgical Center	Plan pays 70%	Plan pays 80%
Anesthetics, Oxygen, Transfusions Anesthetics/oxygen and its administration; blood transfusions, including the cost of blood/plasma, unless there is no charge because it is replaced through a blood bank or in some other way	Plan pays 70%	Plan pays 80%
Chiropractic Care Services include office exams and spinal manipulations Limit of 30 visits per year per person	Plan pays 70%, no deductible	Plan pays 80%
Diagnostic X-rays and Lab Services Performed in and billed by a PCP or specialist's office	Plan pays 70%, no deductible	Plan pays 80%
Diagnostic X-rays and Lab Services Performed in and billed by an outside laboratory or facility	Plan pays 70%	Plan pays 80%
Doctors' Office Visits PCP and Specialist A PCP is a family practitioner, general practitioner, internist, or pediatrician. A specialist is a physician or other health care provider, other than a PCP, such as cardiologist, gynecologist, or physical therapist	Plan pays 70%, no deductible	Plan pays 80%

In-Network Medical Benefits subject to deductible unless otherwise noted		
	PPO	**HDHP**
Drugs and Medicines administered in a PCP office or a specialist's office (for drugs not administered in an office, see "Prescription Drug Benefits")	Plan pays 70%, no deductible	Plan pays 80%
Drugs and Medicines administered in a healthcare facility (for drugs not administered in a health care facility, see "Prescription Drug Benefits")	Plan pays 70%	Plan pays 80%
Durable Medical Equipment and Prosthetic Devices	Plan pays 70%	Plan pays 80%
Elective Abortion	Plan pays 70%	Plan pays 80%
Emergency Room Visits Medical emergencies and nonmedical emergencies	Plan pays 70%	Plan pays 80%
Hearing Aids Up to calendar limit $500 per ear and $250 per ear for repairs	Plan pays 70% up to calendar limit	Plan pays 80% up to calendar limit
Hemodialysis (subject to precertification if inpatient	Plan pays 70%	Plan pays 80%
Home Health Care/Nursing Subject to precertification	Plan pays 70%	Plan pays 80%
Hospice Care Subject to precertification	Plan pays 70%	Plan pays 80%
Hospital Services, Inpatient	Plan pays 70%	Plan pays 80%
Infertility Diagnosis and Treatment Excludes in-vitro fertilization, other artificial insemination procedures and experimental treatments	Plan pays 70%	Plan pays 80%
Maternity Obstetrician or certified nurse-midwife services for pregnancy, childbirth and pregnancy-related conditions Inpatient hospital services including labor and delivery (hospital stay subject to precertification) Outpatient diagnostic testing	Plan pays 70%	Plan pays 80%

In-Network Medical Benefits subject to deductible unless otherwise noted		
	PPO	**HDHP**
Mental Health and Substance Abuse Treatment Subject to maximum of 50 visits/calendar year when both in-network and out-of-network providers are used		
Doctors' Office visits	Plan pays 70%, no deductible	Plan pays 80%
Outpatient and intermediate care	Plan pays 70%	Plan pays 80%
Inpatient care subject to precertification	Plan pays 70%	Plan pays 80%
Newborn Care, Inpatient	Plan pays 70%	Plan pays 80%
Orthotic Shoe Inserts Limit of one set per calendar year	Plan pays 70%	Plan pays 80%
Reconstructive Surgery	Plan pays 70%	Plan pays 80%
Routine Preventive Care/Wellness Not subject to deductible see "Routine Preventive Care/ Wellness"	100%, no deductible	100%, no deductible
Second Surgical Opinions (not required)	Plan pays 70%, no deductible Plan pays70%, deductible required if done at healthcare facility	Plan pays 80%
Skilled Nursing Facility Limit of 365 days per spell of illness	Plan pays 70%	Plan pays 80%
Specialty Care Conditions When Using Blue Distinction Centers for Specialty Care® Facilities ▪ Bariatric surgery ▪ Cardiac services ▪ Complex and rare cancers ▪ Knee and hip replacements ▪ Spine surgery ▪ Transplants	Plan pays 100%, no deductible	Plan pays 100%, after deductible**
Travel to a Blue Distinction Centers for Specialty Care facility and Lodging (subject to precertification)	A combined overall maximum benefit of $10,000 per covered recipient	A combined overall maximum benefit of $10,000 per covered recipient
At facilities other than Blue Distinction Centers for Specialty Care® facilities	Plan pays 70% after deductible	Plan pays 80% after deductible

In-Network Medical Benefits subject to deductible unless otherwise noted		
	PPO	**HDHP**
(subject to precertification)		
Sterilization, Elective	Plan pays 70%	Plan pays 80%
Surgery		
Performed in and billed by a PCP's* office	Plan pays 70%, no deductible	Plan pays 80%
Performed in and billed by a specialist's* office	Plan pays 70%, no deductible	Plan pays 80%
Outpatient facility	Plan pays 70%	Plan pays 80%
Hospital inpatient	Plan pays 70%	Plan pays 80%
Teladoc® Services	$8 copay; no deductible	$8 copay after deductible**
Therapy Services Occupational,physical, rehabilitation (including cardiac rehabilitation) and speech therapy Occupational, physical and speech therapy: limit of 30 visits per year per person for each type of therapy; if you use both in-network and out-of-network providers, the limit is a combined total of 30 visits per therapy type; limits do not apply to rehabilitation therapy		
Performed in and billed by a PCP's* office	Plan pays 70%, no deductible	Plan pays 80%
Performed in and billed by a specialist's* office	Plan pays 70%, no deductible	Plan pays 80%
Outpatient facility	Plan pays 70%	Plan pays 80%
Hospital inpatient	Plan pays 70%	80%

Out-of-Network Medical Benefits Based on reasonable and customary charges and subject to deductible		
	PPO	**HDHP**
Annual deductible	$2,000 per person $4,000 per family (Medical only)	$4,000 employee only $8,000 two or more people (Includes Medical and Prescription)

Out-of-Network Medical Benefits Based on reasonable and customary charges and subject to deductible		
	PPO	**HDHP**
Inpatient Facility Deductible per Admission	$250	Not Applicable
Coinsurance Routine Preventive Care	No coverage	No coverage
Coinsurance PCP Office Visits Specialist Office Visits	Plan pays 50%	Plan pays 60%
Coinsurance Emergency Room Care Other Services	Plan pays 50%	Plan pays 60%
Annual Medical Out-of-Pocket Maximum	$6,000 per person $12,000 per family	$8,5,00 employee only $17,000 two or more*** (Includes Medical and Prescription)
Annual Prescription Drug Out-of-Pocket Maximum	$3,000 per person $6,000 per family	
Allergy Injections, Serum, Testing and Treatment Performed in and billed by PCP or Specialist's office	Plan pays 50%	Plan pays 60%
Ambulance Transportation Only	Plan pays 50%	Plan pays 60%
Ambulatory Surgical Center	Plan pays 50%	Plan pays 60%
Anesthetics, Oxygen, Transfusions Anesthetics/oxygen and its administration; blood transfusions, including the cost of blood/plasma, unless there is no charge because it is replaced through a blood bank or in some other way	Plan pays 50%	Plan pays 60%
Chiropractic Care Services include office exams and spinal manipulations Limit of 30 visits per year per person	Plan pays 50%	Plan pays 60%
Diagnostic X-rays and Lab Services Performed in and billed by a PCP or specialist's office	Plan pays 50%	Plan pays 60%
Diagnostic X-rays and Lab Services	Plan pays 50%	Plan pays 60%

Out-of-Network Medical Benefits Based on reasonable and customary charges and subject to deductible		
	PPO	**HDHP**
Performed in and billed by an outside laboratory or facility		
Doctors' Office Visits PCP and Specialist A PCP is a family practitioner, general practitioner, internist, or pediatrician. A specialist is a physician or other health care provider, other than a PCP, such as cardiologist, gynecologist, or physical therapist	Plan pays 50%	Plan pays 60%
Drugs and Medicines administered in a PCP office or a specialist's office (for drugs not administered in an office, see "Prescription Drug Benefits")	Plan pays 50%	Plan pays 60%
Drugs and Medicines administered in a healthcare facility (for drugs not administered in a health care facility, see "Prescription Drug Benefits")	Plan pays 50%	Plan pays 60%
Durable Medical Equipment and Prosthetic Devices	Plan pays 50%	Plan pays 60%
Elective Abortion	Plan pays 50%	Plan pays 60%
Emergency Room Visits Medical emergencies and nonmedical emergencies	Plan pays 50%	Plan pays 60%
Hearing Aids Up to calendar limit $500 per ear and $250 per ear for repairs	Plan pays 50% up to calendar limit	Plan pays 60% up to calendar limit
Hemodialysis (subject to precertification if inpatient	Plan pays 50%	Plan pays 60%
Home Health Care/Nursing Subject to precertification	Plan pays 50%	Plan pays 60%
Hospice Care Subject to precertification	Plan pays 50%	Plan pays 60%
Hospital Services, Inpatient	Plan pays 50%	Plan pays 60%
Infertility Diagnosis and Treatment	Plan pays 50%	Plan pays 60%

Out-of-Network Medical Benefits Based on reasonable and customary charges and subject to deductible		
	PPO	**HDHP**
Excludes in-vitro fertilization, other artificial insemination procedures and experimental treatments		
Maternity Obstetrician or certified nurse-midwife services for pregnancy, childbirth and pregnancy-related conditions Inpatient hospital services including labor and delivery (hospital stay subject to precertification) Outpatient diagnostic testing	Plan pays 50%	Plan pays 60%
Mental Health and Substance Abuse Treatment Subject to maximum of 50 visits/calendar year when both in-network and out-of-network providers are used		
Doctors' Office visits	Plan pays 50%	Plan pays 60%
Outpatient and intermediate care	Plan pays 50%	Plan pays 60%
Inpatient care subject to precertification	Plan pays 50%	Plan pays 60%
Newborn Care, Inpatient	Plan pays 50%	Plan pays 60%
Organ Transplants At facilities other than Blue Distinction Centers for Specialty Care® facilities (subject to precertification)	Plan pays 50%	Plan pays 60%
Orthotic Shoe Inserts Limit of one set per calendar year	Plan pays 50%	Plan pays 60%
Reconstructive Surgery	Plan pays 50%	Plan pays 60%
Routine Preventive Care/Wellness Not subject to deductible for in-network services see “Routine Preventive Care/ Wellness”		
Routine physical at any age	Not covered	Not covered
Routine gynecological exam and Pap smear	Not covered	Not covered

Out-of-Network Medical Benefits Based on reasonable and customary charges and subject to deductible		
	PPO	**HDHP**
Mammograms (no age-related limits)	Plan pays 50%	Plan pays 60%
Immunizations (excluding those for the sole purpose of travel outside the U.S. and allergy injections)	Plan pays 50%	Plan pays 60%
Second Surgical Opinions (not required)	Plan pays 50%	Plan pays 60%
Skilled Nursing Facility Limit of 365 days per spell of illness	Plan pays 50%	Plan pays 60%
Sterilization, Elective	Plan pays 50%	Plan pays 60%
Surgery		
Performed in and billed by a PCP's* office	Plan pays 50%	Plan pays 60%
Performed in and billed by a specialist's* office	Plan pays 50%	Plan pays 60%
Outpatient facility	Plan pays 50%	Plan pays 60%
Hospital inpatient	Plan pays 50%	Plan pays 60%
Therapy Services Occupational, physical, rehabilitation (including cardiac rehabilitation) and speech therapy Occupational, physical and speech therapy: limit of 30 visits per year per person for each type of therapy; if you use both in-network and out-of-network providers, the limit is a combined total of 30 visits per therapy type; limits do not apply to rehabilitation therapy		
Performed in and billed by a PCP's* office	Plan pays 50%	Plan pays 60%
Performed in and billed by a specialist's* office	Plan pays 50%	Plan pays 60%
Outpatient facility	Plan pays 50%	Plan pays 60%
Hospital inpatient	Plan pays 50%	Plan pays 60%

Ambulatory Surgical Center

The plan covers services provided in an ambulatory surgical center, a public institution or a private institution approved by the claim administrator. The center or institution must:

- Not be the private offices or clinics of doctors or dentists;
- Be equipped and operated for the performance of surgical procedures by doctors;
- Have at least two operating rooms and at least one post-anesthesia recovery room equipped to perform diagnostic X-ray and lab exams required in connection with any surgery to be performed;
- Have the necessary equipment for emergencies resulting from such surgery, including a blood bank or other blood supply;
- Have doctors and licensed anesthesiologists on staff;
- Have full-time services of registered nurses (R.N.s) for patient care in the operating and post-anesthesia recovery rooms;
- Have a written agreement with one or more hospitals in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and
- Have an organized medical staff supervising its operation according to established policy and maintaining adequate medical records for each patient.

Blue Distinction© Centers of Excellence Program

The Blue Distinction program is an optional program that participants may use when one of the following types of specialty care conditions is encountered:

- Bariatric surgery;
- Cardiac services;
- Complex and rare cancers;
- Knee and hip replacements;
- Spine surgery; and
- Transplants.

At the core of the Blue Distinction program are the Blue Distinction Centers for Specialty Care® facilities that Blue Cross Blue Shield recognizes for their distinguished clinical care and processes for the conditions noted above.

You are not required to use a Blue Distinction Center for treatment of the above-mentioned conditions. However, if you do arrange for care through the Blue Distinction program, eligible plan expenses from these facilities for the services that they specialize in will be covered at 100% with no deductible*. In addition, if you use a Blue Distinction facility, you may be eligible for travel and lodging benefits as noted on the next page.

* *For the HDHP plan, the deductible must be applied according to IRS regulations.*

IMPORTANT: Preauthorization must be requested from the claim administrator before you travel to a Blue Distinction Center for care related to any of the conditions noted above. If authorized, a Case Manager will be assigned to you (the covered patient) and, in the case of a transplant, you must contact the Case Manager with the results of the evaluation.

You must ensure that Preauthorization for the actual admission is received. If Preauthorization is not received, benefits may be denied.

For more information on the Blue Distinction program or to find a specialty care facility, go to **www.bcbs.com/why-bcbs/blue-distinction** or contact the claim administrator.

You may be referred by a physician to a Blue Distinction Center or you may contact the claim administrator's customer service department if you have questions about this program. A Care Coordinator will help you find treatment resources using the Blue Distinction Center, facilitate an introduction to the Case Manager at the facility and continue to follow your progress and care throughout the course of treatment.

IMPORTANT: For travel and lodging services to be covered, the patient must be receiving covered services at a facility that has been designated for that type of service through a Blue Distinction Center for Specialty Care Program.

The medical plans cover preauthorized expenses for travel and lodging related to a covered treatment for a covered condition as follows:

- Transportation of the Member (covered patient) and one companion who is traveling on the same day(s) to and/or from the site of the treatment center;
- Travel and lodging expenses are only available if the covered patient lives more than 50 miles from the designated Blue Distinction Centers for Specialty Care facility that is being accessed for covered services through the Blue Distinction program.

A travel and lodging claim form must be completed and returned to the address indicated on the form for reimbursement. A claim form can be obtained by calling the claim administrator at the phone number on the back of your medical ID card. The claim administrator must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include airfare at coach rate, taxi or ground transportation; and/or mileage reimbursement at the IRS rate for the most direct route between the patient's home and designated Blue Distinction Centers for Specialty Care facility.

A combined overall maximum benefit of $10,000 per covered recipient applies for all travel and lodging expenses reimbursed under this program. This benefit applies to the original procedure and to any follow-up visits that occur within three years of the original procedure.

Durable Medical Equipment and Prosthetic Devices

The plan covers medically necessary:

- Rental (or purchase, if rental would be more costly) of durable medical equipment (including wheelchairs) required for therapeutic purposes, as prescribed by a doctor and determined by the claim administrator to be medically necessary;
- Artificial limbs or other prosthetics, but not the replacement of these appliances, unless required due to growth or anatomical change; and
- Orthopedic shoe inserts (one set per calendar year).

For more information about covered durable medical equipment, call the claim administrator at the number on your medical ID card.

Emergency Room Visits

Medical treatment for an emergency (as defined below) is covered under the plan. If you visit an emergency room, the plan pays benefits as shown in the previous charts.

An emergency is an accident or the sudden and unexpected onset of a condition, illness or severe symptoms that require immediate medical care. Examples include fractures, lacerations, motor vehicle accidents, hemorrhage, shock or other conditions associated with deterioration of vital life functions.

Colds, sore throats, flu and infections are examples of non-emergencies, although they may require urgent treatment. The claim administrator determines which conditions and symptoms are medical emergencies using the "prudent layperson" definition of emergency.

A prudent layperson is someone who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person. For example, if someone goes to the emergency room with chest pains and the situation turns out to be indigestion, a prudent layperson would agree that seeking emergency care was appropriate.

Hemodialysis

A hemodialysis program (use of an artificial kidney machine) is covered whether in a hospital outpatient department, in a kidney dialysis facility (a facility engaged in administering programs of hemodialysis) or at home. Covered expenses also include:

- Rental of equipment; and
- Any services and supplies given or used in the home in connection with the program.

Before you start inpatient hemodialysis treatments, both the program of care and the facility must be approved by the claim administrator. Inpatient hemodialysis is subject to precertification.

Home Health Care/Nursing

The plan covers home visits by a staff member of a home health care or private duty nursing agency (including a person under contract or arrangement with the agency) during which any of the following services are provided:

- Part-time or temporary nursing care performed or supervised by an R.N. or a licensed practical nurse (L.P.N.);
- Part-time or temporary care by a home health aide;
- Physical, occupational, speech or respiratory therapy;
- Medical social services, nutritional guidance, hemodialysis, oxygen service or diagnostic services; or
- Short-term care for mental illness when recovery or improvement is deemed likely.

To be covered, home health care must be provided according to a home health care program set up in writing by a doctor. The doctor must state that the patient is, for all practical purposes, confined at home and the medical condition requires home health care.

To be covered, the home health care agency must:

- Meet standards set by Medicare;
- Be approved by the claim administrator; and
- Be approved by your area's health care planning agency (if applicable).
- Contact the claim administrator for approval before arranging home health care services.

Hospice Care

A hospice is a facility set up to give terminally ill patients a coordinated program of inpatient, outpatient and home care as an alternative to hospitalization. A terminally ill person is generally considered to be someone with less than six months to live.

Covered services include:

- Hospice services furnished to a terminally ill person after the date the person enters the hospice care program; and
- Counseling services incurred before the patient's death for the patient and covered members of the family.

To be covered, the hospice care program must:

- Meet standards set by the National Hospice Organization;
- Be approved by the claim administrator;
- Be Medicare approved; and
- Be directed by a doctor.

If the program is required to be state licensed, certified or registered, it also must meet that requirement.

Contact the claim administrator for approval before arranging hospice care services.

Hospital Services

Eligible hospital charges include the following:

- Room and board for a:
  - Semiprivate room, charges are covered at the most common rate;
  - Private room in a hospital with semiprivate rooms, charges are covered only up to the hospital's most common semiprivate room rate. However, if it is medically necessary to stay in a private room, the full charge will be considered a covered medical expense. A private room will be considered medically necessary if the patient's condition requires isolation for health reasons or if the hospital has less costly rooms but they all are in use; and
  - Private room in a private-room-only hospital, the full cost of the private room will be considered a covered medical expense.
- Other hospital services:
  - Services required for medical or surgical care, whether as an outpatient or inpatient;
  - Services of an R.N. or a licensed practical nurse (L.P.N.) if an R.N. is not available;
  - Hospital outpatient services in connection with removal of teeth or other dental work, provided the work must be done at the hospital to safeguard the patient's health; and
  - Emergency room and services.
- Inpatient hospital stay for the diagnosis of a sickness or injury only if:
  - An inpatient hospital stay is mandatory or is required for the safety of the patient or the success of the test(s);

- Advance preparation of the patient can be done only on an inpatient basis; or
- There is a concurrent medical hazard and, as a result, the patient cannot be treated on an outpatient basis.

Contact the claim administrator prior to a nonemergency admission and within 48 hours of an emergency admission.

Infertility Diagnosis and Treatment

The plan covers the diagnosis and treatment of infertility, excluding in-vitro fertilization, other artificial insemination procedures and experimental treatments. Fertility drugs obtained in a doctor's office or health care facility are covered under the medical portion of the plan. Fertility drugs obtained from a pharmacy may be covered under the prescription drug plan; see "Prescription Drug Benefits".

Maternity

The plan covers expenses for hospital stays or birthing centers and obstetrics provided by a doctor or certified nurse-midwife (working under the direction of a doctor) for pregnancy, childbirth or related complications. For the first 31 days after birth, certain expenses of the newborn child, including hospital nursery charges, routine in-hospital pediatric care (including pediatric exam, PKU tests and immunizations) for a healthy infant and circumcision, are covered by the plan. Covered expenses for the newborn child may be billed under the newborn's name and birth date; in this case, they will be separate from expenses incurred by the mother. You must enroll your newborn for coverage under the plan within 31 days after the date of birth. If you fail to do so, any charges incurred after this 31-day period will not be covered and coverage will not become effective until the enrollment is processed (see "Enrolling New Dependents").

A covered spouse or eligible dependent may receive maternity benefits even if pregnant before coverage began, as long as she is covered when the pregnancy ends. If expenses are incurred after coverage ends, no benefits will be paid.

Benefits for any hospital length of stay for the mother and newborn child may not be restricted to less than 48 hours following a normal vaginal delivery or less than 96 hours following a Cesarean section. A provider automatically will receive authorization from the claim administrator for prescribing a length of stay that does not exceed these time frames. The mother and newborn's attending physicians, after consulting with the mother, may discharge the mother and newborn earlier than 48 or 96 hours.

Mental Health and Substance Abuse Treatment

The plan covers inpatient and outpatient care and services for the treatment of mental illness, emotional and psychological disorders and alcohol or other substance abuse problems. To be eligible, covered expenses must be medically necessary, as determined by the claim administrator.

The following services and supplies may be covered expenses.

- Visits to a qualified provider for individual or group psychotherapeutic treatment for you and your covered dependents. Qualified providers, as determined by the claim administrator, include, but are not limited to:
  - Psychiatrist (M.D., D.O.);
  - Licensed psychologist (Ph.D., Psy.D., Ed.D.);
  - Clinical social worker (M.S.W.);
  - Psychiatric nurse specialist (M.S.N.);
  - Master's level licensed psychologist (M.A.);
  - Master's of education (M.E.D.);
  - Marriage, family and child counselor (M.F.C.C.) (in California only); and
  - Licensed professional counselor (L.P.C.) (in Texas only).
- Outpatient services, while the patient participates in an outpatient treatment program, including:
  - Professional and other necessary related services when provided through a day care program or night care program;
  - Drugs and medicines dispensed and charged for by the hospital or facility that provides the treatment as part of regular institutional care programs;
  - Electric shock treatments and related anesthesia;
  - Detoxification immediately before treatment, if needed;
  - Individual and group therapy (including therapy for the patient's family members) or counseling given by staff members; and
  - Psychological testing by a psychologist when prescribed by a doctor.

To be covered, an outpatient service must be received in the outpatient department of a hospital or in an outpatient psychiatric or rehabilitation facility.

An outpatient psychiatric facility is a unit or facility that provides outpatient mental health services and provides a psychiatrist who has regularly scheduled hours in the facility and who assumes overall responsibility for coordinating the care of all patients.

- Outpatient psychiatric facilities include:

- Centers for the care of adults or children, such as hospital outpatient psychiatric clinics, day treatment centers, night care centers and community mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended and services for intermediate care, such as partial hospitalization, residential treatment in a licensed facility or treatment in a halfway house.
- Partial hospital psychiatric treatment may be appropriate whenever a patient does not require the more restrictive and intensive inpatient hospital treatment but does require more intensive and comprehensive service than can be provided on an outpatient basis.
- Residential treatment may be performed at a center that provides active treatment through specialized programs developed by mental health professionals. It is more restrictive than partial hospitalization or outpatient treatment, but less restrictive than inpatient care.

A halfway house is a home-like treatment setting for psychiatric or substance abuse patients. It is intense and closely monitored care in the least restrictive setting possible. It is less restrictive than a residential treatment facility.

- Services during an inpatient stay at a rehabilitation facility, including:
  - Room and board (For a private room, charges are covered only up to the facility's most common semiprivate room rate. If the facility has only private rooms, the full charge will be considered a covered medical expense.); and
  - Professional and other services and supplies needed for the medical care and treatment of the person receiving inpatient treatment.

A rehabilitation facility is a hospital or other facility approved by the claim administrator for the rehabilitation of those suffering from alcohol or drug addiction.

Reconstructive Surgery

Covered reconstructive surgery includes the following.

- Surgery to repair a birth defect (a physical deformity or anomaly that exists at birth) of a dependent child. A medical doctor must certify that the defect adversely affects the child's physical or mental well-being and the procedure must be approved by the claim administrator.
- Surgery to repair:
  - Conditions resulting from accidental injury; or
  - Scars due to surgery that is performed while a person is covered under the plan.

Reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed; reconstructive surgery of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

Routine Preventive Care/Wellness

As required the Affordable Care Act, the Company follows the recommendations of the U.S. Preventive Services Task Force or regulatory agencies regarding the coverage of preventive care/wellness services. The following covered services are subject to change as the recommendations change. As such, please contact the Claim Administrator for the most up to date information for covered routine preventive services. You can also learn more about this list of covered services at **www.healthcare.gov**.

Additional routine preventive/wellness care currently includes, but is not limited to:

- Routine physicals, at any age, which include medical history, physical exam, prostate exam, proctosigmoidoscopic exam, pelvic exam, breast exam, weight/height, blood pressure, total cholesterol, urinalysis, blood glucose and EKG;
- Routine gynecological exam and Pap smear;
- A mammogram, at any age, if recommended by a doctor;
- Colorectal cancer screening (fecal occult blood testing, colonoscopy, sigmoidoscopy);
- Obesity screening;
- Diabetes Type 2 screening;
- Routine immunizations administered in a doctor’s office or health care facility, except immunizations for the sole purpose of travel outside the U.S.;
- Well Baby Care and Well Child Care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services includes, but is not limited to, a review of a child’s physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests;

- Laboratory tests such as fecal occult blood test, complete blood count, comprehensive metabolic panel;
- HPV tests for women, regardless of age, when recommended by a physician;
- Human Papilloma Virus (HPV) vaccine;
- Routine cytologic and chlamydia screening (including conventional and liquid pap test);
- Sexually Transmitted Infections (STI) counseling;
- Human Immunodeficiency Virus (HIV) screening and counseling;
- Interpersonal and domestic violence screening and counseling;
- Osteoporosis screening;
- Routine bone density testing;
- Well-women visits;
- Screening for gestational diabetes;
- HPV (human papillomavirus) DNA testing;
- Breastfeeding support, supplies (including rental of equipment) and counseling;
- FDA-approved contraceptive methods and contraceptive counseling done by a doctor/medical provider in an office that provides medical service. Contraceptive drugs and devices without a generic equivalent will be covered at 100% regardless of whether they are purchased at a retail pharmacy or through mail-service. If they are purchased at a retail pharmacy or through the mail-service program, they are covered under the prescription drug plan at 100%; and
- Tubal ligation.

In-Network preventive care/wellness services are not subject to a deductible. Also, the plan does not pay for routine physicals and gynecological exams/Pap smears from out-of-network providers.

In addition, nutritional counseling is a covered service when prescribed by a physician. Covered services include diet modifications and disease self-management skills training. Coverage is limited to 15 visits per person per year.

Second Surgical Opinions

When a doctor recommends surgery, you may voluntarily obtain a second surgical opinion. Second opinions provide you with more information so that you can make an informed decision about whether to have surgery or follow another course of treatment. If you choose not to obtain a second opinion, your benefits under the plan are not affected.

Skilled Nursing Facility

Skilled nursing facility services are covered if:

- Such services are determined to be medically necessary; and
- The patient is admitted by a doctor and remains under the doctor's care throughout the stay.
- The stay must be for medical reasons due to:
- Recovery from sickness or injury;
- Treatment of a terminal condition; or
- Treatment of a long-term illness for patients who need inpatient care but not continuous hospital care.

Eligible expenses include:
- Room and board (charges are covered up to the facility's most common semiprivate room rate);
- Other skilled nursing services that are performed for medical or surgical care or treatment; and
- Short-term care for mental illness when recovery or improvement is deemed likely.
- Skilled nursing care benefits are paid for a stay of up to 365 days per spell of illness. To determine the maximum number of days, the following rules apply:
- Separate admissions to the facility for non-related causes are counted as separate stays;
- A single admission is counted as one stay; and
- Separate admissions for the same or related cause(s) are counted as one stay. However, a re-admission is counted as a separate stay if the patient has engaged in normal activities for at least three months.

To be covered, the skilled nursing stay must be in a facility that is:
- Considered a skilled nursing facility under Medicare; and
- Approved by the claim administrator.

Contact the claim administrator before using a skilled nursing facility to find out if the stay will be covered.

Surgery

The plan covers medically necessary surgery in a doctor's office, outpatient facility or hospital.

If multiple surgeries are performed at the same time, the first procedure will be paid at the appropriate benefit level (In-Network, Out-of-Network), based on the provider/facility used.

For each additional procedure, the following rules apply:

- If you use an in-network provider, the plan pays 50% of the network-negotiated fee for each additional procedure. In-network providers accept this amount as payment in full for multiple procedures and will not bill you for any additional amount.
- If you use an out-of-network provider, the plan pays 50% of the R&C amount for each additional procedure. In addition to your coinsurance amount, the provider may bill you for the difference between what the plan pays and the charge above the R&C limit for each procedure. You are responsible for these costs.

Teladoc®

Consultations via phone or computer with a Teladoc® doctor. To contact Teladoc®, call 1-800-Teladoc (1-800-835-2362) or go online at **www.teladoc.com/enter**.

Transgender Surgery

Expenses for Transgender Surgery (also called Intersex Surgery) will be considered an eligible expense, subject to medical necessity, under the medical plans. These benefits will be covered at the same coinsurance level that other surgical benefits are covered. Transgender Surgery Benefits are limited to one intersex surgery per covered person per lifetime. For transgender surgery benefits, the criteria for diagnosis and treatment are based on the guidelines set forth by the World Professional Association for Transgender Health (WPATH), formerly known as the Harry Benjamin International Gender Dysphoria Association, Inc. (HBIGDA).

For More Information

If you have a question about a covered service or for more information about a specific procedure or service, contact your claim administrator at the number listed on the back of your medical ID card.

Expenses Not Covered

The following expenses, among others, are *not* covered under the plan:

- Services or supplies that are not medically necessary for diagnosing or treating your condition, as determined by the claim administrator (see definition of medically necessary);
- Services or supplies received before the patient is covered by the plan;
- Services or supplies for which the patient does not have to pay or for which no charges would be made if this coverage did not exist;
- Services rendered by an unlicensed provider;

- Services or supplies for which payment is made to or for the patient through legal action or settlement related to the incident that caused the services or supplies to be provided;
- Services or supplies that are experimental or investigational (see definition), as determined by the claim administrator;
- Services or supplies for sickness, defect, disease or injury due to war or a warlike action in time of peace;
- Services or supplies for sickness or injury that entitles the patient to benefits under a workers' compensation or occupational disease law or any similar law;
- Services and supplies covered by laws or regulations of any government agency, unless specifically covered under the plan;
- Dental care, except for services to correct damage to natural teeth due to an accident that happens while a person is covered under the plan or for reconstruction of the oral cavity required because of surgery necessary to correct a malignant condition (see "Dental Benefits" for information about covered expenses under the dental plan);
- Routine eye exams, eyeglasses, contact lenses or related services, except the initial eyeglasses or contact lenses after a cataract operation or the special contacts necessary to treat keratoconus (see "Vision Benefits" for information about covered expenses under the vision plan);
- Expenses for radial keratotomy or any other surgery to correct refractive errors, unless vision is not correctable to 20/40 with eyeglasses or contact lenses;
- Any hospital stay that is not for the diagnosis or treatment of a sickness or injury or that does not meet the requirements stated above;
- Services for cosmetic reasons, except for covered reconstructive surgery as described above;
- Custodial care/assistance with activities of daily living, whether in a residential care facility, skilled nursing facility or at home, including help in walking, bathing, preparing meals and special diets and supervising use of medication (see definition of skilled nursing facility);
- Services of dieticians and/or nutritionists and nutrition programs, if not prescribed by a physician;
- Fertility treatments, such as in-vitro fertilization, fertility assistance and other artificial insemination procedures;
- Diagnosis or treatment of sexual dysfunction;
- Services, supplies or treatment for the reversal of sterilization procedures;
- Home health care expenses for
  - Custodial care;
  - Meals;
  - Services of housekeepers;

- Drugs, vaccines, serums, etc.;
  - Services of a person who normally lives in the patient’s home or who is a member of the patient’s family;
  - Tuberculosis;
  - Alcoholism or drug addiction;
  - Deafness or blindness;
  - Senility, mental deficiency or retardation;
  - Mental illness, except for short-term care when recovery or improvement is deemed likely;
  - Care received at any time when the patient is not under the care of a doctor;
  - Services that are not prescribed by the doctor in charge of the case; or
  - Services or supplies for which no charge would be made if coverage did not exist;
- Hospice expenses for
  - Services of a person who normally lives in the patient’s home or who is a member of the patient’s family; or
  - Charges incurred after the patient is discharged from the hospice care program;
- Skilled nursing services if they are provided in a place designed mainly for
  - Custodial care;
  - Tuberculosis;
  - Alcoholism or drug addiction;
  - Deafness or blindness;
  - Senility, mental deficiency or retardation; or
  - Mental illness, except for short-term care when recovery or improvement is deemed likely;
- Marital counseling;
- Routine, palliative or cosmetic foot care, including but not limited to treatment for weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; corns or calluses; or non-surgical care of toenails;
- Personal convenience items, such as radio/television rentals, air conditioners, humidifiers, air purifiers, exercise equipment, elastic bandages and non-hospital adjustable beds;
- Charges for failure to keep a scheduled visit, telephone consultations between patient and doctor or completion of claim forms; or
- Services, supplies or treatment primarily for weight reduction or treatment of non-morbid obesity, including but not limited to exercise programs or use of exercise equipment, special diets or supplements, appetite suppressants, weight loss programs and hospital confinements for weight reduction programs.

Precertification

You and your covered dependents must have precertification for inpatient hospitalization and certain other treatments (see charts). **Whether you use In-Network or Out-of-Network inpatient services, you are responsible for precertification.** In some areas, the in-network provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the claim administrator.

How to Precertify

To receive the maximum benefit, you must call the number listed on the back of your medical ID card to precertify an admission or treatment:

- Before any scheduled hospital admission or treatment; or
- Within 48 hours of an emergency or unscheduled admission.

If you do not obtain precertification when it is required, your benefits may be reduced for any days or treatments not certified.

Scheduled Admissions and/or Treatments

For scheduled admissions and/or treatments, you or your doctor must call the claim administrator at the number listed on the back of your medical ID card. Do this at least two weeks before you expect to enter the hospital or begin the treatment.

Medical professionals, employed by the claim administrator, work with your doctor to determine how many days of confinement or treatment are medically necessary. If it is determined that confinement or treatment is not medically necessary, you and your doctor will be notified. Together, you can discuss other options.

Emergency Admissions

If you are admitted to a hospital because of an emergency, your doctor or the facility must call the claim administrator within 48 hours. Your case will be reviewed by the claim administrator to determine how many days of treatment are medically necessary. See "Claims Procedure" for information about urgent care claims.

To Continue Your Hospital Stay and/or Treatment

If a continued stay after a scheduled or emergency admission is not justified, the claim administrator will notify you, your doctor and the treatment facility. The plan pays benefits only up to 24 hours after you are notified, unless your condition changes to show continued stay or treatment is necessary. Medical professionals, employed by the claim administrator, will review any requests for a longer stay or treatment. You must pay for a continued stay or treatment that the reviewer determines is not medically necessary.

Pregnancy and Childbirth

The following special precertification requirements apply to pregnancy and childbirth.

- **Prenatal programs—**The claim administrator should be notified during the first trimester (12 weeks) of the pregnancy so that the mother may take advantage of available prenatal programs.
- **Extended hospital stay for delivery—**You or your doctor must notify the claim administrator before an approved hospital stay is extended beyond the established limits (48 hours for a normal vaginal delivery and 96 hours for a Cesarean section).
- **Nonemergency inpatient confinement—**The claim administrator must be notified *before* any hospital admission for complications during the pregnancy.

Advanced Imaging (Outpatient)

You or your physician are required to notify National Imaging Associates prior to receiving any of the following services on an outpatient basis: Computerized Axial Tomography (CAT scans), Magnetic Resonance Imaging (MRI scans) and Positron Emission Tomography (PET scans), as long as they are not performed in an emergency room, on weekends or on holidays. Pre-certification for CAT, MRI and PET scans is handled by National Imaging Associates (NIA) at 1-800-642-7597, Monday - Friday 8 a.m. to 8 p.m. Eastern Time.

Noncompliance with Precertification

You must pay part or all of the charges the plan normally would pay if you:

- Do not receive precertification for a hospital admission (this applies only if the claim administrator determines that the admission is not medically necessary);
- Do not receive precertification for outpatient Advanced Imaging (CAT, MRI or PET scans); or
- Decide to have treatment that the claim administrator determines is not medically necessary.

If precertification is not obtained before a scheduled admission or during a hospital stay if an emergency admission, the hospital confinement will be reviewed on a retrospective basis. If it is determined subsequently that all or part of the hospital stay was not medically necessary, all or part of the hospital confinement expenses will be denied.

The plan does not pay benefits beyond the number of days the claim administrator considers the admission to be medically necessary.

Case Management

Through the case management program, you receive appropriate health care services for catastrophic medical conditions. This program can provide benefits in addition to those normally covered by the plan.

While many diagnoses may require special attention, the plan uses case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- Burns;
- Coma;
- Inpatient confinement expected to exceed 14 days;
- Multiple sclerosis;
- Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
- Neonatal birth;
- Organ transplant;
- Progressive neurological debilitative disease;
- Certain psychiatric conditions;
- Quadriplegic/paraplegic conditions;
- Stroke; and
- Multiple traumas from a vehicular accident.

Whether you use in-network or out-of-network providers, case management will be involved in these cases either through your in-network provider or the precertification process.

If you were enrolled in the Health Reimbursement Arrangement (HRA) during 2017:

The HRA was eliminated on December 31, 2017. Provided that you enrolled and remained enrolled in the HDHP, account balances were available for claims incurred on or before December 31, 2019, but forfeited after that date.

Health Savings Account (HSA) under the HDHP Medical Option

If you elect the HDHP medical option, you are eligible to participate in the Health Savings Account. You may use the account to pay for current and future health care expenses.

How the HSA Works

The HDHP medical option is made up of two parts:

- A high-deductible health plan, as defined by the IRS, that covers eligible health care expenses after you meet your deductible. This coverage is part of the Company's health care plan.
- A savings account that both you and the Company can contribute to. When you accumulate savings, you can invest in mutual funds. This account is not part of the Company high-deductible health plan.

The savings account works in conjunction with the high-deductible health plan offered by the Company as part of the HDHP medical option. After-tax money you deposit into the account, up to the maximum annual contribution limit, is deductible for federal income tax purposes. The money the Company deposits into your account is not taxable to you and is not subject to federal income tax withholding and FICA (Social Security and Medicare) tax. Also, in some states, it is not subject to state income tax withholding. Pre-tax contributions you make to your account through the HDHP medical option are treated as employer contributions. Therefore, you cannot deduct your pre-tax contributions on your federal income tax return. In addition, if you itemize deductions on your return, you cannot deduct HSA contributions as Section 213 medical expenses.

You must open your HSA account with Smart Choice and deposit funds before paying for eligible expenses. The Company's full annual contribution will be deposited after you open your account. You can use funds in your account to pay for medical and prescription drug expenses, including your deductible and coinsurance amounts, for yourself and your eligible dependents. In addition, you can use tax-free dollars for other qualified expenses, such as dental, vision and alternative medicine expenses and for certain non-health care expenses. If you have a domestic partner, you cannot use funds in the HSA account to pay for his or her expenses, unless he or she qualifies as your dependent under federal tax laws.

If you use the money in your account for non-health care expenses, the amount is subject to ordinary income tax, plus a 10 percent penalty if you are under age 65. A complete list of qualified medical expenses may be found in IRS Publication 502, available at **www.medicare.gov**.

Funds remaining in your account at year-end continue to accumulate to help pay for your future health care expenses. You may choose to pay for small expenses through other funds, leaving your HSA dollars to grow for future needs.

More information about HSA accounts and eligibility requirements is available through the Smart Choice on UPoint .

Government Restrictions on HSA Participation

Participation in the HSA is subject to IRS regulations. You cannot be enrolled in the HDHP medical option, even as a dependent, if you are enrolled in any of the following:

- A flexible spending account, such as the Health Care Fund, unless it is a limited account for dental and vision expenses only;
- Health Reimbursement Arrangement, unless it is a limited account for dental and vision expenses only;
- Coverage under a spouse's plan, including low-deductible medical or prescription drug coverage
- A flexible spending account or Health Reimbursement Arrangement through spouse's employer
- Medicare

HDHP and the Health Care Fund

If you enroll in the HDHP medical option, you can enroll in a limited flexible spending account that can be used for dental and vision expenses only. You cannot enroll in both the HDHP medical option and the Health Care Fund. For detailed information about the Health Savings Account, go to the Smart Choice website on UPoint or see the *Flexible Spending Accounts and Health Savings Account* booklet.

Note that the description of the Health Savings Account is based on laws and regulations on the date of this booklet and may change any time subject to new laws and regulations. You are encouraged to discuss your eligibility and limits of the Health Savings Account with your tax advisor.

PRESCRIPTION BENEFITS

How the Plan Works

The prescription drug plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- Prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- Approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.
- Important information you need to know about your prescription drug benefits is shown below.

Under the program, there is one prescription drug program. When you enroll in one of the medical options, you automatically are enrolled for prescription drug benefits.

There are three coverage categories in the drug plan: Generic, brand 80/20 and brand 50/50 (see “Coverage Categories and Coinsurances” below).

If you elect the HDHP medical option, the prescription drug deductible does not apply. Instead, you must meet the combined medical and prescription drug deductible before the plan begins to pay for drug expenses.

For generic drugs that you order through the mail-service program, you pay a $5 copayment, unless you are enrolled in the HDHP medical option. In this case, you must first meet your combined medical and prescription drug benefit before the $5 copayment applies.

If your doctor prescribes a brand-name drug because it is medically necessary, he or she must provide clinical reasons to the prescription drug administrator’s Prior Authorization Department to obtain approval for the drug to be covered at the brand-name level.

If you enroll in an HMO (if offered), your prescription drug coverage will be provided through the HMO, not through the prescription drug plan.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network. You may purchase covered prescription drugs through the network in one of two ways:
At a network retail pharmacy; or

Through the mail-service program for maintenance medications or any prescription not needed immediately.

Preferred Drug List (Formulary)

Not all prescription drugs available in the United States are covered by the Prescription Drug plan. Similar to other claim administrators, Alcoa USA's prescription drug claim administrator has created a list of covered prescription drugs called a formulary. Prescription drugs that are not listed on the formulary will not be paid for by the Plan. From time to time, the prescription drug claim administrator may change its formulary by removing prescription drugs from the list. This means that a previously covered prescription drug removed from formulary list would no longer be covered under the Plan. For the most up-to-date information about covered prescription drugs, contact the prescription drug claim administrator at 1-888-321-4284.

Coverage Categories and Coinsurances

There are three coverage categories in the prescription drug plan; each has different coinsurances that apply. Also, you will pay an additional 10% of the cost if you order more than three fills (original fill plus two refills) of a maintenance drug at a network retail pharmacy.

The chart below shows coinsurance amounts, coinsurance maximums and any applicable deductibles or additional costs for each category. If you are enrolled in the HDHP medical option, the prescription drug deductible does not apply. Instead, you must meet the combined medical and prescription drug deductible before the plan starts to pay for drug expenses.

- **Generic Drug—**You pay 10% of the cost for a generic drug filled at a network retail pharmacy and there is no deductible, unless you are enrolled in the HDHP medical option as described above. The maximum amount of coinsurance you pay for a generic prescription is $100 at a network retail pharmacy. You will pay an additional 10% of the cost if you buy a maintenance drug at a network retail pharmacy after the third fill (original fill plus two refills). The maximum coinsurance does not apply to this additional cost.

For a generic prescription filled through the mail-service program, the plan pays 100% of the cost. If you are enrolled in the HDHP medical option, you must meet the combined medical and prescription drug deductible before the plan starts to pay for drug expenses.

Using generic drugs when available, instead of costlier brand-name drugs, can save you money. Both the network retail pharmacies and the mail-service program dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed.

- **Brand 80/20 Drug—**This category includes brand-name drugs for which there are no or limited generic drug alternatives. All brand-name drugs used to treat asthma or diabetes are included in this category. You will pay an additional 10% of the cost if you buy a maintenance drug at a network retail pharmacy after the third fill (original fill plus two refills). The maximum coinsurance does not apply to this additional cost.

If there is a generic drug equivalent available and you choose the brand 80/20 drug, you will pay more of the cost as follows:

- For retail purchases, you pay 10% of the generic drug cost plus the difference in cost between the brand-name drug and the generic drug. There is no maximum coinsurance for the difference in cost or for the additional 10% for a maintenance drug filled at retail.
- For mail-service purchases, you pay the difference in cost between the brand-name and generic drug. There is no maximum coinsurance amount for the difference in cost.

The maximum coinsurance you will be required to pay per prescription is limited to $100 at a network retail pharmacy or $200 through the mail-service program.

- **Brand 50/50 Drug—**This category includes brand-name drugs for which generic equivalent drugs and/or appropriate generic drug alternatives are available. A combined deductible of $50/person or $100/family applies to all retail and mail-service purchases. In addition, you will pay an additional 10% of the cost if you buy a maintenance drug at a network retail pharmacy after the third fill (original fill plus two refills). The maximum coinsurance does not apply to this additional cost.

If you choose a brand 50/50 drug over an available generic drug alternative, you pay a 50% coinsurance whether you purchase the drug at a network retail pharmacy or through the mail-service program; the maximum coinsurance costs, per prescription, are $100 and $200 respectively.

If there is a generic drug equivalent available and you choose the brand 50/50, you will pay more of the cost as follows:

- For retail purchases, you pay 10% of the generic drug cost plus the difference in cost between the brand-name and generic drug. There is no maximum coinsurance for the difference in cost or for the additional 10% cost for a maintenance drug filled at retail.
- For mail-service purchases, you pay the difference in cost between the brand-name and generic drug. There is no maximum coinsurance amount for the difference in cost.

Over the counter smoking cessation aids are covered when they are prescribed by a physician and you purchase them at a network retail pharmacy. In this case, the Company pays 100% of the cost, and you pay no deductible.

If you have questions about your drug coverage or brand 80/20 or brand 50/50 drugs, call 1-844-31ALCOA (1-844-312-5262) or the prescription drug claim administrator at 1-888-321-4284.

Specialty Drugs

Specialty drugs, including select injectable and oral medications, are only available through the Specialty Pharmacy Services of the mail-service program. To receive coverage for a specialty drug, you must call the prescription drug claim administrator at the toll-free telephone number at 1-888-321-4284, and identify yourself as an Alcoa USA plan participant. Medications ordered through this service will be shipped to you using next-day air service. This service applies only to drugs for which your doctor writes a paper prescription. It does not include drugs dispensed at the doctor's office.

Preventive Drug Benefits

The Plan provides preventive drug benefits as required by the Affordable Care Act. Please contact the Claim Administrator for the most up to date information for covered drugs. You can also learn more about this list of covered drugs at **www.healthcare.gov**. Currently, the following drugs and medicines are covered at 100% with a doctor's prescription even if they are over-the-counter medicines:

- aspirin to prevent cardiovascular disease for men age 45 to 79 and women age 55 to 79;
- oral fluoride supplementation for children from six months through age 5;
- iron supplementation for children from six to 12 months of age who are at an increased risk for iron deficiency anemia; and
- folic acid supplementation for women of child-bearing age 18 to 45.

Contraceptives

The Plan covers FDA-approved contraceptive methods as required by the Affordable Care Act. The Plan's coverage currently includes FDA-approved barrier methods, hormonal methods and implanted devices, as prescribed by a health care provider. Generic and over-the-counter contraceptives are currently covered at 100% (with no deductible or coinsurance) if prescribed by a health care provider. The Plan's current coverage includes emergency oral contraceptives, but excludes condoms. Contraceptive methods that are generally available over-the counter, such as contraceptive sponges and spermicides, are currently covered if the method is both FDA-approved and prescribed by a health care provider.

In the event a generic or a brand-name contraceptive is unavailable or would be medically inappropriate, as determined by the individual's health care provider, a brand-name contraceptive will be covered at 100% (with no copayment, deductible or coinsurance), subject to satisfaction of the prior authorization requirements of the claim administrator. Brand-name contraceptives are covered under the Plan as outlined in the table below.

The Plan's contraceptive coverage is subject to change based on the requirements of the Affordable Care Act.

Your Deductible

Generally, there are no deductibles under the prescription drug plan. However, a deductible does apply in the following circumstances.

If you order a brand 50/50 drug from a network retail pharmacy or through the mail-service program, you must pay a deductible of $50 per person or $100 per family before the plan begins to pay for drug expenses.

If you are enrolled in the HDHP medical option, you must meet the combined medical and prescription drug deductible before the plan starts to pay for drug expenses.

Maximum Coinsurance Amount

Generally, maximum coinsurance amounts of $100 at a network retail pharmacy and $200 through the mail-service program apply to each prescription drug you purchase. Exceptions to the coinsurance maximum are as follows.

The coinsurance maximum does not apply to the additional 10% cost you must pay if you order more than three maintenance medication fills (original fill plus two refills) at a network retail pharmacy.

If you order a brand 50/50 drug, you must meet the calendar-year deductible before the maximum coinsurance amount applies.

If you order a brand 80/20 or a brand 50/50 drug for which a generic drug equivalent is available, there is no maximum coinsurance for the difference in cost.

Your Prescription Drug Out-of-Pocket Maximum Under the PPO Option

Under the PPO medical option, the prescription drug out-of-pocket maximum limits the amount you pay each year for covered prescription drug expenses. When your share of covered prescription drug expenses (including your deductible and coinsurance amounts) reaches the prescription drug out-of-pocket maximum, the plan pays 100% of your covered prescription drug expenses for the rest of the calendar year. There are separate individual and family out-of-pocket maximums for prescription drugs as shown here:

Prescription Drug Annual Out-of-Pocket Maximum	PPO Option
Individual	$3,000
Family	$6,000

The prescription drug out-of-pocket maximum for a family can be met when covered prescription drugs are used by multiple covered family members, even when no single family member meets the per-person maximum. Also, when the family meets the prescription drug out-of-pocket maximum for covered prescription drug expenses provided to two or more individuals, there is no need for each covered person in the family to meet the individual out-of-pocket maximum.

The prescription drug out-of-pocket maximum does not apply to:

- Expenses covered under the medical, dental, or vision plans;
- Any amounts that do not apply to the Maximum Coinsurance Amount (see above);
- Drugs purchased at out-of-network pharmacies; and
- Expenses not covered under the plan.

Your Prescription Drug Out-of-Pocket Maximum Under the HDHP Option

If you are enrolled in the HDHP medical option, you must meet the combined medical and prescription drug out-of-pocket maximum before the plan starts to pay 100% for covered drug expenses. Any prescription drug expenses that you incur apply to the HDHP out-of-pocket maximum.

If You Use a Network Retail Pharmacy

The Company's retail pharmacy network includes most chain and many local pharmacies. You will receive a prescription drug identification (ID) card from the claim administrator. Present this card to the network pharmacy when you purchase covered prescription drugs, and you will not have to submit a claim form.

For each covered prescription drug, you pay a coinsurance amount for up to a 30-day supply. The coinsurance amount is based on whether you receive generic or brand-name drugs. Coinsurance maximums apply as shown in the chart below.

To identify network retail pharmacies in your area, contact the claim administrator.

If You Use an Out-of-Network Retail Pharmacy

If you use an out-of-network retail pharmacy, you pay the full cost of the covered prescription at the time of purchase, and then submit a claim form and receipt to the prescription drug claim administrator. You will be reimbursed at the network retail level less the coinsurance amount and applicable deductible (if any). You also must pay any difference between the network negotiated rate and the pharmacy's actual charge.

Maintenance Choice

The Maintenance Choice program allows you to receive the mail-service level of benefits for maintenance medications two ways. Use the mail-service to have your maintenance medication delivered to you or take your prescription to your local CVS retail pharmacy. The prescription for your maintenance medication must be written for a 90-day supply for both options. Also note that maintenance choice only applies to CVS locations, not other network pharmacies.

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. For generic drugs, you pay only a $5 copayment. For brand 80/20 or 50/50 drugs, you must pay a coinsurance amount. For generic or brand 80/20 drugs ordered through this program, there is no deductible, as shown in the chart in this section. If you enroll in the HDHP medical option, you must meet the HDHP's combined medical and drug deductibles before prescription drug coverage begins.

The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately. If you order more than three fills (original fill plus two refills) of a maintenance drug at a network retail pharmacy instead of ordering it through the mail-service program, you will pay an additional 10% of the cost.

To fill a prescription through the mail-service program, you must complete an order form and include a major credit card number, check or money order for your coinsurance amount. If you send a check or money order and the amount is incorrect, you will be billed if there is a balance owed or your account will be credited if there is an overpayment. In certain circumstances, if you do not include the coinsurance amount, you will be contacted by the prescription drug claim administrator before your order is filled. With your first order, you also must include the original prescription order written by your doctor (a copy is not legally acceptable) and a completed patient profile form. Mail your orders to the prescription drug mail-service program (see the address on the form).

Your filled prescription is mailed directly to your home or to another address that you provide. Your order will include a preprinted envelope and a refill notice that may be used to request a prescription refill; you do not need a new prescription from your doctor if the prescription is still valid.

For more information, to request an order form or to order refills, contact the claim administrator or visit their website

Prescription Drug Benefits					
	Network Retail Pharmacy (up to a 30-day supply) You pay an additional 10% of the cost if you buy a maintenance drug at a network retail pharmacy after three fills		**Mail-Service Program** (up to a 90-day supply)		
	Coinsurance	**Maximum Coinsurance per Prescription**	**Coinsurance**	**Maximum Coinsurance per Prescription**	**Deductible***
Generic	You pay 10% Plan pays 90%	$100	You pay $5 copay	Does not apply	None for network retail pharmacy or mail-service
Brand 80/20 (includes drugs that treat asthma and diabetes) Brand-name drug with no or few generic drug alternatives** available	You pay 20% Plan pays 80%	$100	You pay 20% Plan pays 80%	$200	None for network retail pharmacy or mail-service
When your brand 80/20 drug has a generic drug equivalent** but you choose the brand	You pay 10% of the generic drug cost plus the difference in cost between the brand-name and generic drug	$100; however, there is no maximum for the difference in cost or for the additional 10% for a maintenance drug filled at retail	You pay 10% of the generic drug cost plus the difference in cost between the brand-name and generic drug	$200; however, there is no maximum for the difference in cost	
Brand 50/50 Brand-name with appropriate generic drug alternatives** available	After deductible is met, you pay 50% Plan pays 50%	$100	After deductible is met, you pay 50% Plan pays 50%	$200	$50 person/ $100 family (one deductible that includes drugs purchased at a network retail pharmacy or through the mail-service)

Prescription Drug Benefits					
	Network Retail Pharmacy (up to a 30-day supply) You pay an additional 10% of the cost if you buy a maintenance drug at a network retail pharmacy after three fills		**Mail-Service Program** (up to a 90-day supply)		
	Coinsurance	**Maximum Coinsurance per Prescription**	**Coinsurance**	**Maximum Coinsurance per Prescription**	**Deductible***
When your brand 50/50 has a generic drug equivalent** but you choose the brand	You pay 10% of the generic drug cost plus the difference in cost between the brand-name and generic drug	$100; however, there is no maximum for the difference in cost or for the additional 10% for a maintenance drug filled at retail	You pay 10% of the generic drug cost plus the difference in cost between the brand-name and generic drug	$200; however, there is no maximum for the difference in cost	
Prescription Drug Out-of-Pocket Maximum (applies to PPO plan)	The out-of-pocket maximum for prescription drug coverage is $3,000 per person/$6,000 per family. When your share of covered drug expenses reaches the prescription drug out-of-pocket maximum, the plan pays 100% of your covered prescription drug expenses for the rest of the calendar year.				
Smoking Cessation Aids Over-the-counter smoking cessation aids prescribed by a physician	You pay nothing Plan pays 100%	Does not apply	Not applicable, retail only		None
Out-of-Network Retail Pharmacy (up to a 30-day supply)					
When you fill a prescription at an out-of-network pharmacy, you pay the full cost of covered prescriptions at the time of purchase, then submit a claim form and receipt to the prescription drug claim administrator. You will be reimbursed at the network retail level less the applicable coinsurance amount and deductible (if any). You also must pay any difference between the network negotiated rate and the pharmacy's actual charge.					

**If you elect the HDHP medical option, you must meet the HDHP's combined medical and prescription drug deductible before prescription drug coverage begins.*

***For definitions of generic drug alternative and generic drug equivalent, see the Definitions section*

Drug Usage Guidelines

Certain limitations and/or criteria may apply to specific drugs to ensure patient safety and adherence to appropriate prescribing patterns. Some examples of programs used by the claim administrator include the following.

Step Therapy

This feature is designed to ensure that you follow a safe and appropriate progression of drug therapy for certain conditions, such as acid reflux, arthritis, glaucoma, allergies/sinus conditions and others. You are required to try an alternative generic drug before the plan will pay for the higher cost drug prescribed by your doctor. Requiring a generic drug first allows you to realize lower costs without compromising safety or effectiveness of treatments. However, the drug that your doctor prescribed may be covered if the alternative drug does not work or if you have a medical condition that prohibits you from taking it. If you wish to obtain approval for when you have not tried a generic drug, your doctor must contact the claim administrator's Prior Authorization Department. You can learn if your medication is included in Step Therapy by calling the prescription drug claim administrator.

Managed Drug Limitations (MDLs)

Under this program, the quantity and dosing level are limited to encourage pharmacists and doctors to adhere to the quantity recommended by the National Prescribing Guidelines and the Federal Drug Administration (FDA). Your retail pharmacist will receive a message on his or her system if you attempt to fill a prescription for a quantity above the established limit. Either you or your pharmacist must contact your doctor, who must then contact the claim administrator's Prior Authorization Department to obtain approval for a quantity above the established limit. If your doctor determines that you need a greater quantity of drugs than the quantity approved by the claim administrator, you can obtain those amounts, but at your own expense. They will not be covered by the plan.

Prior Authorization

Certain prescriptions may require prior authorization by the claim administrator. If you are aware that your prescribed drug requires prior authorization, your doctor must contact the claim administrator's Prior Authorization Department to obtain authorization before you go to the pharmacy to fill your prescription. If you find that the drug requires prior authorization while you are at the pharmacy, you or your pharmacist must contact your doctor, who must then contact the claim administrator's Prior Authorization Department.

The claim administrator's mail-service facility will contact your provider directly if it receives a prescription affected by step therapy, managed drug limitations or prior authorization. You may contact the prescription drug claim administrator if you want to ask if your drug is affected by one of these programs.

Compound Medication Coverage

Compound medications are made by combining, mixing or altering ingredients, in response to a prescription, to create a customized medication. Prior authorization is required for all compound medicine claim exceeding $300. Some bases and bulk compounding powders are excluded from prescription drug coverage. Contact the prescription drug claim administrator at their toll-free telephone number for prior authorization. Select commercially manufactured analgesics (i.e., pain patches) are not compound drugs and are not covered under the Plan.

Covered Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, *are* covered under the plan:

- AZT, Retrovir and other drugs used for the purpose of treating AIDS, unless experimental or investigational;
- Alcohol swabs, when needed for injectable medicines;
- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- Diabetic supplies (such as Chemstrips);
- Drugs to treat narcolepsy and Attention Deficit Disorder (ADD) (e.g., Adderall, Dexedrine, Ritalin); after age 21, prior authorization must be received from the claim administrator for these drugs. Provigil is covered for narcolepsy only and prior authorization is required in all cases;
-
- Insulin, disposable insulin pens, insulin cartridges and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- Prescription fluoride treatments;
- All dosage forms of smoking-cessation aids, whether prescription type (such as Wellbutrin) or physician-prescribed over-the-counter type (such as nicotine patches and nicotine gum);
- Prescription drugs for weight loss;
- Over-the-counter smoking cessation aids prescribed by a physician;
- Compound medication when one ingredient is a legend drug;
- Fertility drugs;
- Oral contraceptives, injectable contraceptives and contraceptive devices (e.g., IUDs and diaphragms);

- Prescription prenatal vitamins;
- Vitamins and dietary supplements that require a prescription;
- Acne drugs (e.g., Retin-A, Avita); however, if the patient is age 35 or older, prior authorization must be obtained from the claim administrator;
- Xolair, only with prior authorization from the claim administrator;
- Pigmenting and depigmenting agents, only with prior authorization from the claim administrator;
- Drugs to treat narcolepsy; however, prior authorization from the claim administrator is required whenever Provigil is prescribed for the treatment of narcolepsy;
- Attention Deficit Disorder (ADD) drugs (e.g., Adderall, Dexedrine, Ritalin); however, if the patient is age 21 or older, prior authorization must be received from the claim administrator; and
- Impotency drugs; however, prior authorization from the claim administrator is required if, within a 30-day period, the prescription is for more than a 10-day supply.

Expenses Not Covered

The following drugs and supplies, among others, are *not* covered under the plan:

- Prescriptions that do not comply with the Drug Usage Guidelines described above;
- Any prescription refilled in excess of the number specified by the doctor or any refill dispensed more than one year after the doctor's original order;
- Drugs or supplies covered under workers' compensation or occupational disease law or any similar law;
- Drugs labeled "Caution—limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Drugs used to treat or cure baldness or hair loss (e.g., Minoxidil);*
- Charges for the administration or injection of drugs;
- Norplant contraception;
- Anti-wrinkle agents (e.g., Renova);*
- Illegal drugs and medicines that may not be prescribed within the scope of the doctor's license;
- Medication administered in a doctor's office or health care facility;
- Prescriptions filled in hospital out-of-network pharmacies at time of discharge;
- Over-the-counter drugs and products, except smoking cessation aids prescribed by a doctor; and
- Therapeutic devices or appliances, support garments and other non-medicinal substances, regardless of intended use.

* *May be purchased under the Discount Program (see next section).*

Discount Program

Under the Discount Program—available at network retail pharmacies only—you may receive discounts on prescription drugs that are not covered under the plan. For example, the following drugs are eligible for the Discount Program:

- Anti-wrinkle agents (e.g., Renova);
- Hair-loss drugs (e.g., Propecia);
- Drugs for hair removal (e.g., Vaniqua); and
- Provigil, except for treatment of narcolepsy (see "Covered Prescription Drugs and Supplies").
- To use the Discount Program, show your prescription drug ID card to the pharmacist when you purchase these prescriptions. Discounts will vary by prescription and may be void during pharmacy and retail store specials.
- The Discount Program is not available at out-of-network retail pharmacies or through the mail-service program.
- Two categories of medications are *not* included in the Discount Program:
- Drugs that are covered under the plan only with prior authorization (e.g., Xolair); and
- Non-prescription (over-the-counter) items.
- If you have questions about the program, contact the claim administrator

DENTAL BENEFITS

How the Plan Works

Important information you need to know about your dental benefits is shown below.

- You must enroll for dental coverage for yourself only or you and your family (see "Coverage Categories") or you may elect to opt out of coverage. Your dental election is made every year (see "Enrollment").
- If you enroll in an HMO, you may elect dental coverage under the plan.
- If you participate in the Health Care Fund or a limited flexible spending account, you may use contributions in these funds to help pay for dental expenses not covered by the plan. If you are enrolled in the HDHP medical option, you may use your HDHP account to help pay for these expenses. For information about how each account may be used to pay for dental expenses, see the *Flexible Spending Accounts and Health Savings Account* booklet.
- Any amounts you pay for covered dental expenses will not apply to your medical or prescription drug deductibles or out-of-pocket maximums, if applicable.

The chart below shows the benefits for covered dental expenses under the plan.

Participating and Non-Participating Dental Providers

Under the plan, your dental benefits are delivered through a Preferred Provider Organization (PPO). A PPO is a type of managed care plan in which a network of licensed dental care providers has agreed to provide services for negotiated rates.

The dental PPO is a "passive" PPO, which means that the benefit amount (or coinsurance percentage) is the same whether you use a participating or non-participating provider. However, because participating providers have agreed to negotiated rates, you will pay less for covered services. Each time you need dental care, you may choose to use a participating or non-participating provider.

For covered services, the plan pays from 50% to 100% of the negotiated rate—called the maximum allowable charge (MAC)—for both participating providers and non-participating providers.

If you use a non-participating provider, you will pay the difference between the MAC allowance and the provider's charge, in addition to your coinsurance. Any excess amount you pay does not apply to your deductible or out-of-pocket maximum. Also, you may be responsible for filing claims.
To encourage good dental health, the plan pays a higher benefit for preventive and diagnostic care.

For information about participating providers, contact the dental claim administrator.

Your Deductible

A deductible is money you must spend on your own for covered expenses before the plan pays benefits. The deductible does not apply to covered preventive and diagnostic care (except for sealants) or to orthodontia. For all other covered services, you must meet the deductible before the plan pays benefits.

Your Coinsurance

Once you meet your deductible (if one applies), the plan pays a certain portion of covered dental expenses, and you are responsible to pay a portion. For example, if you use a participating provider for basic restorative services, the plan pays 80% and you pay 20% of a covered expense. The portion you must pay is a coinsurance. The coinsurance amounts are shown in the chart below.

Maximum Allowable Charge (MAC)

For participating providers, the maximum allowable charge (MAC) for a covered service is determined by the dental claim administrator, based on data compiled by national resources, its own experience and competitive pricing.

For non-participating providers, reimbursement is based on the dental administrators schedule of maximum allowable charges (MACs). Non-participating dentists may bill for any difference between the MAC allowance and their fee (also known as balance billing). As such, if a non-participating provider charges more than the MAC allowance, you must pay the excess in addition to your coinsurance.

IMPORTANT: If You Use a Non-Participating Dentist

If you use an out-of-network dentist, reimbursement of charges from a non-participating provider is subject to allowed amounts set by the Company's dental claim administrator. If a nonparticipating provider charges more than the allowed amount for a covered service, you must pay any excess charges in addition to your coinsurance. You may also be responsible for filing claims

Covered Dental Expenses

The plan covers diagnostic and preventive care, as well as treatment for a disease, defect or accident that injures the teeth and is not work related. Treatment must meet generally accepted dental practice standards and be provided by a licensed provider. Some services, such as cleanings, may be performed by a licensed dental hygienist supervised by a dentist.

Covered dental expenses are divided into five types of care:

- Preventive and diagnostic services;
- Basic restorative services;
- Major restorative services;
- Oral surgery; and
- Orthodontia.

The following chart shows the benefits for covered expenses under the plan. The benefit amount shown is up to the MAC allowance, after the deductible is met.

The chart does not list every service the plan covers. The dental claim administrator sets payments for covered services that are not listed on the chart. For definitions of dental terms, see information below.

Your Dental Benefits	
Covered Expense	**Costs**
Your deductible	$50/$100
Annual Maximum (for all covered services except Orthodontia)	Plan pays $2,000/person

Your Dental Benefits	
Covered Expense	**Costs**
Preventive and Diagnostic Care	Plan pays 100% no deductible except for sealants which are paid at 80% for covered dependent children up to age 14 and are subject to deductible.
Basic Restorative Services	Plan pays 80%
Major Restorative Services	Plan pays 50%
Oral Surgery	Plan pays 80%
Orthodontia (for eligible dependent children to age 19)	Plan pays 50% to separate lifetime maximum of $1,500
Preventive and Diagnostic Services	
Oral exams twice in a calendar year	Plan pays 100%
Prophylaxis (cleaning, scaling and polishing) twice in a calendar year	Plan pays 100%
Surface fluoride treatments	Plan pays 100%
Bitewing X-rays twice in a calendar year	Plan pays 100%
Full mouth X-rays once every three years	Plan pays 100%
Space maintainers that replace prematurely lost teeth for covered dependent children under age 19	Plan pays 100%
Emergency treatment to temporarily relieve dental pain	Plan pays 100%
Sealants for covered dependent children up to age 14. The plan does not cover repair or replacement of sealants within five years of application. (Deductible applies to this service.)	Plan pays 80%
Basic Restorative Services	
X-rays (except as noted under Preventive and Diagnostic Services)	Plan pays 80%
Extractions (except if covered under Oral Surgery or Orthodontia)	Plan pays 80%
Fillings (amalgam, silicate, acrylic, synthetic porcelain, gold and composite)	Plan pays 80%
Periodontics (treatment of the gums and supporting structures of the teeth)	Plan pays 80%

Your Dental Benefits	
Covered Expense	**Costs**
General anesthetics and intravenous agents related to restorative care, but not for local anesthetics such as Novocain	Plan pays 80%
Endodontics (root canal therapy)	Plan pays 80%
Antibiotic drug injections when injected by attending dentist	Plan pays 80%
Repair or rebasing of existing dentures, performed at least six months following the installation of an initial or replacement denture, but not more than one relining or rebasing in any consecutive 36-month period	Plan pays 80%
Major Restorative Services	
Onlays, inlays or crowns to restore decayed or accidentally broken teeth (only if the teeth cannot be restored with a filling of any type)	Plan pays 50%
Initial installation of fixed bridgework, including inlays and crowns as abutments	Plan pays 50%
Initial installation of full or partial removable dentures, including precision attachments (when necessary) and any adjustments during the six-month period after installation	Plan pays 50%
Replacement of existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework or the addition of teeth to an existing partial removable denture or to bridgework, subject to proof that the: ▪ service is required to replace teeth extracted after the existing denture or bridgework is installed; ▪ existing denture or bridgework cannot be used and was installed at least five years before its replacement; or ▪ existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of the initial installation. Normally, dentures will be replaced by dentures; however, if professionally adequate results can be achieved with bridgework only, such bridgework will be covered.	Plan pays 50%
Dental implants (limited to one implant per tooth per lifetime for participants age 18 or older only)	Plan pays 50%
Oral Surgery	
Surgical removal of impacted teeth, including nonbony impacted teeth (predetermination of benefits is required for patients under age 14 and over age 31)	Plan pays 80%

Your Dental Benefits	
Covered Expense	**Costs**
Dental root resection or apicoectomy	Plan pays 80%
Alveolectomy (if in an area that contained at least six teeth) or complete upper and lower	Plan pays 80%
Removal of a radicular or dentigerous cyst	Plan pays 80%
General anesthetics and intravenous agents related to procedures under covered surgery, but not for local anesthetics such as Novocain	Plan pays 80%
Orthodontia	
Limited to covered dependent children up to age 19; but if treatment for this child began before age 19, it will be covered until the child reaches age 20. Corrective treatment of dental problems that require repositioning of teeth to give a normal bite (except for preventive treatment) and that resulted from abnormal growth and development of teeth and their surrounding structures or from accidental injury. Covered orthodontic treatment includes diagnostic procedures and treatment, surgical therapy, appliance therapy and functional/myofunctional therapy (including related oral exams, surgery and extractions). For orthodontic treatment, it is assumed that the first charge will be made on the date appliances are first installed. You must enroll for the Comprehensive dental option each plan year in which you will use these services. In addition, if an approved treatment or payments for an approved treatment continue into a new plan year, you must enroll in dental plan for that year. If you fail to do so, the plan will not cover any treatment or remaining orthodontia expenses, even though they were approved in the previous year.	Plan pays 50% up to a separate lifetime maximum of $1,500/person; no deductible applies

Treatments That May Continue After Coverage Ends

If your dental coverage ends for any reason other than the failure to pay premiums or coinsurance amounts or fraud on your part, treatment may continue in the following circumstances.

For a dental procedure that requires two or more dental office visits on separate days, coverage will extend for 90 days.

For covered orthodontic treatment, coverage will extend for 60 days if the orthodontist is receiving monthly payments; or 60 days or the end of a quarter, whichever is longer, if the orthodontist is receiving quarterly payments.

Predetermination of Benefits

When you or a covered dependent expects to have dental treatment that may cost more than $300, you should request a “predetermination of benefits” (also called a pretreatment estimate) from the dental claim administrator. This lets you and the provider know in advance:

- The estimated cost of the treatment; the estimated benefit payment; and possible alternative methods of treatment that may be less expensive.
- A predetermination estimate does not guarantee benefits from the plan. However, it explains how the plan works in your specific situation and helps you to make an informed decision about whether to go ahead with treatment.

To file for predetermination, have your provider complete a standard American Dental Association (ADA) claim form, describing the planned services and estimated charges and submit it before treatment begins. If the treatment plan changes, your provider should submit another form. The dental claim administrator will notify you and your provider of the benefits payable by sending a Dental Predetermination Notification and Request for Payment form showing what the plan may pay.

Your actual payment may vary if:

- You have other coverage;
- You have additional services performed;
- Your coverage under the plan stops before you are treated or complete treatment; or
- You reach your maximum benefit limit.

If you do not request a predetermination of benefits, the dental claim administrator will decide on the benefits payable after treatment is received and a claim is filed. You will be responsible for any difference between the plan’s payment and the actual charges (see “Claims Procedure”).

Alternative Treatments

Many dental conditions can be treated properly in more than one way. In these situations, the dental claim administrator will determine which treatment method will be covered, based on the:

- Service customarily used nationwide to treat the condition;
- Service recognized by the dental profession as appropriate, based on broadly accepted nationwide standards of dental practice; and
- Overall oral condition of the patient.

You and your provider may choose another method. However, if the costs of the alternative method are higher than the method the plan covers, you will be responsible for the additional costs.

For example, if a tooth can be satisfactorily restored with an amalgam filling and you choose to have a more costly filling material or a crown, the plan will pay only the amount that would have been payable for the amalgam filling. You are responsible for the difference in cost.

Expenses Not Covered

The following expenses, among others, are not covered under the plan. Additional exclusions are presented in the dental policy. Contact your dental claim administrator to be sure a service is covered.

- Expenses covered under the Company's medical or prescription drug benefits;
- Services performed for cosmetic reasons;
- Services or supplies that are experimental or investigational, as determined by the claim administrator;
- Charges for canceled or missed appointments;
- Duplicate devices or appliances;
- Expenses for completing claim forms or filing claims;
- Services and supplies covered by laws or regulations of any government agency, unless specifically covered under the plan;
- Instructions in oral hygiene or diet;
- Plaque control programs;
- Prosthetic devices, and the fitting of these devices, if ordered
  - Before the patient is covered,
  - After coverage stops; or
  - While the patient is covered, but delivered or installed more than 60 days after coverage stops;
- Stainless steel crowns for patients over age 14;
- Replacement of lost or stolen prosthetic devices;
- Replacement or repair of orthodontic appliances;
- Services for periodontal splinting;

- Services or supplies not necessary to restore or maintain function of a tooth;
- Sealants (except for covered dependent children up to age 14);
- Services or supplies received before the patient was covered by the Company's dental benefits;
- Services or supplies for defect, disease or injury due to war or a warlike action in time of peace;
- Services or supplies for injury or disease that entitles the patient to benefits under a workers' compensation or occupational disease law or any similar law;
- Services or supplies for which payment is made to or for the patient through legal action or settlement related to the incident that caused the services or supplies to be provided;
- Services or supplies for which the patient does not have to pay or for which no charges would be made if this coverage did not exist;
- Services or supplies not recommended or approved by the provider in charge of the case;
- Services or supplies that do not meet generally accepted standards of dental practice;
- Services or supplies to increase vertical dimension or restore occlusion;
- Substances or agents given to reduce fear or analgesia (except if the patient is disabled by cerebral palsy, mental retardation or spastic disorders);
- Veneers or similar properties of crowns or pontics, except for the 10 upper or lower front teeth; and
- Services needed because the patient does not follow a professionally prescribed treatment plan.

For example, a dentist advises a participant that a root canal and crown is the prescribed treatment plan for a participant's symptoms. However, the participant chooses to have only the crown done. As a result, the participant has to have the tooth pulled and a bridge put in because the root canal was not done. In this case, the bridge would not be covered under the plan, since the prescribed treatment plan was not followed by the participant.

Dental Terms

Here are some common dental terms. Ask your dental provider to explain any other services or terms you do not understand.

Abutment—A tooth or root that holds or supports a bridge or crown.

Alveolectomy—The trimming and removal of bone or gum tissue, usually at the time of extraction, to eliminate lumps and sharp edges in the dental ridge.

Amalgam—A metal filling for teeth.

Anesthesia—

- **General—**Drugs to make a patient unconscious and completely without pain.
- **Local—**Drugs to cause loss of feeling in a specific place.

Anesthetic—The drug used in anesthesia.

Apicoectomy—Surgical removal of the infected area or root tip in conjunction with root canal therapy.

Appliance—A device used for functional or healing purposes.

Bitewing X-ray—X-ray of both upper and lower teeth at the same time.

Bridgework—

- **Fixed—**A set of one or more false teeth cemented in place in the mouth. Retainers hold pontics to the abutment teeth.
- **Fixed removable—**A set a dentist can remove, but the patient cannot.
- **Removable—**A set usually held by clasps that the patient can remove.

Crown—The enamel or metal covering of a tooth.

Dental Hygienist—A person trained to remove deposits and stains from teeth and to instruct patients about avoiding oral disease. A dental hygienist works under a dentist's supervision.

Denture—A device replacing some or all teeth; it may be fixed or removable.

Endodontics—Root canal therapy.

Extraction—Pulling a tooth.

Fluoride—A solution applied to teeth to prevent decay.

Implantation—Inserting an artificial root into a bone to form a support for a restoration.

Impression—A mold of a tooth or jaw.

Inlay—A filling cemented into a tooth cavity.

Onlay—A filling covering the entire surface of the tooth.

Orthodontics—Treatment to correct the position of the teeth.

Periodontics—Treatment of the gums and supporting structures of the teeth.

Plaque Control—Preventing and removing bacteria buildup on teeth.

Pontic—A false tooth on a fixed bridge.

Prophylaxis—Professional teeth cleaning; may include scaling to remove stains and tartar from teeth.

Prosthesis—False teeth and other dental structures.

Prosthodontics—Treatment to replace missing teeth or other dental structures.

Pulp—The soft, sensitive tissue of a tooth.

Restoration—Repairing and restoring the shape, form or function of part or all of a tooth; may be an inlay, amalgam, crown, bridge or denture.

Root Canal—Treatment to remove damaged pulp of a tooth and fill the remaining hole with a sealant.

Root Resection—Removal of the diseased portion of a root.

Scaling—The removal of tartar and stains from teeth with special instruments.

Sealant—An acrylic substance painted on the grooves and fissures of first and second permanent molars to prevent decay.

Splinting—A process to secure teeth.

Topical—A solution that is applied to the surface of teeth.

Vertical Dimension—The distance between the upper and lower jaws when the teeth close together

VISION BENEFITS

How the Plan Works

Vision benefits under the plan cover routine vision exams, lenses or contacts and frames for you and your covered dependents. A licensed ophthalmologist, optometrist or optician must provide the services.

You may enroll yourself only or you and your family (see "Enrollment"). For information about coverage categories for vision benefits, see "Coverage Categories". If you enroll in an HMO, you still may elect vision coverage under the plan.

Vision Network

Vision benefits are delivered through a network of vision care providers who have agreed to provide services at negotiated rates. Each time you need vision care, you may use an in-network or out-of-network provider.

If you use an in-network provider, a larger portion of your covered expenses is paid by the plan (except for special retail sales/packages) and there are no claim forms to file. For a list of in-network providers in your area, call 1-844-31ALCOA (1-844-312-5262) or visit the vision care website.

If you use an out-of-network provider, you must pay the provider directly and then submit a claim to the vision care claim administrator. You will be reimbursed for covered vision services up to the out-of-network benefit limit.

The chart on the next page shows the in-network and out-of-network vision benefits coverage provided under the plan.

Other important information you need to know about your vision benefits is shown below.
There is no deductible for vision benefits.

Any amounts you pay for covered vision expenses will not apply to your medical, prescription drug or dental deductibles or your out-of-pocket maximums.

If you participate in the Health Care Fund or a limited flexible spending account, you may use contributions in these funds to help pay for vision expenses not covered by the plan. If you are enrolled in the HDHP medical option, you may use your HSA account to help pay for these expenses. For information about how each account may be used to pay for vision expenses, see the *Flexible Spending Accounts and Health Savings Account* booklet.

Under the Company's vision plan, coordination or non-duplication of benefits does not apply. This means vision benefits you may have under another employer's plan will not affect the benefit paid by the plan.

Vision Benefits		
	In-Network*	**Out-of-Network**
Annual Deductible	None	None
Covered Expenses		
Routine Vision Exam (once per calendar year)	Plan pays 100%	up to $35
Standard Lenses** (per set; once per calendar year) ▪ Single vision ▪ Bifocal ▪ Trifocal ▪ Lenticular (Biconvex)	 Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100%	 up to $35 up to $51 up to $68 up to $80
Frames (once every two calendar years)	Plan pays 100% up to $100 retail charge	up to $30
Contact Lens Fitting (once per calendar year)	Plan pays 100%	up to $35
Contact Lenses (instead of standard lenses; once per calendar year)	Plan pays 100% up to $105 retail charge	up to $68

** In-network providers are not obligated to accept these benefit amounts in special retail sales or packages; you may be required to pay the sale/package price and be reimbursed by the claim administrator at the out-of-network allowance.*

***Amounts shown are for standard lenses only. Lens options such as coatings, tints and progressive bifocals are not covered (see "Expenses Not Covered"). If you choose non-standard lens features, you pay the difference between their cost and the plan allowance for standard features. In-network providers may offer a discount on non-standard lens features.*

Covered Vision Expenses

Covered vision expenses are:

- Routine eye exam once per calendar year;
- Standard lenses or contact lenses once per calendar year. (Lenses may be replaced more than once within a calendar year if the covered individual experiences an axis change of at least 20 degrees or a sphere or cylinder change of at least 0.50 diopters, and the new lenses improve visual acuity by at least one line on the standard vision chart.);
- Frames once every two calendar years; and
- Contact lens fitting once per calendar year.

Generally, treatment for disease or injury to the eye is covered under medical benefits coverage.

Expenses Not Covered

The following expenses, among others, are not covered under the plan:

- Expenses covered under medical or prescription drug benefits;
- Vision exams performed and lenses/frames/contacts ordered before you were covered under the plan;
- Additional charges for non-standard lenses, including blended lenses, oversize lenses, progressive multifocal lenses, progressive bifocals, photosensitive or antireflective lenses, coated or laminated lenses, tinted lenses and cosmetic lenses. (Network providers may offer a discount on non-standard lens features.);
- Sunglass lenses (however, lenses with tints 1 and 2 are covered);
- Services in connection with medical or surgical treatment of the eye, including LASIK surgery and radial keratotomy;
- Drugs or medications (except those required for a vision exam);
- Special services and procedures such as orthoptics, vision training, subnormal vision aids, aniseikonic lenses and tomography;
- Services or supplies that are experimental or investigational, as determined by the claim administrator;
- Services or supplies for defect, disease or injury due to war or a warlike action in time of peace;
- Replacement of a lost or broken lens or lenses and/or frames unless, at the time of replacement, it would be a covered vision expense;
- Services not prescribed as necessary by a licensed ophthalmologist or optometrist;

- Services covered by any other part of the plan or by a safety glass program;
- Services or supplies for injury or sickness that entitles the patient to benefits under a workers' compensation or occupational disease law or any similar law;
- Services or supplies covered by laws or regulations of any government agency, unless specifically covered under the plan;
- Services for which the patient does not have to pay or for which no charges would be made if this coverage did not exist;
- Services or supplies for which payment is made to or for the patient through legal action or settlement related to the incident that caused the services or supplies to be provided;
- Services or supplies not furnished by a licensed ophthalmologist, optometrist or optician;
- Services or supplies you receive after your coverage stops;
- Any excess charges above the scheduled vision care benefits; and
- Contact lens solution, over-the-counter eye drops and other related items

DEFINITIONS

Here are the definitions for some terms used in this booklet. If you have questions about these or other terms, call 1-844-31ALCOA (1-844-312-5262).

Actively at Work

You are considered actively at work if you:

- Are presently at work for the Company; or
- Were present at work on the last scheduled working day before:
  - A scheduled vacation;
  - An absence due to a paid holiday, paid jury or witness day or a paid bereavement day;
  - A scheduled day off within your working schedule; or
  - A short-term absence for authorized local union business.

Birthing Center

A facility that provides prenatal, labor, delivery and postpartum care for medically uncomplicated pregnancies.

Blue Distinction© Centers of Excellence

Blue Distinction Centers of Excellence are medical centers/hospitals throughout the country that frequently perform highly specialized medical care and achieve the highest success rates in patient outcomes and care. They are selected on the basis of quality indicators, such as survival rates and morbidity, as well as cost efficiencies (based on national average costs for similar procedures). Typically, the Centers of Excellence are used for specialty care conditions such as bariatric surgery, cardiac services, complex and rare cancers, knee and hip replacements, spine surgery and transplants.

Certified Nurse-Midwife

A registered nurse (R.N.) certified by the American College of Nurse-Midwives. For services to be covered, the nurse-midwife must work under the direction of a doctor, bill for services under the doctor's taxpayer ID and provide services in line with nurse-midwife certification.

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This federal law allows a continuation of health care coverage in certain circumstances.

Coinsurance
The percentage of the cost of covered expenses you must pay after you meet any applicable deductible; for example, when the plan pays 80%, the remaining 20% is your coinsurance.
Company
Alcoa USA Corp. and affiliated companies that have adopted this plan.

Complete Claim (Proper Claim)
A previously incomplete claim for which you have submitted the missing or additional information required for the claim administrator to make a determination.

Concurrent Care Claim
A claim for a benefit that involves an ongoing course of treatment.

Custodial Care
Services and/or care not intended primarily to treat a specific injury or illness (including mental health and substance abuse). Services and care include, but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods or taking medications that usually can be self-administered; and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible
The dollar amount (for individual or family) you must pay each year before the plan begins to pay benefits.

Doctor
A doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.) or a podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Domestic Partner
Your partner of the same gender or opposite gender who is not otherwise your legal same- or opposite-gender spouse or common-law spouse (as defined by federal law). In addition, you and your partner must meet the following criteria:

- You must be living together for one or more years;

- You must be financially interdependent; and
- You must not be blood relatives.
- You must submit an affidavit and supporting documentation as part of the domestic partner verification process.

Eligible Provider

Any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, osteopath, podiatrist, chiropractor, hospital or laboratory.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, a federal law that governs group benefit plans.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the claim administrator makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food & Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use;
- The subject of an ongoing clinical trial that meets the definition of a phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial actually is subject to FDA oversight; or
- Not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Full-Time Employee

An active employee who works on a regular work schedule and is not a part-time or temporary employee.

Generic Drug Alternative

A generic drug that is not the exact equivalent of the brand-name drug but can be used to treat that medical condition. For example, there are generic options to treat high cholesterol.

Generic Drug Equivalent

A generic drug that has the exact same active ingredients as the brand-name drug. When a drug patent expires, other companies may produce a generic version of the brand-name drug. A generic medication, also approved by the Federal Drug Administration (FDA), is basically a copy of the brand-name drug and is marketed under its chemical name. A generic may have a different color or shape than the brand-name, but it must have the same active ingredients, strength and dosage form (i.e., pill, liquid or injection) and provide the same effectiveness and safety.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

Hospice

A facility set up to give terminally ill patients a coordinated program of inpatient, outpatient and home care. The claim administrator must approve the hospice.

Hospital

A legally licensed facility that:

- Is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals; or
- Provides a broad range of 24-hour-a-day medical and surgical services by or under the direction of a staff of doctors and is engaged primarily in providing either:
- General inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control; or
- Specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control or through a written agreement with a hospital that itself qualifies under the above description or with a specialized provider of these facilities.

The term hospital does not include a facility that primarily is a place for rest, a place for the aged or a nursing home.

Improper Claim

A claim that is not filed according to plan procedures. You or your representative will be notified if a claim is determined to be filed improperly. The notice will contain the steps and the time frame that must be followed to resubmit the claim for a determination.

Incomplete Claim

A claim that does not contain sufficient information for a determination to be made. You or your representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

In-Network Provider

A health care professional or facility that is contracted by the claim administrator to provide health care benefits under the plan.

Layoff

A temporary absence from employment because of a reduction in the workforce.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Legend Drug

A drug that is required by federal law to have a prescription in order to be dispensed.

Managed Care

A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork and prescribed standards for medically necessary treatment.

Medically Necessary

Plans cover only medically necessary services and supplies, as determined by the claim administrator. To be medically necessary, all care must be:

- In accordance with standards of good medical practice;
- Consistent in type, frequency and duration of treatment with scientifically based guidelines, as accepted by the claim administrator;
- Required for reasons other than the convenience of the health care provider or the comfort or convenience of the patient;
- Provided in a cost-efficient manner and type of setting appropriate for the delivery of that service/supply;
- Consistent with the eligible diagnosis of the condition;
- Not experimental or investigational, as determined by the claim administrator; and
- Demonstrated through authoritative medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The fact that a doctor performs or prescribes a procedure or treatment or that it may be the only treatment for a particular condition does not mean that it is medically necessary as defined here. The definition of medically necessary used in the Alcoa USA plan may differ from the way a health care provider defines the term.

Medicare
Health Insurance of the Aged and Disabled provisions of the United States Social Security Act, as amended.

Network
A group of doctors, hospitals and other providers contracted by the claim administrator to provide health care services for a plan's members at agreed-upon rates.

Network Pharmacy
A pharmacy contracted by the claim administrator to provide prescription drug benefits under the plan.

Out-of-Network Pharmacy
A pharmacy not contracted by the claim administrator to provide prescription drug benefits under the plan.

Out-of-Network Provider
A health care professional or facility not contracted by the claim administrator to provide health care benefits under the plan.

Out-of-Pocket Maximum
The maximum amount you pay for covered medical and/or prescription drug expenses (including expenses for eligible dependents) in a calendar year. When you reach the out-of-pocket maximum, the plan pays 100% of your eligible covered expenses for the rest of the calendar year.

Part-Time Employee
An active employee who works at least 50% but less than 100% of the regular work schedule for that location, but who is not a temporary employee.

Permanent Separation

The termination of employment through no fault of the employee for lack of work for reasons associated with the business, for whom the Company determines there is no reasonable expectation of recall. A permanent separation from employment occurs on the first day of a month. In no event does a permanent separation from employment occur if the employee is offered suitable employment by the Company, a subsidiary or a successor employer. As used in this booklet, an “offer of suitable employment” for an employee is determined solely by the Company, and the Company has the discretionary authority to make such a determination.

Post-Service Health Claim

A claim for a benefit under the plan that is not a pre-service claim.

Pre-Service Health Claim

A claim for a benefit that, under the terms of the plan, requires you to receive, in whole or in part, prior approval from the claim administrator as a condition to receive the benefit.

Prudent Layperson

An individual who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that:

- Provides for child support with respect to an employee’s child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law; or
- Enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan.

A QMCSO or an NMSN also may be issued through an administrative process established under state law. You must notify the plan administrator if you are subject to a QMCSO or an NMSN.

Qualifying Event

An occurrence, defined by law, entitling a person to elect continuation coverage under COBRA. Qualifying events include termination of employment (or a reduction in hours), death of a covered employee or retiree and divorce or legal separation.

Skilled Nursing Facility

A facility that:

- Qualifies under the Health Insurance of the Aged and Disabled provisions of the United States Social Security Act (Medicare), as amended; and
- Is approved by the claim administrator.

Temporary Employee

An employee paid through the Company's payroll system who:

Does not work on a regular schedule or works less than 50% of the regular hours for that location or works 50% or more of the regular hours for that location but is hired for a specified period not to exceed 12 months; and

Is not eligible for any Company benefits.

Urgent Care Claim

A claim for medical treatment which, if the regular periods observed for claims were adhered to:

Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

- Would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed.
- Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual acting on behalf of the plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

ADMINISTRATIVE INFORMATION

This booklet provides a summary of health care under the Group Benefits Plan for Salaried Employees of Alcoa USA Corp. and the Group Benefits Plan for Hourly Employees of Alcoa USA Corp. These plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

Information in this section applies only to the plans described above. The Health Savings Account is not part of the plans and, therefore, is not governed by ERISA regulations. Questions or issues concerning an HSA account should be directed to the Health Savings Account administrator as follows.

- BenefitWallet-Administrator, Health Savings Account (HSA)P.O. Box 1584Secaucus, NJ 07194-15841-877-472-4200, **www.mybenefitwallet.com**
- Beginning in 2021, the Health Savings Account administrator is Smart Choice, 1-844-312-5262 or access it through the UPoint site.

This section contains legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- How to contact the plan administrator;
- How to contact the claim administrators;
- What to do if a benefit claim is denied; and
- Your rights under ERISA and other federal laws such as COBRA.

Plan Sponsor and Administrator

Alcoa USA Corp. is the sponsor and the plan administrator for these plans. You may contact the plan administrator at the following address and telephone number.

Plan Administrator—Health Care Benefits

Alcoa USA Corp.
Suite 500
201 Isabella Street
Pittsburgh, PA 15212
412-315-2900

As specifically set forth under ERISA, the plan administrator:

- Is responsible for the preparation and the filing with governmental agencies of all summaries, descriptions, annual and other reports, notices and other documents and information;

- Must furnish appropriate information to plan participants;
- Must retain appropriate records; and
- Must have all of the other responsibilities and duties of the administrator of the plans as specifically set forth in ERISA.

In addition, the plan administrator has the discretionary authority to determine eligibility under all provisions of the plans; correct defects, supply omissions and reconcile inconsistencies in the plans; ensure that all benefits are paid according to the plans; interpret plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the plans. Benefits under the plans will be paid only if the plan administrator decides in its discretion that the applicant is entitled to them.

No court shall use any equitable principles in interpreting any ambiguous language in this SPD and shall look solely to the intent of the parties when any ambiguous language was drafted to interpret any such ambiguous language. The interpretation of the Company shall control in all instances.

Upon written request to the plan administrator, you may obtain a list of employer and employee organizations that participate in these plans. You also may inquire whether a particular employee organization sponsors these plans and request the organization’s address. The plans are maintained pursuant to one or more collective bargaining agreements. You may request information about whether the plans cover the members of your particular employee organization, obtain the address of that employee organization if members are covered under the plan and obtain a copy of that collective bargaining agreement.

Plan Year

The plan year is January 1 through December 31.

Type of Plan

These plans are called “welfare plans” and include group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

Following are the Employer Identification Number (EIN) and plan number for each plan.

Alcoa USA Corp.: EIN 37-1808900

- Group Benefits Plan for Salaried Employees of Alcoa USA Corp., Plan 502
- Group Benefits Plan for Hourly Employees of Alcoa USA Corp., Plan 503

When referring to the plan in claims appeals or other correspondence, you will receive help more quickly if you use the full plan name and number

Plan Funding and Type of Administration

Benefits are self-insured and are administered through contracts with claim administrators listed below. HMOs, if any, are fully insured and administered by the insurance company. You receive benefit information directly from that insurer and those benefits are not described in this booklet.

The funding of the plan is through the general assets of the company, less any employee contributions.

Claim Administrators

The plan administrator has contracted with the following companies to administer benefits and pay claims. You also may contact the appropriate claim administrator directly, using the information listed below.

Your claim administrator is listed on your ID card. Claim administrators may change. For the most updated information, call 1-844-31ALCOA (1-844-312-5262).

Medical
Highmark Blue Cross Blue Shield (coverage through PPO Blue Card)
P.O. Box 890062
Pittsburgh, PA 15230
1-844-459-6456
www.highmarkbcbs.com

Prescription Drugs
CVS/Caremark
P.O. Box 52178
Phoenix, AZ 85072Benefits and claims: 1-888-321-4284
Prior authorization: 1-888-413-2723 (physicians only)
Specialty Drug Service: 1-866-387-2573
www.caremark.com

Dental Care
United Concordia
Highmark Blue Cross Blue Shield
P.O. Box 69421
Harrisburg, PA 17106-9421
1-844-459-6456
www.ucci.com

Vision Care
Davis Vision
P.O. Box 1525
Latham, NY 12110
1-844-459-6456
www.davisvision.com

Health Care Fund
Smart Choice (formerly named Your Spending Account™ (YSA)
P.O. Box 785040
Orlando, FL 32878-5040
Phone: 1-844-31ALCOA (1-844-312-5262)
Fax: 1-888-211-9900
digital.alight.com/alcoausa

COBRA Administrator
ALCOA4U
P.O. Box 564115
Charlotte, NC 28256-4115
1-844-31ALCOA (1-844-312-5262)

General Information and Eligibility

The Company has contracted with Alight to handle enrollment and other administrative details of your benefits and provide general benefits information. You may contact Alight either online or by phone.

- **Online—**Log on to the UPoint website at *digital.alight.com/alcoausa* is interactive website is available 24 hours a day, Monday through Saturday, and after 1 p.m. Eastern Time on Sunday.

- **Toll-free by phone—**Call 1-844-31ALCOA (1-844-312-5262). Representatives are available weekdays from 9 a.m. to 5 p.m. Eastern Time. Hearing-impaired callers can use the AT&T Relay Service TTY at 1-800-855-2880.

Agent for Service of Legal Process

If any disputes arise under the plan, papers may be served upon:
Secretary, Benefits Appeals Committee
Alcoa USA Corp.Suite 500
201 Isabella Street
Pittsburgh, PA 15212
412-315-2900
Service of legal process also can be made upon the plan administrator.

Claim Procedure

How to File Claim

- **In-Network Claims—**No claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

- **Out-of-Network Claims—**If you use out-of-network (non-participating) providers, you must pay the provider for covered expenses you incur, along with your coinsurance amount, and any amount above the R&C limit (or MAC allowance in the dental program). Then you must submit a claim form along with an itemized bill for expenses to the appropriate claim administrator. In most cases, the claim administrator will reimburse you directly. Occasionally, however, the claim administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from him or her.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, call 1-844-31ALCOA (1-844-312-5262).
Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

Send the completed claim form to the appropriate claim administrator listed on your ID card along with any proof of payment (i.e., a receipt).

For medical, dental and vision expenses, the respective claim administrator will send you an Explanation of Benefits (EOB) showing what the plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay.

To be eligible for reimbursement under the plan, a claim must be submitted by the end of the year following the year in which the expense was incurred.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims and post-service health claims (see “Definitions”. If you or your representative fail to follow the plan’s procedures for filing a claim or if you file an incomplete claim, the plan will notify you or your representative of the failure according to the time frames shown in the chart on the next page.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the plan administrator. This notice will include the reasons for denial, the specific plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Benefits Appeals Committee which has been designated by the plan administrator to review appeals (see “How to Appeal a Claim”).

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claim administrator determines initial claim is improperly filed (not filed according to plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claim administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claim administrator reviews claim and makes determination of: complete/proper claim (see definition) initial claim	Within 48 hours after the earlier of: receipt of requested information or at end of period allowed for you to provide information Within 72 hours of receipt of initial claim	For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*	Within 15 days after the earlier of: receipt of requested information or at end of 45-day period allowed for you to provide information Within 15 days of date initial claim is received	Within 30 days after the earlier of: receipt of requested information or at end of 45-day period allowed for you to provide information Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of claim administrator	Not applicable	Not applicable	Additional 15 days if plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if plan requires more information from you and provides an extension notice during initial 30-day period

*A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the claim administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number

of treatments.

**Whenever an extension is required, the plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the claim administrator. The time frames for appealing a claim for services are shown in the chart below. An appeal for the plan's determination regarding a person's eligibility to participate in the plan must be received within 180 days of either: (1) the event that first gave rise to the person's claim for eligibility or (2) in the event of a termination of a person's participation, the date of the notice advising the person of the termination of his or her participation in the plan. For example, an appeal for eligibility to participate in the plan based on the birth of a child or a marriage must be filed within 180 days after the date of the birth of such child or marriage. Similarly, if an individual is dropped from coverage for failure to supply required documentation during a dependent audit, the 180-day period begins on the date of notice of cancellation of coverage.

If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Medical, Prescription Drug, Dental or Vision Claims				
Appeal Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
You may submit an appeal of denied initial claim to the claim administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claim administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 30 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Benefits Appeals Committee	Not applicable	Not applicable	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Benefits Appeals Committee reviews your second appeal and makes determination	Not applicable	Not applicable	Within 15 days of date appeal is received	Within 30 days of date appeal is received

External Review Process

In certain circumstances, after you have exhausted the Plan's internal claims and appeals process for medical and prescription drug claims, you will have four (4) months from the receipt of the adverse notification from the Benefits Appeals Committee to request an external review of the decision.

To be eligible for external review, the decision to be reviewed must involve a medical or prescription drug claim that is either:

- a claim that was denied involving medical judgment, including application of the Plan's requirements regarding medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered service or a determination that the treatment is experimental or investigational; or
- a determination made by the Company to rescind your coverage.

The request for external review should include any reasons, material justification and all reasonable necessary supporting information as part of the external review filing.

Your request for an external review of a medical claim, with supporting documentation, should be sent to:

- Highmark Member Grievance and Appeals Department
  Attention: Independent Review Request
  P.O. Box 535095
  Pittsburgh, PA 15253-5095

Your request for an external review of a prescription drug claim, with supporting documentation, should be sent to:

- Alcoa USA Corp.
  Attention: Independent Review Request
  Suite 5J11
  201 Isabella Street
  Pittsburgh, PA 15212

If you participate in an HMO, the HMO should provide for an external review process. Please contact your HMO provider for additional information.

This is not an additional step that you must take to meet the appeal procedures described in this SPD. Your decision to seek an external review does not affect your rights to any other benefits under the Plan. There is no charge for you to request an independent external review. The external review decision is final and binding on all parties except for any relief available through ERISA.

Preliminary Review and Notification. Within five (5) business days from receipt of the request for external review, the Plan will complete a preliminary review of the external review request to determine:

- In the case of a denied claim, whether you are or were covered under this program at the time the covered service which is the subject of the denied claim was or would have been received;
- Whether you have exhausted the Plan's internal appeal process, unless otherwise not required to exhaust that process; and
- Whether you have provided all of the information and any applicable forms required by the Plan to process the external review request.

Following completion of its preliminary review of the request, the Plan will notify you of its determination. In the event that the external review request is not complete, the notification will describe the information and/or materials needed to complete the request in which case you must correct and/or complete the external review request no later than the later of:

- The end of the four month period in which you were required to initiate an external review of the Benefits Appeals Committee's decision; or
- 48 hours following receipt of the Plan's notice of its preliminary review.

Requests for external review received after this time will not be valid. In the event that the external review request is complete but not eligible for external review, notification by the Plan will include the reasons why the request is ineligible for external review and contact information that you may use to receive additional information and assistance.

Final Review and Notification. Requests that are complete and eligible for external review will be assigned to an independent review organization (IRO) to conduct the external review. The assigned IRO will notify you or the health care provider filing the external review on your behalf, that the request has been accepted and is eligible for external review. The notice will further state that the IRO has been assigned to conduct the external review and that any additional information which you or the health care provider may have in support of the request must be submitted, in writing, within 10 business days following receipt of the notice.

The assigned IRO will review all of the information and documents that it timely received and make a decision on the external review request. The decision shall be made without regard or deference to the decision that was made in the Plan's internal appeal process. The assigned IRO shall provide written notice of its final external review decision to the Plan and you or the health care provider filing the external review request on your behalf, within 45 days from receipt by the IRO of the external review request. Written notice of the decision shall provide, among other information, a statement of the principal reasons for the decision including the rationale and standards relied upon by the IRO.

Expedited External Review (applies to urgent care claims only). If the Plan's initial decision or the denial resulting from the Plan's internal appeal process involves an urgent care claim, you may request an expedited external review of the Plan's decision. Requests for expedited external review are subject to review by the Plan to determine whether they are timely, complete and eligible for external review. When the request involves a denied urgent care claim, the Plan must complete its preliminary review and provide notice of its eligibility determination immediately upon receipt of the request for expedited external review. If the request is eligible for expedited external review, the Plan must then transmit all necessary documents and information that was considered in denying the urgent care claim involved to an assigned IRO in an expeditious manner. The assigned IRO will conduct the review and provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours following receipt by the IRO of the request for expedited external review. If notice of the decision by the IRO is not provided in writing, the IRO must provide within 48 hours following initial notice of its final external review decision, written confirmation of that decision to the Plan and you. If you believe that your situation is urgent, you may request an expedited external review by contacting the medical or prescription drug claim administrator as applicable.

Exhaustion of Claims and Appeals; Plan Limitations

You must exhaust the claims and appeals process described above before you are permitted to file a civil action against the Plan for benefits. If you are issued a final determination on appeal, you must bring a civil action within 180 days of the date of the notice of such determination or your right to file a lawsuit against the Plan is forever discharged.

Non-Duplication of Benefits (medical and dental benefits only)

If you or your eligible dependent is covered by the plan and another employer’s plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your plan medical and dental benefits are coordinated with benefits from:

- Other employers’ plans;
- Certain government plans; and
- Motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug and vision benefits.

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- The primary plan is determined and pays the full amount it normally would pay;
- The secondary plan calculates the amount it normally would pay and then pays any portion of that amount not paid by the primary plan; and

You pay any remaining expenses.

If another plan is primary and the Alcoa USA plan is secondary, the plan calculates the amount it would pay as if there were no other coverage, subtracts the amount payable by the primary plan and then pays any eligible remaining amount.

For example, suppose the covered charge is $100 and the Alcoa USA plan normally would pay $80. If the primary plan paid $50, your benefit from the Alcoa USA plan would be $30 ($80 minus $50).

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows:

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the patient and you are not eligible for Medicare, the Alcoa USA plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment and then submit the claim to the Alcoa USA claim administrator with copies of the expenses and the primary plan's Explanation of Benefits (EOB).

When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.

If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.

If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody.

If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.

Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.

A plan that covers an active employee or the dependent of an active employee pays before a plan that covers an inactive or retired employee or the dependent of an inactive or retired employee.

When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

The medical plan coordinates with Medicare as follows.

- **End-stage renal disease—**If you or a covered dependent is eligible for Medicare due to end-stage renal disease, the Alcoa USA plan is primary for the first 30 months of dialysis treatment; after this period, Alcoa USA is secondary to Medicare for this disease only.

- **Mandated coverage under another group plan—**If a person is covered under another group plan and federal law requires the other group plan to pay primary to Medicare, the Alcoa USA plan is tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. The Alcoa USA plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense. This also applies to the benefit that an auto insurance plan would pay if auto insurance is legally required but not in force.

For Maximum Benefit

Generally, claims should be filed promptly with the Alcoa USA claim administrator and any other plan for you to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the plan, the Company has a right to subrogation and reimbursement of the first dollar of any recovery, as defined in the following sections.

Right of Recovery

The plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- Made in error;
- Due to a mistake in fact;
- Advanced during the period you were meeting the calendar year deductible; or
- Advanced during the period you were meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery.

If an error or mistake was made, your claim will be reprocessed, and if the plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the plan will:

- Require that the overpayment be returned when requested; or
- Reduce a future benefit payment for your or your dependent by the amount of the overpayment.

If the plan provides an advancement of benefits to you or your dependent during the period in which you are meeting the calendar year deductible and/or meeting the out-of-pocket maximum for the calendar year, the plan will send you or your dependent a monthly statement identifying the amount you owe with payment instructions. The plan has the right to recover benefits it has advanced by:

- Submitting a reminder letter to you or a covered dependent that details any outstanding balance owed to the plan; and

- Conducting courtesy calls to you or a covered dependent to discuss any outstanding balance owed to the plan.

Right to Subrogation

The right to subrogation means the plan is substituted to any legal claims that you may be entitled to pursue for benefits that the plan has paid. Subrogation applies when the plan has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the plan has paid on your behalf relating to any sickness or injury caused by any third party. The right of subrogation shall apply to the first dollar of any such recovery.

Right to First-Dollar Reimbursement

The right to first-dollar reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment or other recovery, you must use those proceeds to return to the plan 100 percent of any benefits you received for that sickness or injury, starting with the first dollar of any such proceeds.

The plan's right to reimbursement shall apply to the gross recovery that you receive from any third party, before any deduction for attorneys' fees or deduction for any other amount whatsoever, starting with the first dollar of any such proceeds.

Third Parties

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages or who is legally responsible for the sickness, injury or damages;
- Alcoa USA Corp. in workers' compensation cases; or
- Any person or entity who is or may be obligated to provide you with benefits or payments under:
  - Underinsured or uninsured motorist insurance;
  - Medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - Workers' compensation coverage; or
  - Any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a covered person, you agree to the following provisions.

- The plan has a first priority right to receive payment on any claim against a third party before you receive any payment from that third party.
- The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic and punitive damages. The plan's subrogation and reimbursement rights shall apply to the first dollar of any recovery. The plan is not required to help you to pursue your claim for damages or personal injuries or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- No court shall use any equitable principles in interpreting any ambiguous language in this SPD and shall look solely to the intent of the parties when any ambiguous language was drafted to interpret any such ambiguous language. The interpretation of the Company shall control in all instances.

The plan may enforce its subrogation and reimbursement rights regardless of whether you have been "made whole" (fully compensated for your injuries and damages).

You will cooperate with the plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:

- Complying with the terms of this section;
- Providing any relevant information requested:
- Signing and/or delivering documents at its request
- Appearing at medical examinations and legal proceedings, such as depositions or hearings;
- Obtaining the plan's consent before releasing any party from liability or payment of medical expenses

If you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the plan has paid.

If the plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the plan has the right to recover those fees and costs from you. You may not accept any settlement that does not fully reimburse the plan, without its written approval.

You will assign to the plan all rights of recovery against third parties to the extent of benefits the plan has provided for a sickness or injury caused by a third party.

The plan's rights will not be reduced due to your own negligence.

The plan may file suit in your name and take appropriate action to assert its rights under this section. The plan is not required to pay you part of any recovery it may obtain from a third party, even if it files suit in your name.

The provisions of this section apply to the parents, guardian or other representative of a dependent child who incurs a sickness or injury caused by a third party.
In case of your wrongful death, the provisions of this section apply to your estate, the personal representative of your estate and your heirs.

Your failure to cooperate with the plan or its agents is considered a breach of contract. As such, the plan has the right to terminate your benefits, deny future benefits, take legal action against you and/or set off from any future benefits the value of benefits the plan has paid relating to any sickness or injury caused by any third party to the extent not recovered by the plan due to you or your representative not cooperating with the plan.

If a third party causes you to suffer a sickness or injury while you are covered under this plan, the provisions of this section continue to apply, even after you are no longer a covered person.

Payment of Benefits to Others

If you and your beneficiary are unable to care for your own affairs, any payments due may be made to your representative, as determined by the plan administrator.

Your Rights under ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to the following.

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free-of-charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request the certificate before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of plan documents (i.e., summary plan descriptions and summary of material modifications) or the latest annual report from the plan and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court (see "Claims Procedure"). Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans.

HIPAA applies to the medical, prescription drug, mental health, dental, vision and health care spending account coverage of the group health plans sponsored by the plan sponsors. These plans are referred to as “HIPAA Plans.” The HIPAA Plans comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis and the treatment or supplies used in the course of treatment.

The HIPAA Plans may disclose PHI to the plan sponsors only for limited purposes as defined in the HIPAA Privacy Rules. The plan sponsors agree to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for plan administration functions that the plan sponsors perform on behalf of the HIPAA Plans. Such functions include:

- Enrollment of eligible individuals;
- Eligibility determinations;
- Payment for coverage;
- Claim payment activities;
- Coordination of benefits; and
- Claim appeals.

In order to perform these functions, the HIPAA Plans will use and disclose PHI only to Alcoa USA Corp. employees in the following positions/departments:

- Alcoa USA Health and Welfare Customer Service Manager and Benefit Specialists;
- Health and Welfare Benefits Administration Managers and Business Analysts;
- Health and Welfare Benefits Process Managers and Consulting;
- Location Human Resources Representatives;
- Remedy support system staff;
- Privacy Official;
- Security Official;
- Health and Welfare audit team;
- Health and Welfare Financial Accounting;
- Corporate Occupational Health Professionals;
- Designated Legal Department Personnel; and
- Benefits Appeals Committee.

PHI may also be disclosed to third parties who perform functions or other activities on behalf of the plan and who enter a business associate agreement with the plan. If a plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific claims administrator involved with the PHI in question. The claim administrator will advise the plan participant of the procedures to be followed.

The HIPAA Plans maintain policies and procedures that govern the HIPAA Plans' use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plans' policies and procedures also include a mechanism for resolving issues of noncompliance. A Notice of Privacy Practices has been provided to plan participants summarizing the HIPAA Plans' policies and procedures.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage for a specific length of time. The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event."

If you and/or your eligible dependent(s) choose COBRA coverage, the Company is required to offer the same medical, prescription drug, dental and vision coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage.
For the name and address of the Company's COBRA administrator, see above.

COBRA Qualifying Events and Length of Coverage

18-Month Continuation

- Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:
- Employment ends for any reason other than gross misconduct; or
- Hours of employment are reduced.

This coverage also applies to a child born or adopted by you during the 18-month continuation period.

29-Month Continuation

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to the 18-month continuation period (for a total of 29 months of coverage).

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- The participant must have become disabled during the first 60 days of the initial 18-month coverage period;
- The participant must notify the Company within 60 days of the date on the Social Security Administration determination letter; and
- The participant must notify the Company before the initial 18-month COBRA coverage period ends.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- Death;
- Divorce or legal separation;
- Eligibility for Medicare coverage; or
- Dependent child's loss of eligible dependent status under the plan (for example, the dependent exceeds the age limit or marries).

An eligible dependent may be covered under multiple qualifying events, but in no case will COBRA coverage be continued for more than 36 months in total.

How to Continue Coverage

If you or your eligible dependent loses coverage due to your divorce or legal separation or your dependent's own loss of eligibility for any reason, you or your dependent must contact the COBRA administrator within 60 days of the qualifying event. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. For coverage to be continued, you or your eligible dependent must elect and pay the required cost for COBRA coverage (see "Cost of COBRA Coverage" below).

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, except in the case of an 11-month disability extension where you must pay 150% of the cost for coverage.

COBRA Continuation Coverage Payments

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (grace period), COBRA coverage will be cancelled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your plan coverage, the length of your benefit extension period is considered part of the COBRA coverage period and runs concurrently with your COBRA coverage. For example, if you take a leave of absence and receive a 31-day benefit extension, you then could receive COBRA coverage for 17 months (18 months minus one month or 31 days).

If you take a leave under the Family and Medical Leave Act (FMLA), eligibility for COBRA begins:

- At the end of the leave if you do not return after the leave; or
- On the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis.
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan, even though the subsequent plan has a pre-existing condition exclusion, so long as the individual has enough creditable coverage to satisfy the subsequent plan's pre-existing condition exclusion. If the individual does not have enough creditable coverage to meet the new plan's requirement, he or she may continue to purchase COBRA coverage until the earlier of the day he or she is eligible for the new coverage or 36 months.
- The individual becomes entitled to Medicare.
- The Company stops providing group health benefits for plan participants.

Continuing Coverage for a Domestic Partner

Under current law, your domestic partner does not have rights to continue coverage under COBRA; however, he or she may be eligible for continuing coverage under the Choices program when coverage otherwise would end due to your termination of employment or reduction of hours. Your domestic partner is not eligible for continuing coverage if your domestic partner relationship ends. Because this coverage is not actual COBRA coverage, the Company may modify or eliminate it at any time. If you are enrolled in an HMO, contact your HMO for more information about continuation coverage for domestic partners. Not all HMOs offer COBRA-like coverage to domestic partners.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a federal law enacted in 1993 that provides for an unpaid leave of absence for up to 12 weeks per year, as defined by the FMLA policy in effect at your location, for:

- The birth or adoption of a child or placement of a foster child in your home;
- The care of a child, spouse, domestic partner or parent (not including parents-in-law), as defined by federal law, who has a serious health condition; or
- Your own serious health condition.

Ask your HR representative for more information about FMLA and the process for application.

No Obligation to Continue Employment

The plans do not create an obligation for the Company, its affiliates or its subsidiaries to continue your employment. In addition, the right of the Company, its affiliates and subsidiaries to terminate your employment or to take other personnel action is not limited by the effect that the action might have on your (or your beneficiary's) eligibility for benefits under these plans.

Future of the Plan

The Company expects that the plan will continue indefinitely. However, the Board of Directors of the company its delegates can amend, modify, suspend, or terminate all or part of the plan at any time for any reason, subject to any applicable collective bargaining agreement(s).

The Company may change the level of benefits provided under the plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier plan provisions.