

Hertz Custom Benefit Program

Summary Plan Description



The Hertz Custom Benefit Program Summary Plan Description

Benefits Summary

The Hertz Corporation (“Hertz”) recognizes that each employee has unique needs that may change at various stages in their work and personal lives. With these thoughts in mind, Hertz developed the Hertz Custom Benefit Program (the “Program”), a comprehensive and diverse benefits program, which is an integral part of your overall compensation package.

The Program provides you with a broad range of choices and the resources to build your own valuable benefits package. Whether it is the need for comprehensive health care coverage or income protection when time off is required due to disability, the Program is designed to deliver care and support when you need it most. However, the Program may not pay for every cost or benefit that you believe should be covered, and it is important that you carefully consider whether you should participate in the Program.

The Program will provide benefits in accordance with applicable federal laws, including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns’ and Mothers’ Health Protection Act (NMHPA), the Women’s Health and Cancer Rights Act (WHCRA), the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Genetic Information Nondiscrimination Act (GINA), and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively referred to as Health Care Reform).

This Summary Plan Description (SPD) provides you with important information about the various health and welfare plans within the Program. Please be sure to read this SPD very carefully to ensure you fully comprehend the benefits the Program has to offer, and are prepared to make the most of your benefit elections. This SPD describes the Program generally as of July 1, 2017.

Hertz reserves the right to change, amend, suspend, or terminate any or all of the benefits under this Program, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, Hertz and its participating affiliates have not entered into an employment contract with any employee. Nothing in the Program documents or in this SPD gives any employee the right to be employed by Hertz or one of its affiliates, or to interfere with Hertz’s (or its affiliate’s) right to discharge any employee at any time.

Important Information for Residents of Hawaii: This SPD describes Program features that may not be applicable to you. If you are a resident of Hawaii, review the section titled [Hawaii Plan Information](#) before reading this SPD. That section will describe the generally applicable terms for your participation in the Program and will explain where you can obtain more information about your benefits. Unless otherwise noted, all other portions of this SPD apply to residents of Hawaii.

The SPD has been organized into five main sections, with a table of contents in the front of each section, which will assist you in locating specific information that may interest you.

The following is a brief summary of the five main sections of this SPD:

General Information

Fully understanding your eligibility, who you can cover under the various plans within the Program, how to enroll and under what circumstances changes are allowed, will make it easier for you to comply with the administrative procedures and Program provisions.

Health Care Coverage

Health care coverage includes several medical, dental and vision coverage options.

Family Protection Coverage

Family protection coverage includes life and accident insurance for you and your family, and long-term disability coverage to protect your income. The Program offers a variety of coverage levels so you can customize it to fit your lifestyle.

Flexible Spending Accounts

Flexible spending accounts help you save on taxes and manage your health and dependent care expenses. By using before-tax dollars to pay for eligible expenses, you can reduce your taxable income.

Administrative and Legal Information

Program participants have certain legal rights. This section provides you with a statement of these rights and other important information about the Program.

Remember, the better you understand your benefit choices and how the Program works, the more valuable and meaningful it will be. Therefore, you need to:

- Take responsibility for understanding the plans within this Program,
- Choose the benefits that best meet the needs of you and your family, and
- Comply with the administrative procedures and plan provisions.

General Information

Learn about the Hertz Custom Benefit Program (the Program), its eligibility requirements for participation and how to enroll, as well as other information common to the various health and welfare benefits within the Program.

General Information

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Program Membership

Eligibility

Employees

You are eligible to participate in the Hertz Custom Benefit Program if:

- You are an employee of The Hertz Corporation (the “Company”), or of an affiliate of the Company that has adopted the Program, and
- You are a full-time employee or part-time employee who works an average of at least 30 hours a week.*

** (1) For new employees, eligibility will initially be determined based on scheduled hours. If you are a new employee and are reasonably expected on your date of hire to work at least 30 hours per week (as determined by the Plan Administrator), you will be offered coverage that will be effective following the waiting period (see [When Coverage Begins](#)). If you are a new employee and are not reasonably expected on your date of hire to work at least 30 hours per week (as determined by the Plan Administrator), you initially will not be offered coverage; however, if you work an average of 30 hours per week over the 11-month period starting on the first day of the month following or coincident with your date of hire, you will be offered coverage beginning not later than the first day of your fourteenth full month of employment. This initial coverage will continue through the June 30 that is at least 12 months after the commencement of your initial participation (or initial eligibility therefor). Thereafter, your eligibility will be determined based on whether you work 30 hours per week as an ongoing employee. (2) For ongoing employees, your eligibility to enroll during Open Enrollment will be based on average hours worked during the 12-month period from April 2 of the preceding year through April 1 of the current year. If determined to be eligible, eligibility will be for the entire Plan Year of July through June. Coverage may end if there is some other change in eligibility status (e.g., termination of employment, change to casual status, transfer to an affiliate that has not adopted the Program). This measurement period may begin on the first day of the payroll period that includes April 2, or end on the last day of the payroll period that includes April 1. (3) The hours requirement may vary for some collective bargaining units covered under the Program.*

You are not eligible to participate in the Program if you are, or are treated by your employer as, any of the following:

- A leased employee,
- An independent contractor,
- An employee of an affiliate that has not adopted the Program,
- A casual employee,
- An individual who directly or indirectly provides services to the Company under a contractual or other arrangement, written or otherwise, with the Company or a third party, other than one specifically providing for an employment relationship with the Company,
- An individual for whom the Company does not issue an IRS Form W-2 (or any replacement form), or
- An employee who is covered by a collective bargaining agreement (unless the collective bargaining agreement makes the Program or a portion of the Program available to you).

Note: If your collective bargaining agreement provides for participation in certain portions of the Program only, you are not eligible for other portions not provided.

The above exclusions shall not be affected by the Company's misclassification of an individual's employment status, or a determination by a court, government agency, arbitrator, or other authority that an individual is or was a common-law employee of the Company, or that the Company is or was a common-law employer, joint employer, single employer, or co-employer of the individual

Dependents (for Medical, Dental & Vision Plans)

Dependents eligible for coverage under the Medical, Dental and Vision Plans include the following individuals, provided that you have provided the documentation establishing eligibility:

- Your spouse or domestic partner (provided the domestic partner satisfies the eligibility criteria discussed under the [Domestic Partners](#) section).
- Your children under age 26, regardless of their student, employment, or marital status, whether or not they live with you, or whether you provide any of their support.
- Your children not capable of self-support due to a physical or mental handicap that began before age 26.

The term "spouse" means the person to whom you are legally married under applicable law. See the [Working Spouse/Domestic Partner](#) section for limitations on enrolling a working spouse in the Hertz Medical Plan.

The term "children" includes the following:

- Your natural children.
- Your domestic partner's natural children (provided your domestic partner is enrolled).
- Your stepchildren.
- Legally adopted children or children in the process of adoption who have been placed in your home in a parent/child relationship.
- Foster children who live in your home and who qualify as dependents for federal income tax purposes.
- Children for whom you are the legal guardian appointed by a court.
- Children for whom you are legally required to provide coverage by a divorce decree.

Children listed as part of a Qualified Medical Child Support Order (QMCSO) that legally requires an employer to offer coverage also may be enrolled as dependents under the Program. Each QMCSO will be evaluated individually to determine dependent eligibility. Upon request, the Corporate Employee Benefits Department will provide, at no cost to you, information about how to have a child who is the subject of a QMCSO approved for eligibility.

Dependents (For Dependent Life and Dependent AD&D Coverages)

Dependents eligible for coverage under the Dependent Life and Dependent AD&D coverages include:

- Your spouse or domestic partner (provided the domestic partner satisfies the eligibility criteria discussed under the [Domestic Partners](#) section).
- Your dependent children who meet the requirements below.

To be eligible for Dependent Life coverage, a dependent child must be:

- Your unmarried natural, step, foster, guardian or adopted child who is under age 26 and primarily dependent on you for support and maintenance.
- Your unmarried natural, step, foster or adopted child who is age 26 or older, incapable of self-sustaining employment by reason of mental or physical incapacity, and primarily dependent on you for support and maintenance. To qualify, your child must have been covered as a dependent child for Dependent Life coverage prior to reaching age 26.

To be eligible for Dependent AD&D coverage, a dependent child must be:

- Your unmarried natural, step, foster, adopted or guardian child who is dependent on you for support and living in your household, or enrolled as a full-time or part-time student at an accredited college, university or other institution of higher learning or a vocational or licensed technical school. To be covered, a dependent child cannot have a dependent of his or her own and cannot be provided coverage under any other group, blanket or franchise health insurance policy or individual health plan, and cannot be entitled to Medicare. In this case, the dependent child can remain covered until the end of the calendar year in which the dependent child reaches age 26.
- Your unmarried natural, step, adopted or guardian who is age 26 or older, incapable of self-support due to a mental disability or physical handicap, dependent on you for support and living in your household, or enrolled as a full-time or part-time student at an accredited college, university or other institution of higher learning or a vocational or licensed technical school. Proof of disability must be furnished upon enrollment or within 31 days after the child reaches age 26.

When you and your eligible family members meet the eligibility terms and enroll in the Program, you are considered "Covered Persons."

Ineligible Family Members

Certain family members are not eligible to participate in the Program. Family members ineligible under the Program include, but are not limited to:

- Legally separated or divorced spouses.
- Fiancés.
- Parents, siblings or in-laws.
- Cousins.
- Grandchildren.

Verification of Family Member Eligibility

Hertz, third party administrators, and plan insurers reserve the right to request documentation (marriage or birth certificates, adoption records, court orders, tax records, etc.) upon enrollment, or to conduct

random audits during the Plan Year, to verify the eligibility of your family members. A dependent is not eligible to participate unless the dependent meets the eligibility requirements described above and you have provided the documentation establishing this eligibility. This means, if you fail to provide eligibility documentation when required, your dependent will not be enrolled in coverage or will be dropped from the Program.

You will be asked to verify the eligibility of your family members when you first become eligible, during each year's annual open enrollment period before the start of each Plan Year, and if you add a dependent during the Plan Year as a result of a change in status. While your dependent's eligibility is being confirmed, the dependent will **not** be enrolled in coverage. Accordingly, it is very important that you follow the steps to confirm your dependent's eligibility as soon as possible.

If you enroll a dependent when you first become eligible or during open enrollment, you must provide the eligibility verification prior to the effective date of coverage. If you fail to confirm your family member's eligibility prior to your effective date (the date you start participating), your dependent will not be enrolled in coverage. You will have 30 days after the start of your coverage in order to provide proof of your dependent's eligibility. As soon as proof is provided, your dependent's coverage will begin (retroactive coverage will not be permitted); provided, that you must confirm your dependent's coverage within 30 days or you will have to wait until the next annual open enrollment period.

If you enroll a dependent as result of a status change, you must provide the eligibility verification before your dependent's coverage will be effective. As described in the section below titled [Changing Your Coverage](#), you have 31 days after the date of the status change in order to enroll your dependent. Then, you will have 30 days to provide documentation providing your dependent's eligibility. As soon as proof is provided, your dependent's coverage will begin (retroactive coverage will not be permitted except in the case of a special enrollment for birth, adoption or placement for adoption).

When you are asked to verify the eligibility of your enrolled family members, Hertz, its third party administrator or insurer, will send you an inquiry specifying the documents needed for verification. This may include some or all of the following:

- Proof of marital status
 - Joint federal tax return.
 - Marriage certificate.
 - Proof of joint ownership.
 - Affidavit of common law marriage.
- Proof of domestic partner status
 - Affidavit of domestic partnership.
 - Proof of joint ownership.
- Proof of child relationship
 - Birth certificate.
 - Approved adoption or placement order or modified birth certificate.
 - Proof of joint ownership or joint federal tax return with step-child's parent.

- Proof of relationship with domestic partner.
- Legal guardianship or custodial court documents.
- Proof of financial support and disability.

This list provides an example of the documents that may be requested from you. You will receive notice of the documents required when you enroll your dependent. If you do not submit adequate and timely documentation to confirm the eligibility of your dependent(s) in accordance with the instructions provided to you, your dependent(s) will be deemed ineligible and will not be enrolled in coverage or, if your dependent is already enrolled, they will be removed from coverage. You will not have another opportunity to enroll your dependent until the next annual enrollment, unless you experience a change in status. The list of required documents may be updated from time to time without prior notice to you.

Intentionally providing false information, enrolling a dependent you know to be ineligible or willfully falsifying the documentation required to enroll a dependent constitutes fraud. If it is discovered, via audit or otherwise, that you are covering an ineligible dependent(s), the result will be the immediate loss of all coverage for the ineligible dependent(s), which may be applied retroactively. Such ineligible dependents will not be eligible for COBRA continuation. In addition, you may be required to reimburse Hertz and/or its benefit plans for any expenses, including benefit payments, incurred as the result of covering an ineligible dependent(s). **Falsification of dependent eligibility information is grounds for disciplinary action, up to and including termination of employment and possible civil action.**

Domestic Partners

Under the Program, the term “domestic partner” includes both same-sex and opposite-sex domestic partners.

Domestic partners and the child(ren) of domestic partners are eligible to participate in the Program’s Medical, Dental and Vision Plans, as well as the Dependent Life Insurance and Accidental Death and Dismemberment (AD&D) plans, and are eligible as survivors under the Long Term Disability (LTD) plan. If you enroll your domestic partner and his/her children, they must be enrolled in the same medical, dental and vision coverage that you are enrolled in. In order to enroll the child(ren) of your domestic partner, your domestic partner must also be eligible for and enrolled in coverage. The following eligibility criteria must be met for domestic partners and children of domestic partners:

- The domestic partner relationship is one that is registered with any governmental domestic partnership registry authorizing such registrations, or

The domestic partner relationship satisfies ALL of the following criteria:

- You and your domestic partner have shared a continuous committed relationship with each other for no less than six (6) months, intend to do so indefinitely, and have no such relationship with any other person,
- You and your domestic partner are jointly responsible for each other’s welfare and financial obligations,
- You and your domestic partner reside in the same household,
- You and your domestic partner are not related by blood to a degree of kinship that would prevent a marriage from being recognized under the laws of their state of residence,
- You and your domestic partner must each be over age 18, of legal age, and legally competent to enter a contract,

- Neither you nor your domestic partner may be married to a third party, and
- A signed, notarized Affidavit is provided to the Company, along with such documentation as may be required by the Company and/or a third party insurer to substantiate the existence of the domestic partner relationship. Refusal or failure to submit requested documentation shall result in the denial or withdrawal of eligibility of the domestic partner and his/her children.

Children of an employee's enrolled domestic partner will be eligible for medical, dental, vision, life and/or AD&D coverage if they otherwise qualify as a dependent as defined in the [Dependents](#) section.

See the [Working Spouse/Domestic Partner](#) section for limitations on enrolling a working domestic partner in the Hertz Medical Plan.

Dependent Residency for Full-Time Students (Where Required)

Children who are full-time students living away at school, who would otherwise be residing in your household, will be considered to be residing in your household for purposes of any residency requirements in the dependent sections above.

Working Spouse/Domestic Partner

If your spouse or domestic partner is eligible for minimum value coverage through his/her employer, they are not eligible for medical coverage under the Program's Choice Plan A, the Consumer Health Account Plans or the Economy Plan. Your spouse or domestic partner is considered to be eligible for minimum value coverage through his/her employer if your spouse or domestic partner is an employee or has another title (such as owner, consultant, partner or principal) and the coverage meets the minimum value requirements under Health Care Reform. This rule applies whether or not your spouse or domestic partner actually enrolls in coverage through his/her employer.

In order to enroll your spouse or domestic partner in the Choice Plan A, the Consumer Health Account Plans or the Economy Plan, you must verify during the open enrollment period, and during any verification period thereafter, that your spouse or domestic partner is not eligible for minimum value medical coverage through his/her employer. If you enroll your spouse or domestic partner, and he/she later becomes eligible for minimum value medical coverage through his/her employer, you must provide notification on BenefitsPlus within 31 days after your spouse or domestic partner becomes eligible. If your spouse or domestic partner is no longer eligible for minimum value coverage through his/her employer, you can enroll your spouse or domestic partner within 31 days after the loss of the other coverage or loss of eligibility for other coverage.

Enrollment

How to Enroll

You will receive enrollment materials when you first become eligible to enroll and during the annual open enrollment period before the start of each Plan Year. You can also find Program materials (including a copy of this SPD) on BenefitsPlus.

To enroll, simply:

- Make the elections for the coverages that meet your needs.
- Authorize any necessary payroll deductions.
- Complete and submit any additional paperwork, including dependent eligibility verification forms.

Hertz Custom Benefit Program Plan Year

The Plan Year is the 12-month period beginning each July 1 and ending the following June 30.

Domestic Partners and Their Children

If you wish to enroll your domestic partner and any children of your domestic partner who meet the eligibility criteria, log on to BenefitsPlus for the required Domestic Partner materials. Your domestic partner and his/her children will not be eligible for coverage until after you provide proof of eligibility.

You may elect medical, dental and vision coverage for yourself and your domestic partner (and children, as applicable) under the following dependent categories:

- Employee + Domestic Partner (DP),
- Employee + DP + DP Child(ren) | use this dependent category if covering your domestic partner and your domestic partner's child(ren), but not your own child(ren), and
- Employee + DP + All Child(ren) | use this dependent category if you are covering your domestic partner and just your own child(ren) or your own child(ren) and domestic partner's child(ren).

You may elect Dependent Life Insurance coverage for your domestic partner (and his/her children) by electing the Dependent Life Option of your choice.

You may elect AD&D coverage for your domestic partner (and his/her children) by electing the AD&D Family Coverage Option.

Coverage If You Do Not Enroll — Default Coverage

If you do not enroll when you are initially eligible, you will be automatically enrolled in Life Insurance coverage of one times your base pay. You will not be enrolled in any other coverage, including medical coverage. By waiving medical coverage, you are certifying that you have coverage elsewhere.

If you do not re-enroll during an open enrollment period, the coverage you had in effect on June 30 will carry over to the next Plan Year, and your contribution amounts will automatically be adjusted to reflect the costs in effect for the new Plan Year. However, if you contributed to either Flexible Spending Account (FSA) in the previous Plan Year, you will not be re-enrolled in the FSA unless you affirmatively elect that coverage, and will not be able to make contributions to the FSA unless you later have a Qualified Change in Status, as described in the [Changing Your Coverage](#) section.

Coverage upon Reemployment or Transfer of Employment

If your employment terminates and you have a break in service of at least 13 consecutive weeks, you will be treated as a new hire upon your reemployment. Before you can begin participation, you must satisfy the eligibility terms described in the [Eligibility](#) section, including the waiting period.

If you are reemployed following a break in service of less than 13 weeks, you will be treated as a continuing employee for eligibility purposes. This means that your eligibility to participate upon reemployment will be determined by your eligibility prior to the break. If you return within 30 days of your termination and you are eligible to participate, your prior elections will continue (you will not be permitted to make a change to your elections unless you also experience a qualified change in status that permits you to make new elections). If you return after 30 days, but during the same Plan Year, and you are eligible to participate, your prior elections (except for Flexible Spending Account elections) will be reinstated unless you make a change within the first 30 days of employment. If you return during a new Plan Year and you are eligible to participate, your prior elections will not be reinstated, and you are required to make new elections during the first 30 days of employment.

If you transfer employment within the Company, your coverage generally will not change unless you are changing service areas or moving to Massachusetts. If you move into or out of an HMO service area or a CDC Dental Plan network service area, you will be enrolled in the lowest cost Medical Plan and/or Dental Plan option of the same benefits that you were previously enrolled in. For example, if you transfer into or out of Hawaii, and you were previously enrolled in medical and dental coverage, you will be automatically enrolled in the lowest cost medical and dental coverage in your new location, unless you make an election otherwise. If you move to Massachusetts, and you were previously enrolled in the Economy Plan, you cannot continue to participate in the Economy Plan. Upon your move, you will be enrolled in the next lowest cost Medical Plan option unless you make an election otherwise.

When Coverage Begins

If you meet the eligibility terms as described in the [Eligibility](#) section, your elected coverage takes effect on the first day of the month following 60 continuous days of employment. The period between your hire date and the date your coverage takes effect is called a “waiting period.” For example, if you are hired on August 1 and work continuously, your elected coverage will take effect on October 1. If you are hired on August 15 and work continuously, your elected coverage will take effect on November 1.

If you are hired and expected to work variable hours or to work less than 30 hours per week, you are not eligible for coverage as described in the [Eligibility](#) section (your hours will be counted to determine if you will become eligible after the initial measurement period). If, however, your job status changes or you transfer to a position in which you are expected to work more than 30 hours per week, you will be eligible for coverage beginning the first of the month following 60 days after your change to an eligible status.

If your waiting period is interrupted due to a non-health related leave of absence, upon your return to work, your coverage will take effect after you have completed a waiting period. If you take a health-related leave of absence before completing your waiting period, your elected coverages under the Medical, Dental and Vision Plans will still become effective on the first of the month following 60 continuous days of employment. However, coverages elected under the Life, Dependent Life, Accidental Death and Dismemberment (AD&D) and Long-Term Disability (LTD) Plans will not begin until a complete waiting period has been fulfilled following your return to work.

Coverage for your enrolled dependents generally begins on the date your coverage begins, provided that you have verified their eligibility. If you have a qualified change in status, coverage for your dependents generally begins on the date you verify the eligibility of your dependents. If you enroll and verify the eligibility of a new child within 31 days of birth, coverage will be retroactive to the date of birth, adoption or placement for adoption. See the [Changing Your Coverage](#) section for details.

Your newborn child and/or new spouse will automatically be covered under the Dependent Life Insurance and Accidental Death and Dismemberment (AD&D) Family coverage if you were already enrolled in these coverages at the time of the birth, placement for adoption, or marriage.

Having a newborn child or getting married are Qualified Change in Status events that generally will permit you to make changes in your coverages. See the [Changing Your Coverage](#) section for details.

Changing Your Coverage

Open Enrollment

There will be an annual open enrollment period prior to the start of each Plan Year (July 1 to June 30). During that time, you will have an opportunity to change your elections, including the plans you select, and the dependents you choose to cover.

Qualified Change in Status

You may change your elections under the Health Care Plans (Medical, Dental, and Vision) and the Health Care Flexible Spending Account during the Plan Year only if you experience a qualified change in status or are eligible for special enrollment. Under certain circumstances, you may also cease participation in the Dependent Life Insurance Plan, terminate family coverage in the AD&D Plan and change the amount of your contributions to the Dependent Care Flexible Spending Account. Any change you request, must be on account of, and consistent with, the reason for the change. You must change the elections online on the BenefitsPlus website within 31 days after the qualifying event. The BenefitsPlus website can be found at www.hertz.com/benefitsplus. If you have any problems with making your election change on BenefitsPlus, you must contact AskHR. Refer to the following chart for examples of events that may allow you to change your coverage.

You are responsible for notifying Hertz of your qualified change in status. The willful failure to notify Hertz within 31 days after your dependents become ineligible for coverage for any reason (for example, as a result of divorce) may lead to cancellation or rescission of coverage and/or the repayment of insurance benefits erroneously paid on that individual's behalf.

Events	Election Changes You May Make
<ul style="list-style-type: none"> • You have a change in your legal marital status, including marriage, legal separation, divorce, annulment or death of a spouse. • You have a change in the number of your dependents, including birth, death, adoption, or placement for adoption. • There is a change in the employment status of you, your spouse, or your dependent, including termination, commencement of employment, commencement of, or return from, an unpaid leave of absence and any other change in employment status that affects eligibility under a plan. • Your dependent satisfies or ceases to satisfy an eligibility requirement (such as due to your child's age or your spouse/domestic partner becoming eligible for coverage from his/her employer under the working spouse rule). 	<ul style="list-style-type: none"> • You may enroll and add your new spouse and children who meet the definition of a dependent under the Program. • You may drop your coverage and coverage for any dependent children that your spouse is adding to his/her coverage. • You must drop coverage for your spouse or dependent that no longer meets the definition of a dependent under the Program (for example, when a child reaches age 26 or when a spouse becomes eligible for coverage from his/her employer). • You may enroll (or increase) your election in the Health Care or Dependent Care FSA to accommodate a new spouse or children. • You may cease (or decrease) your election in the Dependent Care FSA for a spouse or children who lose eligibility. You cannot cease (or decrease) your Health Care FSA following a status change event.
<ul style="list-style-type: none"> • You move into or out of an HMO service area or a CDC Dental Plan network service area (or you move to Massachusetts and you were previously enrolled in the Economy Plan). 	<ul style="list-style-type: none"> • You will be eligible to elect a different medical (or dental) coverage option under the Program for the remainder of the Plan Year.
<ul style="list-style-type: none"> • Your hours are, or will be, reduced to below 30 hours per week, even if that reduction does not result in your ceasing to be eligible for the Medical Plan. 	<ul style="list-style-type: none"> • Within 31 days of such event, you may revoke Medical Plan coverage, for you and your dependents. (You must furnish evidence that, promptly after such revocation, you have or will be enrolled in another medical coverage that provides minimum essential coverage (as defined under the Affordable Care Act) for you and your dependents, with such coverage effective no later than the first day of the second month following the month in which your revocation occurs.)
<ul style="list-style-type: none"> • The occurrence of an open enrollment period for a "health care marketplace" (as defined under the Affordable Care Act) or a special enrollment period if you are eligible for it. 	<ul style="list-style-type: none"> • Within 31 days before, or during such an enrollment period, you may revoke Medical Plan coverage for you and your dependents. (You must furnish evidence that, promptly after such revocation, you and your dependents will have or will be enrolled in such a "marketplace", with such coverage effective no later than the day after coverage under the Medical Plan ends.)
<ul style="list-style-type: none"> • Involuntary loss of alternate medical coverage, if you previously waived medical coverage under the Program. 	<ul style="list-style-type: none"> • You will be eligible to elect coverage for yourself and eligible dependents under a Medical and/or Dental Plan for the remainder of the Plan Year.
<ul style="list-style-type: none"> • Your spouse's open enrollment period. 	<ul style="list-style-type: none"> • You may add or discontinue coverage for yourself, your spouse and any dependent children during your spouse's annual open enrollment period.

<ul style="list-style-type: none"> • If a Qualified Medical Child Support Order (QMCSO) is issued. 	<ul style="list-style-type: none"> • You will be eligible to add a dependent to coverage under a valid QMCSO, or • You will be eligible to drop a dependent because the dependent has other coverage through a valid QMCSO. • <i>You must submit your QMCSO to AskHR.</i>
<ul style="list-style-type: none"> • Medicare or Medicaid Entitlement or loss of Entitlement. 	<ul style="list-style-type: none"> • You will be eligible to add or discontinue your medical coverage.*

* Special rules apply to Coordination of Benefits provided under Medicare with benefits provided through the Program. Refer to the [General Information About Healthcare Plans](#) section.

Additional changes are also permitted under the Dependent Care FSA, including the following events:

- If you have a change in your child care providers (including changes to your in-home child care) or if the cost of your child care provider changes, you can increase or decrease your election amount consistent with the change in your child care expenses.
- If you or your spouse changes work schedules, changing the hours of child care required, you can increase or decrease your election amount consistent with the change in cost.
- If your child reaches age 13 and is no longer a qualifying child, you can cancel or decrease your election.

Special Domestic Partner Rules

Adding your eligible domestic partner mid-Plan Year to the Program will only constitute a qualified change in status if:

- You submit a notarized Affidavit of Domestic Partnership as required for eligibility (refer to [Domestic Partners](#) under [Eligibility](#) in this section), and
 - You submit proof of the effective date of the domestic partnership (i.e., a certificate of Domestic Partnership, Civil Union, etc., from an official city, county or state agency), from which the qualifying change in status date can be determined, or
 - You submit proof of a change in employment status of your domestic partner that affects his or her health coverage, providing that the change is consistent with the qualifying event.

The above documents will be requested from you when you make the qualifying mid-year change to add your domestic partner. Without proof of a qualified mid-year change in status you may only add your domestic partner to the Program during open enrollment. You must provide proof of your Domestic Partner's eligibility before coverage will be effective.

Children of your domestic partner who satisfy the eligibility criteria for coverage under the plans will be subject to the same Qualified Change in Status rules as other eligible dependent children under the plans. Children of your domestic partner can only be enrolled if your domestic partner is eligible and enrolled in the Program and you have provided eligibility verification documentation. Refer to [Qualified Change in Status](#) and [Special Enrollment](#) in this section for additional information.

Your coverage elections will remain in effect until the end of the Plan Year. However, if your domestic partner relationship terminates for any reason, you must notify the Company within 31 days after the termination of the relationship. You must complete and submit the Affidavit for Termination of Domestic Partnership Benefits, a copy of which is available on BenefitsPlus.

Special Enrollment

Special rules apply if you waive coverage under the Medical Plan when first eligible and either of the following events occur:

- You originally had medical coverage elsewhere and you subsequently become ineligible for that coverage, or
- You acquire a new eligible dependent.

You must make your special enrollment elections on the BenefitsPlus website not more than 31 days after one of these events occurs. Under such circumstances, you may elect medical coverage for yourself and/or your dependent(s) within 31 days of the occurrence of the event. When your eligibility for special enrollment is due to your acquisition of a new dependent, coverage will become effective as of the date of birth, adoption or placement for adoption, provided that you make the change on the BenefitsPlus website within 31 days after the date of birth, adoption or placement for adoption. If the special enrollment is on account of marriage, coverage will be effective the date notification is received, provided that you make the change on the BenefitsPlus website within 31 days after the date of marriage. If you fail to enroll your new dependent (including your newborn child) in a timely manner, your dependent will not have coverage under the Program and you will have to wait until the next open enrollment to enroll them. All enrollments will be subject to the verification and associated provisions described in the [Verification of Family Member Eligibility](#) section.

Special rules also apply if you or your dependents waive coverage under the Medical Plan when first eligible and either of the following events occur:

- You or your dependents had medical coverage under Medicaid or the State Children's Health Insurance Program ("CHIP") and you or they become ineligible for that coverage, or
- You or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must make your special enrollment election not more than 60 days after one of these events occurs. Under such circumstances, you may elect medical coverage for yourself and/or your dependent(s) within 60 days of the occurrence of the event.

The special enrollments described above must be completed online on the BenefitsPlus website (if completed within 31 days after the event) or through AskHR (if more than 31 days have elapsed). In all cases, the special enrollment elections must be completed within the time frames specified above. When your eligibility for special enrollment is due to such an event, coverage will be effective the date your enrollment change is made (either through Benefits Plus or AskHR). All such enrollments will be subject to the verification and associated provisions described in the [Verification of Family Member Eligibility](#) section.

Late Election

If you experience a change in status and fail to make a benefit election within the 31-day period after the qualifying event, your late election may be accepted if:

- You submit your election with a written explanation (and any supporting documentation) as to why you failed to make a timely election and why you had a reasonable cause for the delay,
- Your election and written explanation (and any supporting documentation) are provided within 30 days after the expiration of the 31-day period, and

- Accepting your late election is otherwise permissible under the Program and applicable law.

Submit your request and documentation to AskHR. If your request for a late election is accepted, coverage will become effective on the date the Employee Benefits Department (and, if applicable, the insurance carrier or Claims Administrator) is satisfied that the change is being made on account of and consistent with the qualifying event. Coverage will not be provided retroactively.

How to Change Your Elections

If you wish to change your elections due to a qualifying change in status, you must do so within 31 days after the qualifying event (except in the case of the 60-day special enrollment events). You must change the elections online within 31 days on the BenefitsPlus website. The change will take effect on the date you make the change on the BenefitsPlus website. Retroactive changes will not be allowed under any circumstances other than with respect to new children who are enrolled within 31 days following birth, adoption or placement for adoption. You must complete the online change each time you add or drop a dependent, even if your contribution amounts do not change. If you are eligible to make a change after 31 days, you must contact AskHR.

Coverage During a Leave of Absence

Specific rules apply to help you continue benefit coverage for you and your family while you are on an approved leave of absence. If you are receiving a paycheck, your deductions will automatically continue. If you are not receiving a paycheck, the Company may waive the contribution requirement while you are on leave, and any such waiver will be applied in a non-discriminatory manner and will be communicated to you.

You may continue coverage during your approved leave of absence, for up to a maximum of 24 months (or less if covered by a collective bargaining agreement that states less than 24 months). If you are enrolled in the FSA, your coverage will only continue until the end of the Plan Year in which your leave began. While you are on an approved leave of absence, you will participate in open enrollment as if you were an active employee. If you elect a benefit which would require proof of health if you were an active employee, you must also provide the proof of health while you are on an approved leave of absence.

Termination of Coverage

Refer to **General Information** at the end of each section in this SPD for details on when particular plan coverage ends. These **General Information** sections will also provide information for you and your dependents on whether or not you are able to continue coverage under COBRA or convert to an individual policy after you are no longer eligible.

Program Costs

Under the Program, the Company contributes a significant portion of the overall cost of your benefits, particularly the Medical Plan. Your plan costs, which reflect the net cost to you after Company contributions, will be communicated to you. During each annual open enrollment period, changes in these amounts will also be communicated. All your costs for plan coverage will be communicated in pay period amounts. Some of your costs are calculated based on your age and/or salary. When these factors change during the Plan Year, your costs for such coverages are subject to change accordingly.

Contributions and Tax Implications

Your contribution amounts (as reflected on BenefitsPlus) are deducted on a before-tax basis, except for Dependent Life Insurance contributions and Long Term Disability (LTD) contributions, if you elected the after-tax LTD contribution option.

If your employee life insurance is greater than \$50,000, you are required to pay taxes on the cost of the life insurance in excess of \$50,000. This tax applies to the excess only; there are no tax consequences if the total amount of coverage does not exceed \$50,000. Refer to [Tax Implications](#) in the [Life Insurance Plan](#) section for further information.

Before-tax contributions are not subject to federal income, Social Security and Medicare (FICA and H.I.) taxes, and in many locations, state and local income tax. Before-tax contributions are not considered income by the government when determining your Social Security benefit. For most employees, the value of the immediate tax savings from reduced taxes outweighs any potential reduction in Social Security benefits.

Covering dependent children up to age 26 as allowed under Health Care Reform may be considered taxable in some states.

Domestic Partner Benefits

During each annual open enrollment period, you will be advised of the cost of various group health plan coverage options that are available to you, your domestic partner, your children, and your domestic partner's children who are principally dependent on you and/or your domestic partner for maintenance and support.

In accordance with IRS regulations, enrollment of your domestic partner and his/her children for group health coverage will result in federal tax consequences to you, unless your domestic partner qualifies under federal tax law as your "dependent." Your domestic partner will qualify as your "dependent" only if:

- You provide more than half of your domestic partner's support for the year,
- Your domestic partner earns less than the IRS exemption amount, and
- Your domestic partner is a member of the household that you maintain and occupy.

It should be noted that your domestic partner cannot be considered a member of your household if the domestic partner relationship is in violation of local law or if your domestic partner is the dependent of another individual. Enrollment of your domestic partner also may have state tax consequences for you. Consult your own tax advisor for more information.

If your domestic partner is not your "dependent" for federal tax purposes (as described above, based on Sections 151 and 152 of the Internal Revenue Code), the value of the coverage provided to your domestic partner and his/her children is taxable to you. The value of the coverage is "imputed income," subject to income tax and FICA and H.I. taxes, and will be reported as income on the W-2 Form you

receive from the Company. Your imputed income will equal the fair market value of the coverage provided for your domestic partner and his/her children, reduced by your after-tax contributions toward the cost of that coverage.

Withholding for domestic-partner coverage will be taken in accordance with the W-4 Form that you have on file with payroll. **The Company will assume your domestic partner does not qualify as a dependent as defined by the IRS unless you advise us, and can demonstrate to our satisfaction, otherwise. This SPD should not be considered tax advice to you, and the Company cannot provide you with tax advice about your domestic partnership. Because of the tax consequences of domestic partner coverage, we encourage you to seek the advice of a tax advisor before electing benefits for your domestic partner.**

A Credit to Your Health Program – Medical Premium Credits

The A Credit to Your Health program is a voluntary program for Medical Plan participants to earn credits to offset contributions for Medical Coverage. Participants can earn Initial Credits during their first month of coverage by taking an online Health Survey and getting an Annual Physical or Biometric Screening. Initial Credits are generally provided beginning with the fourth month of medical coverage and end when Full Credits are applied.

Generally, Full Credits can be earned between March 1 and February 28 to be applied toward medical contributions for the subsequent Plan Year beginning July 1. Full Credits may be earned for taking an online Health Survey and getting an Annual Physical or Biometric Screening, as well as meeting certain target test values or completing a related telephonic Wellness Coaching Program. Refer to the section titled [**A Credit to Your Health Program**](#) for more details.

Non Tobacco User Credits

Medical Plan participants can earn credits to offset contributions for medical coverage if they do not use tobacco. To qualify, an employee (and spouse/domestic partner, if covered) must be tobacco free for the six months prior to enrolling in the medical plan. During the annual open enrollment, an employee (and spouse/domestic partner, if covered) must be tobacco free for six months as of July 1 or must have completed at least four coaching calls under the Quit-for-Life tobacco cessation program by May 1. If an employee covers a spouse or domestic partner and only one, not both, meets this requirement, then no credit is earned. The Quit-for-Life program is free and available to Program participants by calling 866-784-8454 or through the website www.quitnow.net.

Whom to Contact With Questions

Visit the BenefitsPlus website at www.hertz.com/benefitsplus for information about your benefits, to enroll or to make changes to your benefits

If you cannot access BenefitsPlus, contact AskHR. Your local Human Resources Business Partner and the Corporate Employee Benefits Department are also available to answer any questions you may have to help you understand your benefit options under the Program.

AskHR can be reached at 800-654-3373. Your local Human Resources Business Partner can usually be contacted at your regional or local area office. The Corporate Employee Benefits Department can be reached through Hertz's Corporate Headquarters.

Health Care

The Hertz Custom Benefit Program offers you and your family comprehensive medical, dental and vision coverage. You have the flexibility to choose the level of coverage you need.

Health Care

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Medical Plans

The Medical Plans are designed to assist you and your family in maintaining your health and well-being. Options are offered to provide you with a choice of coverage alternatives that afford varying levels of protection against the cost of health care.

Medical Plan Options

Available Medical Plan Options are described on the following pages. However, please note:

- Employees hired, or first becoming eligible for benefits, on or after July 1, 2010, are not eligible for Choice Plan A.
- Employees residing in Massachusetts are not eligible for the Economy Plan.

All options provide comprehensive medical benefits and generally cover the same types of expenses. Your out-of-pocket costs vary depending on the option you elect, and whether you obtain services from in-Network or Out-of-Network Providers. The Economy Plan and the Choice Plan A provide no coverage for services obtained from Out-of-Network Providers.

You also have the option to waive medical coverage, as long as you have medical coverage elsewhere.

Waiving Coverage
Due to the high cost of medical expenses, it is essential that everyone have some form of medical coverage. Today, a single medical emergency could burden an uninsured individual or family with a long-term financial hardship. You are provided with the option to enroll in or waive medical coverage under this Program. You can waive coverage only if you already have coverage under another medical plan (your spouse's plan, for example). By waiving coverage, you are certifying to Hertz that you are <u>covered under another medical plan.</u>

When making your medical election, remember you will keep the option you choose until the next enrollment period, unless you experience a qualifying event that enables you to make a change in accordance with the criteria in [Changing Your Coverage](#) section.

Comparing the Costs of Your Options

In addition to considering any payroll contributions associated with the various medical options available to you, you should also evaluate your other potential out-of-pocket expenses, for example:

- **Deductibles** – A Deductible is the amount of Covered Expenses you must pay each Plan Year before your chosen plan begins to pay benefits. The Deductible amounts vary depending on the Medical Plan Option you choose (prescription drugs are not subject to Medical Plan Deductibles).
- **Coinsurance** – The Medical Plan Options pay a percentage of eligible charges for care. The percentage varies depending on whether you obtain care from an in-network or Out-of-Network Provider. You pay only the remaining portion of the cost not covered by the Plan. In the chart below, the Coinsurance percentages are the amounts covered by the Plan *after* you have met the Deductible (prescription drugs are not subject to Medical Plan Deductibles).
- **Copayments** – Copayments (or Copays) are the amounts you must pay when you receive certain services. In the chart below, the Copays are the fixed dollar amounts that you must pay each time you receive the service.

- **Health Reimbursement Account (HRA)** – Consumer Health Account Plans 1 and 2 provide an HRA funded by Hertz. When a medical claim is processed, the money in this account will be used to offset your out-of-pocket expenses such as Deductibles and Coinsurance.
- **Services that are limited or not covered** – Some expenses may not be covered, or benefits may be limited based on the rules of the plan you choose. For example, under all of the Medical Plan Options, benefits will be paid for certain therapies up to a limited number of visits in a Plan Year. You pay the full cost for visits beyond the plan limits. You may still benefit from discounts if the services are obtained from in-Network Providers.

In-Network and Out-of-Network Coverage

If you enroll in one of the Consumer Health Account Plans, you may receive care from an in-Network or Out-of-Network physician or health care professional each time you need care. You will receive a higher level of benefits when you visit an in-Network Provider. The Economy Plan and the Choice Plan A provide no coverage for services obtained from Out-of-Network Providers.

In-Network Providers

UnitedHealthcare contracts with its in-Network Providers to render services at pre-negotiated rates. To verify a provider's status or request a provider directory, call UnitedHealthcare at the toll-free number on your Medical Plan ID card or log onto www.myuhc.com. Keep in mind, a provider's network status may change. Always check to be sure that your physician is still in the network before your visit to avoid paying unnecessary extra costs.

In-Network Providers are independent practitioners and are not employees of Hertz or UnitedHealthcare.

Summary of Benefits

The following chart provides a summary of the coverage available under the Medical Plan Options for common covered services. Refer to the sections [Deductibles, Coinsurance, Out-of-Pocket Maximums](#) and [Health Reimbursement Account](#) for additional information.

Covered Service or Supply*	Choice Plan A ^[1]	Consumer Health Account Plans 1 & 2		Economy Plan ^[2]
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Physician Services				
Physician Office Visits (OV)	\$35 copay	80%	60%	70%
Specialist Office Visits (OV)	\$50 copay	80%	60%	70%
24/7 Telemedicine Services	\$30 copay	\$30 copay	N/A	\$30 copay
Chiropractic – (\$500 max benefit per Plan Year)	\$50 copay	80%	60%	70%
Mental Health and Substance-Related and Addictive Disorders	\$35 copay (outpatient) 80% (inpatient)	80%	60%	70%
Preventive Care – refer to section entitled “Preventive Care” for more details				
Well Child Care (frequency based on child’s age)	100%	100%	60%	100%
Immunizations	100%	100%	60%	100%
Physical Exams/Annual Exams (1 per Plan Year)	100%	100%	60%	100%
Routine Gynecological Exams and Pap tests (1 per Plan year)	100%	100%	60%	100%
Mammograms (frequency based on age)	100%	100%	60%	100%
Prostate Exams (frequency based on age)	100%	100%	60%	100%
Colonoscopy (frequency based on age)	100%	100%	60%	100%
Laboratory Services	80%	80%	60%	70%
Radiology Services				
X-Rays	80%	80%	60%	70%
Imaging (MRI’s, CAT Scans, etc.)	80%	80%	60%	70%
Physical, Occupational and Speech Therapies (limit of 45 visits per Plan Year combined)	80%	80%	60%	70%
Hospitalization & Surgery				
Inpatient Hospital Stays	80%	80%	60%	70%
Emergency Room Services	\$200 copay, then 80%	\$200 copay, then 80%	\$200 copay, then 80%	\$200 copay, then 70%
Ambulatory / Outpatient Surgery Center	80%	80%	60%	70%
Ambulance	80%	80%	80%	70%
Surgeon’s fees	80%	80%	60%	70%
Prescription Drugs (separate plan – not subject to Medical Plan Deductibles or Coinsurance and not eligible for reimbursement from the HRA under Consumer Health Account Plans 1 or 2).				
Retail (30-day supply) Generic Brand Formulary Brand Non-Formulary	80% \$10 min / \$100 max 75% \$30 min / \$160 max 70% \$75 min / \$225 max			

Covered Service or Supply*	Choice Plan A ^[1]	Consumer Health Account Plans 1 & 2		Economy Plan ^[2]
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Mail Order or Preferred Retail Pharmacy (90-day supply) Generic Brand Formulary Brand Non-Formulary		80% \$20 min / \$200 max 75% \$60 min / \$320 max 70% \$150 min / \$450 max		

*Prior Authorization requirements apply to some covered services and supplies. See [Prior Authorization](#) and [Personal Health Support](#) in this section for information about these requirements.

- (1) Choice Plan A is not available to employees hired or first becoming eligible for the Program on or after July 1, 2010.
- (2) The Economy Plan is not available to employees residing in Massachusetts.

Deductibles, Coinsurance, Out-of-Pocket Maximums and Lifetime Benefit Maximum

All of the Medical Plan options provide coverage for the same eligible services. However, the level of coverage varies under the plans as a result of the applicable Deductibles, Coinsurance and/or out-of-pocket maximums. The chart below shows the applicable Deductibles, Coinsurance and out-of-pocket maximums under each option. Deductibles and out-of-pocket maximums are per Plan Year.

	C Plan A	CHA Plan 1	CHA Plan 2	Economy Plan
Deductibles⁽¹⁾				
In-Network				
Individual	\$700	\$1,400	\$2,200	\$2,700
Employee & 1 Dep ⁽²⁾	\$1,400	\$2,125	\$3,325	\$4,050
Family ⁽²⁾	\$2,100	\$2,850	\$4,450	\$5,400
Out-of-Network				
Individual	N/A ⁽⁵⁾	\$2,800	\$4,400	N/A ⁽⁵⁾
Employee & 1 Dep ⁽²⁾	N/A ⁽⁵⁾	\$4,250	\$6,650	N/A ⁽⁵⁾
Family ⁽²⁾	N/A ⁽⁵⁾	\$5,700	\$8,900	N/A ⁽⁵⁾
Coinsurance ⁽³⁾				
In-Network	80%	80%	80%	70%
Out-of-Network	N/A ⁽⁵⁾	60%	60%	N/A ⁽⁵⁾
Out-of-Pocket Maximums ⁽⁴⁾				
In-Network				
Individual	\$4,000	\$4,600	\$6,400	\$6,850
Employee & 1 Dep ⁽²⁾	\$8,000	\$6,900	\$9,600	\$10,275
Family ⁽²⁾	\$12,000	\$9,200	\$12,800	\$13,700
Out-of-Network				
Individual	N/A ⁽⁵⁾	\$9,200	\$12,800	N/A ⁽⁵⁾
Employee & 1 Dep ⁽²⁾	N/A ⁽⁵⁾	\$13,800	\$19,200	N/A ⁽⁵⁾
Family ⁽²⁾	N/A ⁽⁵⁾	\$18,400	\$25,600	N/A ⁽⁵⁾
Lifetime Benefit Maximum	Unlimited			

- (1) *The in-network Deductible does not qualify towards satisfying the out-of-network Deductible, and the out-of-network Deductible does not qualify toward satisfying the in-network Deductible.*
- (2) *All Family Deductibles and out-of-pocket amounts are aggregates: Both/all family members contribute until satisfied, but no one family member satisfies more than the individual Deductible or out-of-pocket amount.*
- (3) *Coinsurance is the percentage the plan pays after the Deductible is satisfied.*
- (4) *The out-of-pocket maximums include medical copays (Plan A), prescription drug plan copays, and amounts applied to the Deductibles. Out-of-pocket maximums are also separate for in-network and out-of-network services.*
- (5) *The Economy Plan and the Choice Plan A provide only In-Network coverage. Services obtained from Out-of-Network Providers are excluded.*

Health Reimbursement Account (HRA)

Consumer Health Account Plans 1 & 2 include an HRA funded by Hertz. The funds in the HRA are used to offset your eligible out-of-pocket expenses, like Deductibles and Coinsurance. Each year, Hertz will deposit a specified amount (see chart below) into your account, based on your coverage election. Any unused balance in your account at the end of each Plan Year is carried forward to the next Plan Year, provided you remain in one of the Consumer Health Account Plans. The amount in your account can build each year if unused.

Hertz Contribution to HRA		
Coverage Level	Consumer Health Account Plan 1	Consumer Health Account Plan 2
Employee Only	\$600	\$600
Employee & 1 Dep	\$900	\$900
Family	\$1,200	\$1,200

For the Employee & 1 Dependent and Family coverage levels, the HRA fund is an aggregate balance that can be used by one or all covered family members. For example: If you are enrolled for the Family coverage level, one family member may use the entire \$1,200 HRA. Note: The Claims Administrator will automatically apply HRA funds to out-of-pocket expenses in the order in which claims are received. HRA funds will be used before your FSA dollars, if you are enrolled in the Health Care FSA.

Contributions to the HRA by Hertz will be prorated for individuals whose coverage begins after the beginning of the Plan Year (for example, new employees or mid-Plan Year status changes with a qualifying event). Proration will be in monthly amounts equal to 1/12th of the full year contribution amounts shown in the chart above, for the number of months remaining in the Plan Year when the individual's coverage becomes effective.

If your coverage with Hertz terminates, any balance in your HRA account is forfeited, with the following exceptions:

- You may use the funds in the account for any expenses incurred up to your coverage termination date.
- If you elect to continue coverage under COBRA, the HRA funds will remain available while you are covered under one of the Consumer Health Account Plan options. Hertz will contribute the specified amount (see above) at the beginning of each Plan Year.
- If you retire, and are eligible for the Post-Retirement medical coverage (refer to [Coverage After You Retire](#) at the end of the Medical Plans section), the HRA funds will remain available while you are covered under one of the Consumer Health Account Plan options. Hertz will contribute the specified amount (see above) at the beginning of each Plan Year.

Plan Year

The Plan Year is the 12-month period beginning each July 1 through the following June 30.

What the Plans Cover

All of the Medical Plan options provide you and your covered dependents with coverage for Medically Necessary Covered Health Services and supplies. The charts in the previous sections outline the applicable Copayments, Deductibles and benefit Coinsurance percentages for eligible charges. This section provides further details on services covered under the plans.

Prior authorization is required for some services. If prior authorization is required, you must follow the prior authorization procedures or you may pay a penalty. Personal Health Support is also provided (or

required) for certain services. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for more information.

Acupuncture Services

- Acupuncture services for pain therapy, provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:
 - Doctor of Medicine;
 - Doctor of Osteopathy;
 - Chiropractor; or
 - Acupuncturist.
- Covered Health Services include treatment of nausea as a result of:
 - Chemotherapy;
 - Pregnancy; and
 - Post-operative procedures.

Ambulance Services

- Licensed ambulance service for Emergency transportation to the nearest Hospital properly equipped to treat the patient's illness or Injury.
 - Ambulance service by air is covered in an Emergency, if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services may be covered.
- Ambulance service between two Hospitals is only covered if needed to provide treatment that is not available at the originating facility.

See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for limitations.

Bariatric Services and Obesity Surgery

Bariatric surgical treatment of obesity is covered if you:

- Are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4;
- Have a minimum Body Mass Index (BMI) of 40, or a BMI of greater than 35 with at least 1 co-morbid condition present;
- Enroll in the Bariatric Resource Services (BRS) program;
- Use a designated Bariatric Resource Services (BRS) provider and facility;

- Have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation; and
- Have a 6-month physician supervised diet documented within the last 2 years.

Benefits are limited to one surgery per lifetime unless complications occur. Excess skin removal post bariatric surgery is not covered, unless Medically Necessary. Prior authorization is required. All services must be initiated through the Bariatric Resource Services (BRS) program. To receive the highest level of benefits, you must contact BRS prior to surgery and prior to the time a pre-surgical evaluation is performed.

Bariatric Resource Services (BRS)

BRS is a surgical weight loss solution for those individual(s) who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process. The BRS program provides support in preparation for surgery, information and education in the selection of a bariatric surgery program, and post-surgery and lifestyle management. Call BRS toll-free at 866-936-7246.

Cancer Resource Services (CRS)

The plans pay benefits for Medically Necessary oncology services without a Copayment or Deductible when provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined under [Important Terms You Should Know](#) in the [General Information About Health Care Plans](#) section.

For oncology services and supplies to be considered Medically Necessary Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered dependent has cancer, you should:

- Call CRS toll-free at 866-936-6002;
- Visit www.myoptumhealthcomplexmedical.com; or
- Be referred to CRS by a UnitedHealthCare [Personal Health Support](#) nurse.

The services described under [Transportation and Lodging](#) are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

If you receive oncology services from a facility that is not a Designated Facility, the plans pay benefits as otherwise payable for Hospital, Physician and/or healthcare provider services and you will not qualify for the [Transportation and Lodging](#) benefits.

Cancer Clinical Trials and related treatment and services are covered by the Medical Plans when coordinated through the Cancer Resource Services program. Such treatment and services must be recommended and provided by a Physician in a cancer center. The cancer center must be a Designated Facility participating center in the Cancer Resource Services program at the time the treatment or service is given.

To receive the highest level of benefits, you must contact CRS prior to obtaining Covered Health Services. The Medical Plans will only pay benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that network).

Clinical Trials

The Medical Plans pay for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of:

- Cancer;
- Cardiovascular disease (cardiac/stroke); and
- Surgical musculoskeletal disorders of the spine, hip, and knees; and
- Other diseases or disorders for which, as determined by the Claims Administrator, a Clinical Trial meets the qualifying Clinical Trial criteria stated below.

Benefits include the reasonable and necessary items and services used to diagnose and treat complications arising from participation in a qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Clinical Trial as defined by the researcher. Benefits are not available for preventive Clinical Trials. Routine patient care costs for Clinical Trials include:

- Covered Health Services for which Benefits are typically provided absent a Clinical Trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an investigational item or service.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain Category B devices;
 - Certain promising interventions for patients with terminal illnesses; or
 - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

To be a qualifying Clinical Trial, a Clinical Trial must meet all of the following criteria:

- Be sponsored and provided by a cancer center that has been designated by the National Cancer Institute (NCI) as a Clinical Cancer Center or Comprehensive Cancer Center or be sponsored by any of the following:
 - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI).)

- Centers for Disease Control and Prevention (CDC);
- Agency for Healthcare Research and Quality (AHRQ);
- Centers for Medicare and Medicaid Services (CMS);
- Department of Defense (DOD); or
- Veterans Administration (VA).
- Have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The Claims Administrator may, at any time, request documentation about the trial; and
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Benefits are available when the Covered Health Services are provided by either Network or non-Network Providers, however the non-Network Provider must agree to accept the Network level of reimbursement by signing a Network Provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network Provider does not agree to accept the Network level of reimbursement.)

Please remember that you must notify Personal Health Support as soon as the possibility of participation in a Clinical Trial arises. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for limitations.

Congenital Heart Disease (CHD) Services

The following services will be covered without a Copayment or Deductible when ordered by a Physician and received at a CHD Resource Services Designated Facility. The services cannot be experimental or investigational or an unproven service. Designated Facility is defined under [Important Terms You Should Know](#) in the [General Information About Health Care Plans](#) section.

- Outpatient diagnostic testing, in utero services and evaluation, CHD surgical interventions;
- Interventional cardiac catheterizations (insertion of a tubular device in the heart);
- Fetal echo cardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by Personal Health Support to be proven procedures for the involved diagnoses.

Personal Health Support notification is required for all CHD services. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for further information. If you do not meet those requirements, your benefits may be reduced. Contact Personal Health Support at the toll-free number on your ID card for information about CHD services.

The services described under [Transportation and Lodging](#) in this section are covered only in connection with services received at a CHD Resource Services Designated Facility.

When the covered services above are not performed in a CHD Resource Services Designated Facility, benefits will be paid the same as otherwise payable for Hospital, Physician and/or other health care provider services and you will not qualify for the [Transportation and Lodging](#) benefits.

Dental-Related Services

Hospital and doctor's charges for dental work due to accidental Injuries to the natural teeth or jaw are covered if:

- Treatment is necessary because of accidental damage;
- Dental services are received by a doctor of dental surgery or doctor of medical dentistry; and
- The dental damage is severe enough that initial contact with a Physician or Dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Treatment for accidental Injuries is limited to:

- Emergency examination;
- Necessary diagnostic X-rays;
- Endodontic (root canal) treatment;
- Temporary splinting of teeth;
- Prefabricated post and core;
- Simple minimal restorative procedures (fillings);
- Extractions;
- Post-traumatic crowns if such treatment is the only clinically acceptable treatment; and
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident, or if not covered under the Program at the time of the accident, within the first three months of coverage under the Program, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not covered under the Program at the time of the accident, within the first 12 months of coverage under the Program.

Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Benefits are also provided for dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition in the following situations:

- Dental services related to medical transplant procedures;

- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system); and
- Direct treatment of acute traumatic Injury, cancer or cleft palate.

Durable Medical Equipment (DME)

Rental or purchase of Durable Medical Equipment (DME) that is:

- Ordered or provided by a Physician for outpatient use,
- Used for medical purposes,
- Not consumable or disposable,
- Not of use to a person in the absence of a Sickness, Injury or disability,
- Durable enough to withstand repeated use, and
- Appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive benefits only for the most cost-effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of DME that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece the Claims Administrator has determined is the most cost-effective.

Generally, the plan covers rental of DME. However, in some cases it may be determined by the Claims Administrator that it is more practical to cover purchase of the DME (i.e., in cases where the equipment will be required for an extended or indefinite period of time, such that rental fees would exceed the purchase price). In no event will rental charges be covered in excess of the purchase price.

Coverage is provided for the replacement of a piece of DME only once every three Plan Years, to the extent such replacement is Medically Necessary. At the Claims Administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouthpieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three-year timeline for replacement.

If the rental price or purchase price of the DME meets or exceeds \$1,000, you must contact Personal Health Support. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below.

Examples of covered DME include, but are not limited to:

- Braces that stabilize an injured body part and braces to treat curvature of the spine, Rental of home kidney dialysis equipment,
- Equipment to assist mobility, such as a wheelchair,
- Hospital beds,
- Equipment to administer oxygen, and

- Tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the paragraphs above.

Note: DME is different from prosthetic devices – see [Prosthetic Devices](#) in this section.

Extended Care – Skilled Nursing/Inpatient Rehabilitation

Facility services for a stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered, when it is a necessary Covered Health Service, including:

- Supplies and non-physician services received during the inpatient stay;
- Room and board in a semi-private room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are covered at a Skilled Nursing Facility or Inpatient Rehabilitation Facility when the services are needed on a daily basis or when they are for treatment of a Sickness or Injury that would have otherwise required an inpatient stay in a Hospital. Coverage will only be provided if:

- The confinement was or will be a cost effective alternative to an inpatient stay in a Hospital; and
- The skilled care services are not primarily Custodial Care.

Skilled care services (skilled nursing, skilled teaching, and skilled rehabilitation services) must:

- Be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provided for your safety;
- Be ordered by a Physician;
- Not be delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- Require clinical training in order to be delivered safely and effectively.

Skilled care does not include services that are provided simply because there is not an available caregiver. Benefits may be denied or shortened if the Covered Person is not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Services provided by a Physician in a Skilled Nursing Facility or Inpatient Rehabilitation Facility may be covered under other sections of this Program.

Gender Dysphoria Services

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses,
- Cross-sex hormone therapy,

- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting,
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy, and
- Medically Necessary surgery for the treatment of Gender Dysphoria.

Personal Health Support notification is required for Gender Dysphoria services. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for further information. Documentation may be required for surgeries. If you do not meet those requirements, your benefits may be reduced.

Hearing-Related Services

- Hearing exams, related testing, fittings and hearing aids. Eligible Expenses for the hearing device will be based upon the least costly standard hearing aid that meets the functional purpose intended by the prescription. Hearing aids *do not* include bone anchored hearing aids unless the device is for a person who has craniofacial anomalies where abnormal or absent ear canals preclude the use of a wearable hearing aid or hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
- Hearing aid(s) replacements will be covered only when there is a change in the participant's hearing capabilities and the current hearing aid cannot be adjusted to correct the participant's hearing deficiency. Replacement parts and repairs are not covered.

Home Health Care

The following services provided by an approved Home Health Care Agency are covered when prescribed by a Physician:

- Home health care and services,
- Medical equipment and supplies, prescription drugs and medicines and laboratory services,
- Nursing services, provided or supervised by a registered nurse, and
- Physical, occupational, speech or respiratory therapy provided by a registered or licensed therapist.

Hospice

An approved Hospice program is covered under the Medical Plans if a participant becomes terminally ill with a life expectancy of less than six months. An approved Hospice care program is one which provides services designed to meet the special needs of a terminally ill person, and his or her family unit, during the final stages of illness and bereavement. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the terminally ill person is receiving Hospice care.

See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for more information. For out-of-network services, you must obtain prior authorization from the Claims Administrator five business days before admission for an inpatient stay in a Hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, the Coinsurance will be reduced by 10% (for example, from 60% to 50%). Benefits are available only when Hospice care is received from a licensed Hospice agency, which can include a Hospital.

Hospitalization-Related Expenses

- Semiprivate room, board and other Hospital services,
- Private room, covered at the Hospital's standard semiprivate room rate. If no semiprivate accommodations are available, the standard semiprivate rate will be considered to be 90% of the Hospital's lowest daily rate for a private room. Charges for a private room are eligible in full when isolation is required for treatment of a communicable disease, as well as a depressed immune system,
- For the mother or newborn child, a minimum Hospital stay of 48 hours following a vaginal delivery birth and 96 hours following a Cesarean birth (Under federal law, a shorter stay may be agreed upon by the mother's or newborn's attending provider, after consulting with the mother.) If your inpatient Hospital stay will exceed these time limitations, contact Personal Health Support. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below. In any case, no authorization is required from the Program or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours, as applicable),
- Ambulatory Surgical Center services (that would have been payable if done in a Hospital),
- Birthing Center services and supplies (that would have been payable if done in a Hospital),
- Hospital nursery charges for a child who is a covered dependent (separate Deductibles will apply for the mother and the newborn),
- Kidney dialysis treatment services provided as a Hospital outpatient or in a free-standing kidney dialysis facility,
- Non-experimental organ transplant procedures (i.e., kidney, heart, heart/lung, lung, pancreas, liver, corneas, skin, tissue, bone and bone marrow). Refer to [Transplantation Services](#) in this section for further information.

Other covered hospitalization expenses are explained under other sections of this booklet.

If you are being admitted to, or having services performed in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility, or if you are receiving Home Health Care or Hospice Care, see [Personal Health Support](#) in this section for further information. If you do not meet those requirements, your benefits may be reduced.

Infertility Services and Reproductive Resource Services

The Medical Plans pay for therapeutic services for the treatment of infertility when provided by or under the direction of a Physician. Benefits for infertility are covered when provided by Designated Facilities participating in the *Reproductive Resource Services (RRS)* program (described below). Diagnostic services are covered as provided under [Physician and Other Health Care Provider Services](#).

Benefits are limited to:

- Ovulation induction and controlled ovarian stimulation;
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI);

- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI);
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of sperm;
- Embryo transportation related network disruption; and
- Cryopreservation for up to 12 months.

To be eligible, you must:

- Have failed to achieve a Pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months, if the woman is over age 35;
- Have failed to achieve Pregnancy following twelve cycles (under age 35) or six cycles (age 35 or over) of donor insemination;
- Have failed to achieve Pregnancy due to impotence/sexual dysfunction;
- Have infertility that is not related to voluntary sterilization;
- Be under age 44, if female and using own oocytes (eggs);
- Be under age 50, if female and using donor oocytes (eggs);

For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

- Have diagnosis of a male factor causing infertility (e.g. treatment of sperm abnormalities including the surgical recovery of sperm).

The waiting period may be waived when Covered Person has a known infertility factor, including but not limited to: congenital malformations, known male factor, known ovulatory disorders, diminished ovarian reserve, impotence/sexual dysfunction, moderate or severe endometriosis, or documented compromise of the fallopian tubes

Coverage Limits

The lifetime maximum benefits for covered infertility services are as follows:

- Medical Plan: \$25,000, and
- Prescription Plan: \$10,000 (administered by OptumRx).

You must obtain prior authorization before receiving infertility services. See the [Prior Authorization](#) section below for more information.

Reproductive Resource Services (RRS)

The Reproductive Resource Services (RRS) program provides education, counseling, infertility management and access to a national network of premier infertility treatment clinics. For infertility services and supplies to be covered, contact RRS and enroll with a nurse consultant prior to receiving services. You should:

- Be referred to RRS by the Claims Administrator;
- Call the telephone number on your ID card; or
- Call RRS directly at 1-866-774-4626.

Kidney Resource Services (KRS)

The Medical Plans pay benefits for Medically Necessary treatment of both chronic kidney disease and End-Stage Renal Disease (ESRD) without a Copayment or Deductible when provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined under [Important Terms You Should Know](#) in the [General Information About Health Care Plans](#) section.

In order to receive benefits under this program, KRS must provide the proper notification to the Network Provider performing the services. This is true even if you self-refer to a Network Provider participating in the Program. Notification is required:

- Prior to vascular access placement for dialysis, and
- Prior to any ESRD services.

You or a covered Dependent may:

- Be referred to KRS by Personal Health Support (call Personal Health Support at the toll-free number on your ID Card), or
- Call KRS toll-free at 888-936-7246 and select the KRS prompt.

The services described under [Transportation and Lodging](#) are Covered Health Services only in connection with KRS-related services received at a Designated Facility.

If you receive services from a facility that is not a Designated Facility, the plans pay benefits as otherwise payable for Hospital, Physician and/or health care provider services and you will not qualify for the [Transportation and Lodging](#) benefits.

To receive benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The plan will only pay benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self-refer to a provider in that Network).

Laboratory, X-Ray and Diagnostic Services

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis, including:

- Laboratory tests and radiology,
- Diagnostic X-rays and other imaging procedures, and
- Mammography (including Digital Breast Tomosynthesis).

Services may be performed on an outpatient basis at a Hospital or Alternate Facility.

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services are also covered when received on an outpatient basis at a Hospital or Alternate Facility.

When these services are performed in a Physician's office, these benefits are subject to Physician office visit fees.

See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for more information.

Mental Health Services

Mental Health Services include those received on an inpatient or Intermediate Care basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits for Mental Health Services include:

- Inpatient services/treatment;
- Residential treatment;
- Partial Hospitalization / Day Treatment;
- Intensive Outpatient Treatment;
- Outpatient treatment;
- Diagnostic evaluations, assessment and treatment planning;
- Medication management and other associated treatments;
- Individual, family and group therapeutic services;
- Provider-based case management services; and
- Crisis intervention.

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for referrals to providers and coordination of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for more information.

The Mental Health/Substance-Related and Addictive Disorders Administrator is responsible for coordinating all of your care. Contact the Mental Health/Substance-Related and Addictive Disorders Administrator regarding Benefits for Mental Health Services at the phone number on the back of your medical ID card.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Administrator may become available to you as part of your Mental Health Services benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Administrator, who is responsible for coordinating your care or through other pathways as described in the program

introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders

The Medical Plans pay Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder,
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision; and
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section. Benefits include:

- Inpatient treatment;
- Residential treatment;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment;
- Outpatient treatment;
- Diagnostic evaluations, assessment and treatment planning;
- Treatment and/or procedures;
- Medication management and other associated treatments;
- Individual, family therapeutic group and provider-based case management services;
- Crisis intervention; and
- Provider-based case management services.

Autism Spectrum Disorder services must be authorized (see the section titled [Prior Authorization](#)) and overseen by the Mental Health/Substance-Related and Addictive Disorders Administrator. Contact the Mental Health/Substance-Related and Addictive Disorders Administrator regarding Benefits under this section. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for more information.

Nursing Services

- Services of a Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse for up to 30 visits in a Plan Year when ordered by a Physician and not rendered during hospitalization. Any shift of nursing up to eight hours will be counted as a visit. For shifts over eight hours, each eight hours or part thereof will be counted as a visit.

- Services provided by a Certified Nurse Midwife (CNM).

Physician and Other Health Care Provider Services

- Anesthesia and its administration,
- Charges for a second or third opinion,
- Charges for healing services from an accredited nurse or sanatorium,
- Chemotherapy and/or radiation therapy,
- Chiropractic services:
 - Payable benefit up to \$500 per Plan Year.
- Foot care is limited to the following charges:
 - Fractures, disease or deformities, (except as listed under [Exclusions and Limitations](#) in this section), and
 - Treatment when surgery is performed involving exposure of bones, tendons or ligaments.
- The Program will provide, in compliance with the Women's Health and Cancer Rights Act, certain coverage for medical and surgical benefits relating to a mastectomy including:
 - Reconstruction of the breast on which the mastectomy has been performed,
 - Surgery and reconstruction of the other breast to produce symmetrical appearance,
 - Treatment of physical complications in all stages of the mastectomy including lymphedemas (swelling associated with the removal of lymph nodes), and
 - Prostheses

Benefits for breast reconstruction are subject to annual Plan Deductibles and Coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

- Initial sterilization procedures,
- Necessary medical and surgical charges of doctors, surgeons and other specialists, both in and out of the Hospital, unless specifically listed under [Exclusions and Limitations](#) in this section (Also see covered sections: [Mental Health Services](#), [Substance-Related and Addictive Disorders](#) and [Therapy Services – Rehabilitative and Habilitative](#).),
- Respiratory therapy, and
- Services provided by a licensed clinical social worker, when practicing within the scope of their license, and services are otherwise considered eligible under the plan. (See the [Mental Health Services](#) and [Substance-Related and Addictive Disorders](#) sections.)

Pregnancy and Maternity Services

Pregnancy benefits include all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications. Benefits include the services of a genetic counselor when provided or referred by a physician. See the section titled [Hospitalization Related Expenses](#) for hospitalization information.

Prescription Drugs, Medicines and Related Items (Administered by OptumRx)

Charges for prescription drugs which cannot be obtained “over-the-counter” will be covered only if they are:

- Legally obtained in the United States,
- Legally imported to the United States, or
- Legally obtained and used in a foreign country, provided use of the drug is also legal within the United States. Refer to [Prescription Drug Benefits](#) later in this section for further details.

Preventive Care

In general, the plans cover preventive care services 100% (in-network) as required by law and in accordance with A and B recommendations of the U.S. Preventive Services Task Force (USPSTF). If the USPSTF’s recommendations change, the Preventive Care benefits may also change. Preventive care services include (but are not limited to) the below items. For all preventive care services, frequency, age and other limits may apply based on generally accepted medical standards. These limits may change from time-to-time pursuant to reasonable medical management or as required by law.

- Women’s Preventive Care Services:
 - Breast feeding support, supplies (including breast pumps) and counseling
 - Contraception methods and counseling
 - Domestic violence screening
 - Gestational diabetes screening
 - HIV screening and counseling
 - Human Papillomavirus (HPV) testing
 - Sexually transmitted infections counseling
 - Well-woman visits
- Immunizations
- Mammography (one baseline exam every one to two years for women over 40)
- Pediatric exams
- Prostate exam

- Annual Exam (only when provided by an in-Network Provider):
 - One routine physical per Plan Year for individuals ages 18 and older, including preventive labs, x-rays and other diagnostic tests associated with the routine physical.
- Colorectal Cancer Screening (only when provided by an in-Network Provider)

Under the Prescription Drug Benefits, certain prescriptions are also available at a \$0 copay as required by law. Preventive care benefits also includes FDA approved contraceptive medications and devices for women with reproductive capacity (under 55 years of age) when prescribed by a healthcare provider (where a generic is available, brand name medications will be subject to the normal copay).

For questions about your preventive care benefits under this Plan, you can call the number on the back of your ID card. A full list of preventive care benefits under Health Care Reform is available on the U.S. Department of Health and Human Services website (www.hhs.gov).

Prosthetic Devices

Prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- Artificial limbs,
- Artificial eyes, and
- Breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than a breast prosthesis.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Coverage is provided for replacement of a prosthetic device only once every three Plan Years, to the extent such replacement is Medically Necessary. At the Claims Administrator's discretion, replacement of prosthetic devices may be covered sooner than the five-year timeframe (1) for damage beyond repair with normal wear and tear, (2) when repair costs are less than the cost of replacement, or (3) when there is a change in the Covered Person's medical condition. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME – see [Durable Medical Equipment \(DME\)](#) in this section.

Substance-Related and Addictive Disorders

Substance-related and addictive disorders services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include:

- Inpatient treatment,
- Residential treatment,
- Partial Hospitalization / Day Treatment,
- Intensive Outpatient Treatment,
- Outpatient treatment,
- Diagnostic evaluations, assessment and treatment planning,
- Treatment and/or procedures,
- Medication management and other associated treatments,
- Individual, family and group therapy,
- Crisis intervention,
- Provider-based case management services, and
- Transitional Living services.

The Mental Health/Substance-Related and Addictive Disorders Administrator, who will authorize the services, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. See the sections titled [Prior Authorization](#) and [Personal Health Support](#) below for more information.

Referrals to a provider are at the sole discretion of the Mental Health/Substance-Related and Addictive Disorders Administrator, who is responsible for coordinating all of your care. Substance-related and addictive disorders services must be authorized and overseen by the Mental Health/Substance-Related and Addictive Disorders Administrator. Contact the Mental Health/Substance-Related and Addictive Disorders Administrator regarding Benefits for substance-related and addictive disorders services at the phone number on the back of your medical ID card.

Special Substance-Related and Addictive Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Administrator may become available to you as part of your Substance-related and Addictive Disorder Services benefit. The Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Substance-Related and Addictive Disorder which may not be otherwise covered under this Plan. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Therapy Services – Rehabilitative and Habilitative

Short-term outpatient rehabilitative and habilitative services, limited to:

- Physical therapy,

- Occupational therapy,
- Manipulative treatment,
- Speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, congenital anomaly, or Autism Spectrum Disorder,
- Post-cochlear implant aural therapy,
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident,
- Pulmonary rehabilitation, and
- Cardiac rehabilitation

Rehabilitation services must be provided by a licensed therapy provider, under the direction of a Physician (when required by state law). Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a home by a Home Health Care Agency are provided as described under the [Home Health Care](#) section. Benefits may be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

Habilitative services (Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living) are covered when the services:

- Are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain the Covered Person's current condition or to prevent or slow further decline,
- Are ordered by a Physician and provided and administered by a licensed provider,
- Are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair,
- Require clinical training in order to be delivered safely and effectively,
- Are not Custodial Care, respite care, day care, therapeutic recreation, vocational training or Residential Treatment.

Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. A service will not be determined to be skilled simply because there is not an available caregiver.

In addition to the above, Benefits are provided for habilitative services for Covered Persons with a disabling condition if:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician, and

- The initial or continued treatment is not Experimental and Investigational.

A treatment plan, medical records, clinical notes, or other necessary data may be required to allow the Claims Administrator to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, the Claims Administrator may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Eligible Expenses for the therapies listed below are limited to a total of 45 visits in a Plan Year (for each type of therapy), when performed on an outpatient basis.

- Occupational therapy,
- Physical therapy, and
- Speech therapy in the following circumstances:
 - To restore speech after a loss or impairment (not caused by a mental, psychoneurotic or personality disorder) of a demonstrated, previous ability to speak, or
 - To develop or improve speech, after surgery to correct a defect that both existed at birth and impaired or would have impaired the ability to speak.

Transplantation Services

The organ and tissue transplant procedures listed below will be covered without a Copayment or Deductible when ordered by an in-Network Physician and received at a Designated Facility. The services cannot be Experimental or Investigational or an Unproven Service.

The services described under [Transportation and Lodging](#) in this section, are covered only in connection with a transplant received at a Designated Facility.

Personal Health Support notification is required for all transplant services. See [Personal Health Support](#) in this section for further information. If you do not meet those requirements, your benefits may be reduced. Contact Personal Health Support at the toll-free number on your ID card for information about Transplantation Services.

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants are covered services. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is covered.
- Cornea Transplants (Personal Health Support notification is not required).
- Heart transplants.
- Heart/lung transplants.
- Lung transplants.
- Kidney transplants.
- Kidney/pancreas transplants.

- Pancreas transplants.
- Liver transplants.
- Liver/kidney, or liver/intestinal transplants.
- Small bowel transplants.

Services are covered for both the donor and the recipient when the recipient is covered under the plan.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Personal Health Support to be a proven procedure for the involved diagnoses.

Under the plan there are specific guidelines regarding benefits for transplant services. Contact Personal Health Support at the telephone number on your ID card for information about these guidelines.

When the covered services above are not performed in a Designated Facility, benefits will be paid the same as otherwise payable for Hospital, Physician and/or other health care provider services, and you will not qualify for the [Transportation and Lodging](#) benefits.

Transportation and Lodging

Transportation and Lodging benefits are available only to patients receiving [Cancer Resource Services \(CRS\)](#), [Congenital Heart Disease \(CHD\) Services](#), [Kidney Resource Services \(KRS\)](#), or [Transplantation Services](#) at a Designated Facility participating in the respective program. The services described below are Covered Health Services only in connection with services approved and received under one of the programs and facilities noted above.

Personal Health Support will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging for the recipient of the CRS, CHD, KRS, or Transplantation services and a companion are available under the plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where services are given for the purposes of an evaluation, the procedure or other treatment, or necessary post-discharge follow-up.
- Reasonable and necessary lodging expenses for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.
- Travel and lodging expenses are only available if the patient resides more than 50 miles from the CHD Resource Services program or Designated Facility.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the \$100 per diem rate.

There is a combined overall lifetime maximum of \$10,000 per Covered Person for all transportation and lodging expenses incurred by the patient and companion(s) and reimbursed under this plan in connection with all transplant procedures, CHD services, CRS services, or KRS services.

Vision-Related Services

- Vision surgery except as listed under [Exclusions and Limitations](#) in this section.

Personal Health Support

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support Nurse program includes:

- **Admission counseling** – Nurse Advocates are available to help you prepare for a successful surgical admission and recovery. Call the number on the back of your ID card for support.
- **Inpatient care management** – If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission management** – This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk management** – Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network Provider, you are responsible for obtaining prior authorization before you receive the services. Services for which prior authorization is required are identified.

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network Provider, you may want to contact UnitedHealthcare to verify that the Hospital, Physician and other providers are Network Providers and that they have obtained the required prior authorization. Network facilities and Network Providers cannot bill you for services they fail to prior authorize as required. You can contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network Providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network Provider intends to admit you to a Network facility or refers you to other Network Providers.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

You do not need prior authorization from UnitedHealthcare or your Primary Physician in order to obtain access to obstetrical or gynecological care from a health care professional who is a Network Provider that specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Some prescription drugs are subject to prior authorization. See the section titled [Prescription Drug Benefits](#) for information about the prior authorization requirements that apply to prescription drugs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization is required even if you have a referral from your Primary Physician to seek care from another Network Physician.

Network Providers are generally responsible for obtaining prior authorization from Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for obtaining prior authorization from Personal Health Support. When you choose to receive certain Covered Health Services from non-Network Providers, you are responsible for obtaining prior authorization from Personal Health Support before you receive these services. In many cases, your non-Network Benefits will be reduced if Personal Health Support has not provided prior authorization.

The services that require Personal Health Support authorization are:

- Ambulance – non emergent air,
- Bariatric surgery (contact BRS),
- Clinical Trials,
- Congenital Heart Disease services,
- Durable Medical Equipment when the rental or purchase price will exceed \$1,000,

- Gender Dysphoria,
 - Genetic testing – BRCA,
 - Home health care,
 - Hospice care,
 - Hospital Inpatient Stay- all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery,
 - Infertility Services,
 - Lab, X-Ray and Diagnostics – Outpatient - sleep studies.
 - Lab, x-ray and major diagnostics - CT, PET scans, MRI, MRA and Nuclear Medicine including diagnostic catheterization and electrophysiology implants.
 - Mental Health Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders – inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA),
 - Pregnancy Hospital admissions which exceed the following timeframes:
 - 48 hours for normal vaginal delivery, or
 - 96 hours for a Cesarean section.
- Refer to [Hospitalization-Related Expenses](#) for further details.
- Reconstructive procedures,
 - Skilled Nursing Facility/Inpatient Rehabilitation Facility services,
 - Substance Use Disorder Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility and Transplantation services.

Notification is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

If you do not obtain prior authorization from Personal Health Support when required, the payable Coinsurance percentage for out-of-network services will be lowered by 10%. For example, under the Personal Health Account Plans 1 and 2, the Out-of-Network Coinsurance will be reduced from 60% to 50%.

Contacting Personal Health Support is easy – simply call the toll-free number on your ID Card.

Resources to Help You Stay Healthy

Hertz believes in giving you the tools you need to be an educated health care consumer. Hertz has made available several convenient educational and support services, accessible by phone and the Internet, which can help you:

- Take care of yourself and your family members,
- Manage a chronic health condition, and
- Navigate the complexities of the health care system.

Not all of the available programs are described below. Call the toll-free number on the back of your ID card or visit www.myuhc.com to learn more about the programs listed in this section and other programs that may be available to you.

The programs described in this section are voluntary. In some cases, the Claims Administrator may contact you about the disease management programs if you qualify. You are not required to participate and will not be punished if you choose not to participate.

Note: Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor (except that the Virtual Visits program connects you with a doctor electronically). The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Hertz are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Health Information on myuhc.com

UnitedHealthcare's member website, myuhc.com, provides information at your fingertips anywhere and anytime you have access to the Internet. The myuhc.com website opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With myuhc.com you can:

- Complete a health survey on the Rally platform to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources,
- Receive personalized messages that are posted to your own website,
- Research a health condition and treatment options to get ready for a discussion with your Physician,
- Search for in-Network Providers available in your plan through the online provider directory,
- Access all of the content and wellness topics from Optum NurseLine/Connect24 including Live Nurse Chat 24 hours a day, seven days a week,
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area, and
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Self-Service Tools

Tools available on www.myuhc.com allow you to:

- Make real-time inquiries into the status and history of your claims,
- View eligibility and plan benefit information, including Copayments and annual Deductibles,
- View and print all of your Explanation of Benefits (EOBs) online, and
- Order a new or replacement ID card, print a temporary ID card, or check on an ID card request.

Registering on myuhc.com

If you have not already registered as a myuhc.com subscriber, simply go to www.myuhc.com and click on "Register Now." Have your United Healthcare ID card handy. The enrollment process is quick and easy.

Health Survey

You are invited to learn more about your health and wellness at myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health survey is kept confidential. Completing the survey will not impact your benefits or eligibility for benefits in any way.

To find the health survey, log in to www.myuhc.com. After logging in, click on Rally. If you need any assistance with the online survey, please call the number on the back of your ID card.

United Healthy Living Programs

This web-based program, which can be accessed through myuhc.com, provides you with a lifestyle action plan tailored to your risk, preferences and lifestyle. Action plans are available for:

- Physical activity,
- Nutrition,
- Stress management,
- Weight management,
- Blood pressure,
- Cholesterol,
- Smoking cessation,
- Diabetes, and
- Cancer prevention.

In addition, you will receive a personalized weekly e-mail to help you in your personal health management.

Live Telephonic Health Coaching

The Healthy Living Programs are online and self-directed. But perhaps you need more personalized help and prefer to work with a live Health Coach. UnitedHealthcare's telephonic Health Coaches are available to assist you with the same types of service available through the online programs. Your coach will help you set goals and develop a plan, call you to help motivate you, monitor and help you track your progress and success, and more. To speak with a Health Coach, call UnitedHealthcare at the number on the back of your medical ID card.

HealthNotesSM

UnitedHealthcare provides a service called HealthNotes to help educate members and make suggestions regarding your medical care. HealthNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealthNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process, patients are identified whose care may benefit from suggestions using the established standards of Evidence Based Medicine (EBM) as described under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealthNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Live Events on myuhc.com

Periodically, myuhc.com hosts live events with leading health care professionals. After viewing a presentation, you can chat online with the experts. Topics include:

- Weight control,
- Parenting,
- Heart disease,
- Relationships, and
- Depression.

For details, or to participate in a live event, log onto www.myuhc.com.

Optum NurseLine/Connect24

Optum NurseLine/Connect24 is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse anytime, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Hertz has available to help you improve your health and well-being or manage a chronic condition. Call anytime when you want to learn more about:

- A recent diagnosis,
- A minor Sickness or Injury,
- Men's, women's, and children's wellness,
- How to take prescription drugs safely,
- Self-care tips and treatment options,
- Healthy living habits, or
- Any other health-related topic.

Optum NurseLine/Connect24 gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages. There are also 590 messages available in Spanish.

Optum NurseLine/Connect24 is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling Optum NurseLine/Connect24.

Example: Your child is running a fever and it's 1:00 am. What do you do?

Call Optum NurseLine/Connect24 toll-free at the number on your ID card, any time, 24 hours a day, seven days a week. You can count on Optum NurseLine/Connect24 to help answer your health questions.

Live Nurse Chat

With NurseLine/Connect24, you also have access to nurses online. To use this service, log onto www.myuhc.com and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions anytime, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto www.myuhc.com.

Want to learn more about a condition or treatment?

Log on to www.myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Healthy Pregnancy Program

If you, or your spouse or domestic partner, are pregnant and enrolled in the Medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card.

The Healthy Pregnancy Program helps expectant families from the time they consider starting or expanding their family through the first few months of the new baby's life. Experienced, specialized maternity nurses provide education, support and special care based on the family's unique needs.

This program features:

- Dedicated Maternity Nurses
 - Maternity Nurse support offered before, during and after pregnancy to provide assistance, guidance, answers and education.
- Pregnancy Consultations
 - Multiple phone consultations with Maternity Nurse that focus on wellness and screen for health risks providing a comprehensive end-to-end maternity experience. Ideally, the consultations begin with pre-conception planning and continue all the way through to after the birth to screen for postpartum depression and offer information on newborn care.
- Support for Special Health Care Needs
 - Specialized support services created specifically for high-risk pregnancies.
- Customized Maternity Education Materials
 - Upon enrollment, education materials are provided based on the member's unique needs. Topics include eating healthy, prenatal care, exercise, information on how a baby grows, premature labor and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call anytime, 24 hours a day, seven days a week, with any questions or concerns you might have.

Neonatal Resource Services

Under this program, you can have consultations with neonatal nurses, access to some of the top

Neonatal Intensive Care Unit (NICU) treatment in the nation, and continued consulting during your baby's NICU stay.

UnitedHealthcare's network Physicians can determine during your pregnancy if you are likely to need NICU treatment. That's why the Neonatal Program works with the Healthy Pregnancy Program and will encourage you to deliver your baby at a Neonatal Centers of Excellence network facility if needed. Delivering at a Neonatal Centers of Excellence network facility provides mothers and babies with an opportunity for better outcomes.

The program also provides access to a toll-free neonatal nurse line to help answer your questions about delivery and neonatal care. The program's nurse consultants have extensive NICU experience. After delivery, your Neonatal Program nurse consultant monitors your baby's progress and answers questions about your baby's care.

Participation is completely voluntary and without extra charge. To take advantage of the program, contact a neonatal nurse consultant toll-free at 888-936-7246 from 8 a.m. to 4:30 p.m. Central Time, Monday through Friday, excluding holidays. For general information about the program, call the toll-free Customer Care number on your medical ID card.

Virtual Visits Program

Under this program, you can see and talk to a doctor from your mobile device or computer with an appointment. This service is for non-emergency medical health issues that arise when your doctor or pediatrician is not available, or when it's not convenient for you to leave home or work. Most visits take about 10-15 minutes and the doctor may be able to write you a prescription.

To use this service, log onto www.myuhc.com and choose from provider sites where you can register for a virtual visit. You will be required to pay a copay.

This service may not be available in all states and is not appropriate for all conditions. Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities.

Note: If you have a medical emergency, call 911 instead of logging onto www.myuhc.com.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions. This program offers:

- Access to accurate, objective and relevant health care information,
- Coaching by a nurse as you make decisions in your treatment and care,
- Explanation of what to expect during treatment, and
- Information on high quality providers and programs.

Conditions for which this program is available include:

- Back pain,
- Knee and hip replacement,
- Prostate disease,
- Prostate cancer,
- Benign uterine conditions,
- Breast cancer, and
- Coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

Diabetes Prevention Program and Diabetes Control Program

UnitedHealthcare provides two programs that identify, assess, and support members over the age of 18 living with diabetes or pre-diabetes. The program is designed to support members in preventing pre-diabetics from progressing to diabetes and assist members living with diabetes in controlling their condition and protect from developing complications.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.

The Diabetes Control Program (DCP) is available to members living with diabetes and offers face-to-face consultations with trained local pharmacists who will review diabetes history and medication, provide diabetes management education materials and assist individuals living with diabetes with managing their condition. The goal of this program is to reduce the risk of serious health complications through medication management and ongoing monitoring for complications.

Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance or Deductibles that need to be met when services are received as part of the DPP or DCP programs. (Note: The DPP and DCP programs may not be available in all areas.) If you think you may be eligible to participate or would like additional information regarding the programs, please call the Diabetes Prevention and Control Alliance (DPCA) call center directly at 888-688-4019.

Cancer Management Program (aka Cancer Support Program)

UnitedHealthcare provides a program that identifies, assesses, and supports members who have cancer. The program is designed to support you. This means that you may be called by a registered nurse who is a specialist in cancer and receive free educational information through the mail. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to advise you and to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer education on cancer, and self-care strategies and support in choosing treatment options.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call the Customer Service number on the back of your ID card or call the program directly at 866-936-6002.

For additional information regarding benefits for cancer treatment, refer to [Cancer Resource Services \(CRS\)](#).

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure and coronary artery disease, diabetes, and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications,
- Access to educational and self-management resources on a consumer web site,
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care, and
- Toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

- Education about the specific disease and condition,
- Medication management and compliance,
- Reinforcement of on-line behavior modification program goals,
- Preparation and support for upcoming Physician visits,
- Review of psychosocial services and community resources,
- Caregiver status and in-home safety,
- Use of mail-order pharmacy and Network Providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth PremiumSM Program

UnitedHealthcare designates network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels: quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- Help you make informed decisions on where to receive care,
- Provide you with decision support resources, and
- Give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto www.myuhc.com or call the toll-free number on your ID card.

Exclusions and Limitations

The Medical Plans generally cover charges for Medically Necessary Covered Health Services recognized by the medical profession, which are provided and utilized in a legal manner. For example, educational or experimental procedures will not be covered, nor will prescription drugs illegally imported into the United States. There are other expenses not covered by the Medical Plans. These include but are not limited to charges for the following:

Alternative Treatments

- Acupressure,
- Aromatherapy,
- Hypnotism,
- Massage Therapy,
- Rolfing (holistic tissue massage), and

- Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine of the National Institutes of Health.

Comfort and Convenience

- Supplies, equipment and similar incidentals for personal comfort. Examples include:
- Television,
- Telephone,
- Air conditioners,
- Beauty/barber service,
- Guest service,
- Air purifiers and filters,
- Batteries and battery chargers,
- Dehumidifiers and humidifiers,
- Ergonomically correct chairs,
- Non-Hospital beds and comfort beds,
- Devices and computers to assist in communication and speech, and
- Home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails and stair glides).

Custodial/Maintenance Care Services

- Custodial Care, regardless of where it is furnished, which is designed primarily to assist in the activities of daily living, whether or not the individual is totally disabled. Such activities include, but are not limited to:
 - Assistance in walking or getting in and out of bed,
 - Bathing,
 - Dressing,
 - Feeding,
 - Preparation of special diets,
 - Routine administration of medical gases after a regimen of therapy has been set up,
 - Routine exercise programs including carrying out of maintenance exercise programs that do not need the skills of a therapist, and
 - Supervision over medication which can normally be self-administered.

- Charges for maintenance care. This is care that prevents the existing condition from worsening, rather than actively treating the condition or illness, when maximum medical improvement has been reached.
- Charges for personal comfort and convenience items and services, even if ordered by a doctor.

Dental Related Services

- Dental care (including dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia). This exclusion does not apply to:
 - Dental care required for the direct treatment of a covered medical condition. This is limited to transplant preparation, the direct treatment of acute traumatic Injury, cancer or cleft palate, and must be prior to the initiation of immunosuppressive drugs.
 - Treatment of accidental injuries to the natural teeth or jaw if the dental damage is severe enough that initial contact with a Physician or Dentist occurs within 72 hours of the accident and the service is covered under the section titled [What the Plans Cover](#).
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including, for example, extractions, restoration, replacement of teeth, medical or surgical treatments of dental conditions, and services to improve dental clinical outcomes.
- Dental implants, bone grafts, and other implant-related procedures (except in the case of accidental injuries that are covered under the section titled [What the Plans Cover](#)).
- Dental braces (orthodontics).
- Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a congenital anomaly.

(These charges may be considered expenses under one or more of the Dental Plan Options.)

Experimental and Investigational or Unproven Services

- Experimental and Investigational or Unproven Services, unless the plan has agreed to cover them as stated in the section entitled [Important Terms You Should Know](#).

This exclusion applies even if Experimental and Investigational or Unproven Services are the only available treatment options for your condition.

Foot Care

- Routine foot care, except when needed for severe systemic disease, or in conjunction with necessary surgery involving exposure of bones, tendons or ligaments, or partial or complete removal of nail roots. Routine foot care services that are not covered include:
 - Cutting or removal of corns, calluses, bunions, warts or hyperkeratoses,
 - Nail trimming or cutting, and
 - Debriding (removal of dead skin or underlying tissue).

- Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet,
 - Applying skin creams in order to maintain skin tone, and
 - Other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot.
- Treatment of flat feet,
- Treatment of subluxation (joint or bone dislocation) of the foot,
- Shoes (standard or custom), lifts and wedges, and
- Orthotic appliances and devices, except when the following are met:
 - Prescribed by a Physician for a medical purpose, and
 - Custom manufactured or custom fitted to an individual covered person.

Gender Dysphoria

- Cosmetic procedures, including:
 - Abdominoplasty,
 - Blepharoplasty.
 - Breast enlargement, including augmentation mammoplasty and breast implants.
 - Body contouring, such as lipoplasty.
 - Brow lift.
 - Calf implants.
 - Cheek, chin, and nose implants.
 - Injection of fillers or neurotoxins.
 - Face lift, forehead lift, or neck tightening.
 - Facial bone remodeling for facial feminizations.
 - Hair removal.
 - Hair transplantation.
 - Lip augmentation.
 - Lip reduction.
 - Liposuction.

- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Hearing-Related Services

- Charges made for replacement hearing aid(s) unless:
 - There is a change in the individual's hearing capabilities, and
 - The current hearing aid cannot be adjusted to correct the individual's hearing deficiency.
- Replacement of lost hearing aids,
- Replacement batteries, or
- Repair of hearing aids.

Hospitalization-Related Services

- Charges incurred in connection with cosmetic surgery, except:
 - To correct a congenital anomaly in a child born while the mother was covered under the plan,
 - For reconstructive breast surgery following a mastectomy, and
 - For reconstructive surgery following injuries sustained in an accident that occurred while covered under this plan.
- Hospital stays for diagnostic purposes, unless for a Medically Necessary Covered Health Service.

Mental Health/Substance-Related and Addictive Disorder Services (MH/SA)

In addition to exclusions listed in this [Exclusions and Limitations](#) sections, the exclusions listed below directly apply to services described under the sections titled [Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders](#) and [Substance-Related and Addictive Disorders](#)

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
- Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
- Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
- Transitional Living services

Miscellaneous Health Care-Related Services

- Any state-mandated benefits not otherwise listed under [What the Plans Covers](#) in this section.
- Autopsies and other coroner services and transportation services for a corpse,
- Charges for:
 - Missed appointments,
 - Room or facility reservations,
 - Completion of claim forms,
 - Record processing, or
 - Services, supplies or equipment that are advertised by the provider as free.
- Charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency,
- Charges for services resulting from or occurring:
 - During the commission of a crime by the participant, or
 - While engaged in an illegal act, illegal occupation or aggravated assault.

- Charges incurred prior to the effective date or after the termination date of coverage under the plan,
- Charges prohibited by federal anti-kickback or self-referral statutes,
- Charges that are in excess of the Eligible Expense limits, even when considered by professional medical standards as safe and effective,
- Chelation therapy, except to treat heavy metal poisoning,
- Diagnostic tests that are:
 - Delivered in other than a Physician's office or health care facility, or
 - Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests.
- Growth hormone therapy,
- Medical and surgical treatment of snoring, except when provided as part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded,
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
 - Required solely for purposes of career, education, sports, camp, employment, insurance, marriage or adoption, or as a result of incarceration,
 - Conducted for purposes of medical research,
 - Related to judicial or administrative proceedings or orders, or
 - Required to obtain or maintain a license of any type.
- Respite care,
- Rest cures,
- Reverse sterilization,
- Services for which there would be no charge in the absence of insurance.
- Services or supplies received as a result of war or an act of war, declared or undeclared, while part of any armed service force of any country.
- Services or supplies received for any illness or accidental bodily injury that is eligible for reimbursement under Workers' Compensation, Medicare, legal action or settlement from a third party, or any federal, state or local government plan or program of any country (except Medicaid).
- Sex transformation operation,
- Speech therapy to treat stuttering, stammering or other articulation disorders, or

- Expenses for services or supplies not listed will be evaluated in a manner consistent with standard claim paying procedures.

Nursing Services

- Services of a private duty nurse during hospitalization.

Nutrition and Health Education

- Megavitamin and nutrition-based therapy,
- Nutritional counseling for either individuals or a group,
- Food of any kind, unless it is the only source of nutrition, even if it is specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Foods that are not covered include:
 - Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk,
 - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes,
 - Oral vitamins and minerals,
 - Meals you can order from a menu, for an additional charge, during an inpatient stay, and
 - Other dietary and electrolyte supplements.
- Health club memberships and programs, and spa treatments, and
- Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

Cosmetic procedures are excluded from coverage. Examples include:

- Liposuction,
- Pharmacological regimens,
- Nutritional procedures or treatments,
- Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures),
- Breast implant(s), unless covered by the Women's Health and Cancer Rights Act (see [Physician and Other Health Care Provider Services](#) under [What the Plans Cover](#)).
- Replacement of an existing intact breast implant if the earlier breast implant was performed as a cosmetic procedure,

- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation,
- Weight loss programs, whether or not they are under medical supervision for medical reasons, even for morbid obesity,
- Wigs, regardless of the reason for hair loss, except for temporary loss of hair resulting from treatment of a malignancy,
- Treatments for hair loss,
- A procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy,
- Varicose vein treatment of the lower extremities, when it is considered cosmetic, and
- Treatment of benign gynecomastia (abnormal breast enlargement in males).

Physician and Other Health Care Provider Services

- Charges for services incurred in connection with cosmetic surgery (see Physical Appearance in this section), except:
 - To correct a congenital anomaly in a child born while the mother was covered under the plan,
 - For reconstructive breast surgery following a mastectomy, and
 - For reconstructive surgery following injuries sustained in an accident which occurred while covered under this plan.
- Charges made by an assistant surgeon in excess of 25% of the surgeon's allowable charge.
- Charges by a doctor for or in connection with a surgery which exceeds the following maximum: when two or more surgical procedures are performed during the same operative session, the maximum allowable amount will be the Eligible Expenses or pre-negotiated in-network amount for the most expensive procedure, and one-half of the Eligible Expenses otherwise payable for all other non-incidentally surgical procedures.
- When it is Medically Necessary for two surgeons to perform a procedure as co-surgeons, each surgeon will be reimbursed as a co-surgeon with a total allowable for both being 125% of the Eligible Expenses otherwise allowed if the surgery was performed by a single surgeon.
- Charges for services incurred for or related to routine physical examinations, screening examinations, well-baby care, pre-marital or school examinations, except as provided under [Preventive Care](#).
- Services provided by a relative, including your spouse, parent, parent-in-law, child, sister, brother, sister-in-law or brother-in-law.

Pregnancy and Infertility

- Surrogate parenting, gestational carrier, and host uterus,

- Male member without a female partner (except as specifically provided in the section titled [Infertility Services and Reproductive Resource Services](#)),
- Reversal of voluntary sterilization,
- Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes,
- Fetal surgery, unless as described under Congenital Heart Disease in this section,
- Services provided by a doula (labor aide),
- Parenting, pre-natal or birthing classes,
- The following infertility treatment-related services:
 - Cryopreservation (if more than 12 months),
 - Any storage for any length of time for reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue,
 - Donor services and non-medical costs of oocyte or sperm donation (e.g., donor agency fees),
 - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes,
 - Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma,
 - All costs associated with surrogate motherhood; non-medical costs associated with a gestational carrier,
 - Ovulation predictor kits,
 - Infertility treatment following a voluntary sterilization procedure,
 - Female member without a male partner. The Plan will cover the transfer of any resulting embryos to an individual from whom the oocytes were NOT derived, and
 - Infertility treatment for a child dependent.

Prescription Drugs, Medicines and Related Items

The following are excluded except as otherwise covered under the [Preventive Care](#) section under [What the Plans Cover](#).

- All non-prescription (over-the-counter) smoking deterrents, including, but not limited to, patches, nicotine gum, and lozenges,
- Cosmetic and dietary supplements
- Cosmetic drugs,

- Experimental or investigational drugs or substances not approved by the Food and Drug Administration,
- Health and beauty aids,
- Obesity drugs,
- Orthotic appliances and devices, except when the following are met:
 - Prescribed by a Physician for a medical purpose; and
 - Custom manufactured or custom fitted to an individual Covered Person.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics, cranial bands, or any braces that can be obtained without a Physician's order.

- Over-the-counter items, or prescription items for which there is an over-the-counter equivalent or alternative,
- Syringes and needles other than for use with insulin,
- Vitamins, including prescription vitamins, except for pre-natal vitamins,
- Prescription drugs brought in (or shipped) from another country unless the FDA announces the drug can be legally imported by an individual,
- Prescription drugs that have no clinical or cost-effective advantage over currently available prescription drug products.

Therapy Services

- Developmental speech therapy.

Transplants

- Organ or tissue transplants except as identified as eligible under [Transplantation Services](#), unless the Claims Administrator determines the transplant to be appropriate according to their transplant guidelines,
- Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available), and
- Donor costs for organ or tissue transplantation to another person not covered under the plan (these costs may be payable through the recipient's benefit plan).

Travel

- Health services provided in a foreign country, unless in an Emergency, and
- Travel or transportation expenses, even if ordered by a Physician, except as specifically identified under Travel and Lodging for [Cancer Resource Services](#), [Congenital Heart Disease Services](#), [Kidney Resource Services](#) and [Transplantation Services](#).

Vision-Related Services

- Charges for vision care services and supplies in connection with special procedures such as orthoptics, vision training and tonography,
- Charges in connection with medical or surgical treatment of the eye, such as radial keratotomy, laser keratoplasty or Lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring),
- Vision exams and vision aids including but not limited to, lenses, frames and contact lenses. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.

Wellness Services

Except as otherwise provided in the section titled [Resources to Help you Stay Healthy](#):

- Programs to assist you to stop smoking,
- Vitamin and dietary counseling,
- Weight loss and exercise programs and related prescriptions of any kind.

A Credit to Your Health Program

If you and your spouse or domestic partner are enrolled in a Medical Plan administered by UnitedHealthcare, you are both automatically enrolled in the A Credit to Your Health program. There are two aspects of the program.

- By taking a Health Survey, Annual Physical or Biometric Screening in your first month of plan coverage, you can receive an initial reduction in your medical premiums (“Initial Credits”).
- You can start earning credits under all aspects of the program that can reduce your medical premiums even more in future years (“Full Credits”).

Participation in *A Credit to Your Health Program* is voluntary. You are not required to participate and you will not be penalized if you do not participate. Whether or not you choose to participate will have no effect on your eligibility for the Medical Plan or any other health plan sponsored by Hertz. Hertz will not take any adverse employment action or retaliate against, interfere with, coerce or intimidate any employee who chooses not to participate in *A Credit to Your Health Program*.

A Credit to Your Health Program is confidential and will be administered to protect your privacy. You may be provided with personalized confidential recommendations based on the results of your tests or screenings. Your employer will not see your individual results. On a collective level, Hertz may view aggregate data in order to help build an organizational culture of health and wellness.

January/February Initial Coverage Effective Date

You have one month from your coverage effective date to complete the Health Survey, Preventive Exam and Biometric Screenings to earn your Initial Credits. However, those initial Health Actions will not apply to the Full Program Credit Earning Period. That is, you will need to again complete the Health Survey, Annual Physical and Biometric Screenings along with other Health Actions between March 1 and February 28 to earn Full Credits (up to \$600) for the following Plan Year.

March through December Initial Coverage Effective Date

You have one month from your coverage effective date to complete the Health Survey, Annual Physical and Biometric Screenings to earn your Initial Credits. Additionally, those initial Health Actions will also apply to the Full Program Credit Earning Period. That is, you do not need to again complete the Health Survey and Annual Physical or Biometric Screenings between your coverage effective date and February 28 to earn credits for these actions for the following Plan Year.

This chart shows the "Initial Credits" you can earn during your first month of coverage to be applied toward your medical premiums beginning the fourth month of your medical coverage, and ending when your "Full Credits" begin. The chart also shows the Full Credits you can earn during the Full Program Credit Earning Period (March 1 through February 28) which will be applied beginning the next July 1.			
Health Actions	What You Can Do	Initial Credits*	Full Credits*
Complete Your Health Survey	Take the Health Survey at www.myuhc.com and you will see how your lifestyle and habits are helping you stay healthy, and where you can make changes to live healthier. The Health Survey is a confidential survey that helps you measure personal health risks by asking about things such as your health, diet, fitness and general lifestyle.	\$50	\$50
Get Your Annual Physical	Make an annual physical exam appointment with your doctor. <i>In-network preventive health exams are covered by each of the Hertz medical plans at 100%.</i>	\$100	100
Get Your Biometric Screenings	Through a Biometric Screening, you will get a snapshot of your health, measuring things such as your cholesterol, blood pressure, Body Mass Index (BMI), etc.	\$100	\$100
Achieve Target Test Values OR Complete a Related Telephonic Wellness Coaching Program	Achieve a BMI target value of less than 30 or complete a related telephonic wellness coaching program.	N/A	\$125
	Achieve an LDL cholesterol target value of less than 130 or complete a related telephonic wellness coaching program.	N/A	\$75
	Achieve a Fasting Blood Sugar target value of less than 100 or an A1c target value of less than 5.7% or complete a related telephonic wellness coaching program.	N/A	\$75
	Achieve a Blood Pressure target value of less than 140/90 or complete a related telephonic wellness coaching program.	N/A	\$75
Total Annual Available Credits	<i>*Earned annual credits are prorated to per pay period amounts</i>	\$250	\$600

Biometric Screenings

Biometric screenings are available through Quest Diagnostics Patient Service Centers, your doctor, and onsite. Visit www.MyQuestForHealth.com for more information. If you use Quest Diagnostics Patient Service Centers, your screening results will be submitted on your behalf in order for you to earn credits. If you visit your doctor, download the required health provider screening form from www.MyQuestForHealth.com and then turn in the completed form by fax or online. Onsite screenings will be announced by the Company.

Tracking Results

Track your progress with the help of your Rally Rewards. You and your spouse or domestic partner (if covered) may get your own Personal Rally Rewards card mailed to you periodically throughout the year, but you also can track your progress online. The online rewards will be updated regularly. You can view it soon after your coverage is effective at www.werally.com/rewards/. To access your Rally Rewards, you will need to register and establish a username and password, separate from your www.myuhc.com username and password. We encourage you to check your online rewards regularly to confirm that your credits have been recorded.

Wellness Coaching Over the Phone

If you do not meet the target biometric test values required to earn credits, you can still earn credits by completing telephonic wellness coaching. Your coach will help you set goals and develop a plan, call you to help motivate you, monitor and track your progress and success, and more. Enroll early by calling 800-478-1057 so that you can complete the wellness program before the program deadline. Please note that Coaching Programs usually start about two to three weeks following your initial enrollment call. Most wellness programs last on average six to seven weeks, but can take longer, and include three to five phone calls. Completing one telephonic wellness coaching program can earn you multiple credits. For example, the Diabetes coaching program will earn you credits for both BMI and Fasting Blood Sugar.

If you do not meet the target for:	You can participate in a coaching program for:
BMI	• Weight • Exercise • Nutrition • Diabetes • Heart Health
LDL Cholesterol	• Nutrition • Heart Health
Fasting Blood Sugar	• Weight • Exercise • Nutrition • Diabetes
Blood Pressure	• Weight • Stress • Exercise • Heart Health

How Are My Credits Entered Into My Personal Rewards Scorecard?

For some Health Actions, your rewards are automatically updated by our wellness partner, UnitedHealthcare. This includes completing the Health Survey, your Annual Physical or Biometric Screening, and participation in telephonic wellness coaching programs. To receive credits for completing a Health Action (i.e., achieving target test values, or for an exemption), you and/or your provider must complete the appropriate form: Provider Notification Form or Member Notification Form. Both forms include instructions for when they should be used, and are available at the Information Center after logging onto www.myuhc.com or on BenefitsPlus – or from your local Human Resources Representative. Print the appropriate form, complete the member information, and if necessary ask your provider to complete the provider information. Then, follow the instructions to send it to UnitedHealthcare.

Important note for new enrollees: In order to ensure you receive your Initial Credits for your preventive exam or biometric screening, you must have the Provider Notification Form completed and faxed to UnitedHealthcare no later than 15 days following the end of your first month of coverage.

Prescription Drug Benefits (Administered by OptumRx)

Retail Prescription Drug Program

Participants in our Medical Plans receive discounts on covered prescription drugs purchased at participating retail pharmacies. For information about how to locate a participating pharmacy, or for questions regarding the retail prescription drug discount program, contact the Prescription Drug Plan Administrator or go to www.optumrx.com.

The Retail Prescription Drug Program covers Medically Necessary drugs and supplies for which a written prescription is required. You may fill your prescriptions at either a participating or non-participating licensed retail pharmacy. Participating pharmacies will dispense prescriptions at a discounted cost.

Filling a Prescription at a Participating Retail Drug Pharmacy:

When filling a prescription at a participating retail pharmacy, show your Prescription Drug Plan ID card. This will be mailed to you shortly after you enroll. You are not required to submit a claim under the Medical Plan for your prescription. The cost of your prescription is not subject to your Medical Plan Deductible. For each eligible prescription, you can receive up to a 30-day supply and pay only a Copayment based on the classification of your prescription. For Copayment amounts, refer to the table under [Comparing the Costs of Your Options](#).

Filling a Prescription at a Non-Participating Retail Drug Pharmacy:

When filling a prescription at a non-participating retail drug pharmacy, you will pay for the entire cost of the prescription and file a claim for reimbursement through the Prescription Drug Plan Administrator at the address on your card (not the Medical Plan administrator). You will be responsible for the amount that you would have paid as a Copayment at a participating retail pharmacy. You will be reimbursed the rest of the cost of the prescription by the Prescription Drug Plan. The cost of your prescription is not subject to your Medical Plan Deductible or the out-of-pocket provision.

Incentive Mail-Order/Preferred Retail Pharmacy Provision

After two fills of the same long-term maintenance prescription using a retail pharmacy (other than Mail Order or a Preferred Retail Pharmacy; see [Preferred Retail Pharmacy Network](#)), your Copayment for a 30 day supply will be double the usual amount. Please note: this means that the minimum and maximum Copayment for subsequent refills will also be double the amount for the first two fills. By using the Mail-Order/Preferred Retail Pharmacy Prescription Drug Program, you may obtain a 90-day supply for the same or a lower Copayment.

Mail-Order/Preferred Retail Pharmacy Prescription Drug Program

Participants in our Medical Plans are eligible to participate in the Mail-Order/Preferred Retail Pharmacy Prescription Drug Program. If you use long-term maintenance medications, the Mail-Order/Preferred Retail Pharmacy Prescription Drug Program can save you both time and money. For each eligible prescription, you can receive up to a 90-day supply and pay only a Copayment based on the classification of your prescription. For Copayment amounts, refer to the table under [Comparing the Costs of Your Options](#).

Visit the BenefitsPlus website or www.optumrx.com for forms to begin participating in Mail-Order. To see what retail pharmacies are considered Preferred see [Preferred Retail Pharmacy Network](#) below, or go to www.optumrx.com.

Prescriptions ordered through Mail-Order will be conveniently mailed to your home through the U.S. Postal Service. Mail the form, your prescription and the required Copayment to the Prescription Drug Plan Administrator following the instructions on the form. Orders are usually processed within 48 hours of receipt. You should allow approximately one week from the processing date for delivery. Refills can be conveniently ordered by phone or using the Prescription Drug Plan Administrator's website.

Why Use the Mail-Order (Home Delivery) Service?

The Mail-Order (Home Delivery) Program offers you the following benefits:

- **Savings:** The Copayment for one 90-day supply of your prescription drug through mail order is less expensive for you than the Copayment for three 30-day supplies of

your medication under the Retail Prescription Drug Program. For Copayment amounts, refer to the table under [Comparing the Costs of Your Options](#).

- **Convenience:** Prescriptions are delivered directly to your home, and standard delivery is free; order refills easily by mail, phone or online; you get up to a 90-day supply, meaning fewer refills and fewer trips to the pharmacy.
- **Safety:** Pharmacists check every prescription for accuracy and potential drug interactions.
- **Service:** Talk confidentially to a pharmacist Monday – Friday 7:00am – 9:00pm EST and Saturday – Sunday 8:00am – 6:30pm EST.

It's easy to get started with Home Delivery. If you have already purchased a maintenance medication through the Retail Prescription Drug Program, you can simply transfer that prescription to Home Delivery. Just visit www.optumrx.com, click the "Mail Service Link" and follow the online instructions, or call 855-871-6277 to talk to a customer service representative who can help you get started in Home Delivery.

For new maintenance medication prescriptions you will have to mail a Home Delivery order form with the original prescription from your Physician.

Please see the [Incentive Mail-Order Provision](#) and [Preferred Retail Pharmacy Network](#) for important additional information.

Preferred Retail Pharmacy Network

The Preferred Retail Pharmacy Network provides more aggressive preferred pricing at some of the country's best known pharmacy chains including **Walgreens**¹, **Walmart**², and **Kroger**³. Using these preferred pharmacies can lower your out-of-pocket costs.

Additionally, at the Preferred Retail Network Pharmacies, you may purchase either a 30-day or 90-day supply of maintenance medications. If you purchase a 90-day supply, the [Incentive Mail-Order Provision](#) will not apply. The usual mail-order copay will apply to your 90-day supply of maintenance medications, when purchased at a Preferred Retail Network Pharmacy.

¹Walgreens Pharmacies include Walgreens, Duane Reade Pharmacy and Happy Harry's Pharmacy and all USA Drug/Super Di Pharmacy and Kerr Pharmacy locations

²Wal-Mart Pharmacies include Wal-Mart, Sam's Club and Neighborhood Market

³Kroger Pharmacies include Baker's, City Market, Copps, Dillons, Fred Meyer, Fry's, Gerbes, Jay C, King Soopers, Kroger, KwikShop, Marianos, Metro Market, Owen's, Payless, Pick 'n save, QFC, Ralphs, Roundy's, Smith's, and Tom Thumb.

Formulary

The Prescription Drug Program includes a voluntary "formulary" feature. A formulary is a list of commonly prescribed medications that have been selected based on their effectiveness and cost savings. By asking your doctor to prescribe formulary medications, you will reduce your out-of-pocket cost, and can help control rising costs while maintaining high-quality care. The Prescription Drug Plan Administrator has a procedure for regularly reviewing the drug formulary. Based on their review, the formulary is subject to change. The formulary is available on the Prescription Drug Plan Administrator's web site. Due to Program exclusions and coverage limitations, not all drugs listed on the Prescription Drug Plan Administrator's formulary are covered by the Program.

Mandatory Generic Drug Provision

The Prescription Drug Program has a mandatory Generic Drug provision to encourage participants to request Generic Drugs whenever available and appropriate. By requesting a Generic Drug, you pay a lower Copayment and help to control the rising cost of prescription drugs.

The Mandatory Generic Drug Provision requires the Mail Order or Network Retail Pharmacy to fill a prescription with the generic equivalent drug unless the prescription states “dispense as written” (DAW) or “do not substitute.” In some cases, as part of your Prescription Drug Program, the pharmacist may discuss with your Physician whether an alternative drug might be appropriate for you. However, be assured that your Physician always makes the final decision on your medication. If your prescribing Physician has specified DAW, the prescription will be filled with the brand drug. If DAW is not specified, the pharmacy will automatically dispense a generic equivalent.

If your Physician has not specified DAW, and you choose a brand drug when a generic equivalent is available, you will pay the generic Copayment plus the difference in cost between the brand drug and the generic equivalent.

Generic vs. Brand-Name Drugs
<p>The brand name is the product name under which a drug is advertised and sold. Generic equivalent medications contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength and purity as their brand-name counterparts. Generally, Generic Drugs cost less than Brand-name Drugs.</p> <p>If you want to save money, you can ask your doctor to prescribe Generic Drugs whenever appropriate.</p>

Step Therapy

The plan, in some cases, requires the use of less expensive front-line prescription drugs before it will pay for more expensive back-up prescription drugs. Front-line prescription drugs are safe and effective medications used for the treatment of a medical condition or disease. For information on drugs in the Step Therapy program, contact customer service at the number on your Prescription Drug Card.

Unless you meet certain medical criteria or have a prior history of use of the front-line prescription drugs, your pharmacist will receive a message that the prescription will not be covered. The message will specify what kind of alternative drugs should be used. You or your pharmacist will then need to contact your Physician to have your prescription changed, or you will have to pay the full cost of the prescription. For instance, with high cholesterol Step Therapy, pravastatin or simvastatin are examples of front-line prescriptions that could be tried prior to back-up agents such as Pravachol or Zocor. In certain situations a member may be granted a *prior authorization* for a backup prescription drug if specific medical criteria have been met without the trial of a front-line prescription drug. Your doctor can request a prior authorization by calling OptumRx at 855-871-6277.

Prescription Refill Limits

To protect your safety, the Prescription Drug Plan has limits on how soon you may refill your prescriptions. The Retail Prescription Drug Program has a 75% refill limit for 30-day prescriptions and the Mail-Order/Preferred Retail Pharmacy Prescription Drug Program has an 80% refill limit for 90-day prescriptions. This means you can refill a 30-day prescription 7½ days before you reach the end of your supply, and you can refill a 90-day prescription 18 days before you reach the end of your supply.

Prior Authorization

This program monitors certain prescription drugs and their **costs so that you can get the right drug at the right cost**. That is, you receive an effective drug which is *also* covered by your benefits. It works much like a health plan that requires approval of some medical procedures beforehand, to make sure you're getting tests you need; some prescriptions need to be pre-approved to be covered.

Prior Authorization encourages the use of prescription drugs that are just as safe and effective as popular Brand-name Drugs, but that cost less. They could be generic versions of Brand-name Drugs, or they could be Brand-name Drugs that are similar to a more expensive one. This helps you save money on the treatment you need, and also helps our organization provide a quality prescription drug benefit.

What Prescription Drugs Are in the Program?

The prescription drugs in the Prior Authorization program are:

- Drugs that the plan wants to make sure you need for a medical condition, and
- Drugs that could be used for non-medical purposes – for instance, a drug that treats a skin condition but that could also be used for cosmetic purposes.

For information on drugs requiring prior authorization, contact customer service at the number on your Prescription Drug Card.

How to Use the Program

- If a drug you use requires a Prior Authorization, your doctor can contact OptumRx. An OptumRx representative will see if the plan can cover the drug.
- Your pharmacist might also tell you that a drug needs a prior authorization. If this occurs, the pharmacist can call your doctor and ask him or her to contact OptumRx to see if the plan can cover the drug.

When a prescription drug is approved for coverage, you'll pay the applicable Copayment. If a drug you're taking cannot be covered and you still want to take it, you'll need to pay the full cost.

Prior Authorization helps you get a prescription drug that works well for you and that is covered by your plan. If you have questions, please contact OptumRx at 855-871-6277.

Specialty Medication Drug Program

Participants are required to use Walgreens Specialty for all specialty medications. Specialty medications treat chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. OptumRx has partnered with Walgreens Specialty to provide specialty medications to patients and their doctors. Walgreens Specialty is staffed by knowledgeable employees who specialize in working with patients taking these complex medications to create optimal outcomes.

Specialty medications are defined as injectable and non-injectable drugs having one or more key characteristics, including:

- Used to treat rare or complex conditions.
- Requirement for frequent dosing adjustments and intensive clinical monitoring.
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals.
- Limited or exclusive product availability and distribution.

How to Utilize the Program

- If you need a specialty medication, call Walgreens Specialty at 866-823-2712 for prescription submission instructions. If necessary, Walgreens Specialty will contact your doctor for a new prescription.
- Your order can be shipped to your home, work location, or Physician's office. Patients are normally contacted within 48 hours from the receipt of the referral. Orders are not

shipped until Walgreens has spoken with the patient and delivery has been coordinated. Refrigerated medications are shipped for next day service and non-refrigerated medications are delivered within one to nine business days. Your medication will arrive at the correct temperature needed for storage.

- All appropriate supplies are provided to patients at no charge for self-administered and home infused medications.
- Nurses and Pharmacists are available during regular business hours Monday – Friday 8:00am – 8:00pm EST and Saturday 9:00am – 5:00pm EST. Pharmacists are available 24/7 for urgent patient counseling.
- Walgreens Specialty pharmacy will contact you for refill reminders and to initiate delivery arrangements each month.

If You Need a Specialty Drug Right Away

The plan will allow you to fill a specialty medication at your local pharmacy one time only. If you choose not to use Walgreens Specialty for future fills of the specialty medication, you will be responsible for the full cost of the medication.

Claiming Benefits

Medical Plans Administered by UnitedHealthcare

A claim must be filed in order to receive payment under the Medical Plans. In-Network Providers will always file claims for you. In many cases, Out-of-Network Providers will also file claims for you. However, if you must file the claim, follow this procedure to file a claim for eligible medical services:

- After you or your covered dependents receive services, complete a Medical Benefits Claim Form in its entirety including an itemized list of services. Claim forms are available from:
 - The BenefitsPlus website; or
 - The Claims Administrator (refer to your ID Card for the phone number and/or web site address)
- Mail the claim form and itemized bills to the Claims Administrator at the address on the form.
- If the claim is eligible for payment, the payment will be sent to you or your provider, depending on whether or not you assigned benefits on the claim form.
- Each month in which the Claims Administrator processes at least one claim for you or a covered dependent, you will receive a Health Statement in the mail, summarizing how the claims were processed.
- You have the right to an appeal if you disagree with the payment decisions. See the [**Claims and Appeals – Health Care Plans and Health Care FSA**](#) section under [**Administrative and Legal Information**](#) for information about the appeal procedures and time frames in which your appeal will be reviewed.

- You should submit your claim to the Claims Administrator as soon as possible. You must submit your claim within 12 months of when the expense was incurred (services were received).

Coverage After You Retire

You may be eligible for post-retirement (pre-65) medical coverage or the Medicare Supplement Plan if you were hired before January 1, 1990* and have had continuous service since that date (this includes your coverage under the prior plan). If you are Medicare eligible when you retire, you must enroll in Medicare in order to participate in the Medicare Supplement Plan. The Company has the right to designate which Company-sponsored plan you or your dependents can participate in once any of you become eligible for Medicare either due to age or disability. Contact the Corporate Employee Benefits Department for details.

*Employees of affiliates acquired after January 1, 1990 are not eligible for post-retirement medical coverage or the Medicare Supplement Plan.

Termination of Coverage

Please refer to the [General Information About Health Care Plans](#) section for information on termination of coverage, continuing coverage through COBRA and conversion privileges.

Important Reminder
Remember that you can reduce your out-of-pocket costs by using a Health Care Flexible Spending Account to pay for unreimbursed Eligible Expenses with before-tax dollars. See the Flexible Spending Accounts section for more information.

Dental Plans

Good dental care is an important part of maintaining your overall health. That is why Hertz offers Dental Plan Options designed to provide coverage for a broad range of dental services, from basic care to comprehensive coverage.

Dental Plan Options

You can select from the following three Dental Plan Options, or you can choose not to participate in a Dental Plan.

- **Option A, CIGNA Dental Care (CDC)**, is a dental HMO type plan. You choose a Dentist from a list of participating Network General Dentists, and that Dentist is your starting point whenever you need dental care or a referral to a specialist.

With the CDC option, there are no Deductibles or dollar maximums for covered services. Your out-of-pocket expenses are limited to the fees in the Patient Charge Schedule (*a copy of the Schedule is included in your enrollment kit*). Services covered generally include preventive, restorative and orthodontic care.

The CDC option is available in most, but not all, Hertz locations. To find out if this option is available in your area, see [Finding a CDC Network General Dentist](#) later in this section.

- **Option B** is a dental PPO Plan that gives you the flexibility to use any licensed Dentist you choose. This option covers 100% of Reasonable and Customary Charges for eligible diagnostic and preventive care. It also pays a percentage of the Reasonable and

Customary Charges for other covered services, including restorative procedures and orthodontic care for your children, after the Deductible has been met. You are responsible for the cost of any other dental services you might need.

- **Option C** is also a dental PPO Plan that allows you to receive care from any licensed Dentist you choose. This option covers 100% of Reasonable and Customary Charges for eligible diagnostic and preventive care only – you are responsible for the cost of any other dental services you might need.

You will keep the option you choose until the next enrollment period, unless you experience a qualifying event that enables you to make a change in accordance with the criteria in the [Changing Your Coverage](#).

Comparing the Costs of Your Options

In addition to considering any payroll contributions associated with the various dental options available to you, you should evaluate your other potential out-of-pocket expenses, for example:

- **Patient charges** – If you enroll in CDC, you will be responsible for paying the amounts shown on the Patient Charge Schedule included in your enrollment kit.
- **Deductibles** – If you enroll in Option B (see the Dental Plan Highlights chart under [What the Plans Cover](#) in this section), the plan will pay benefits after you have fulfilled an annual Deductible. No Deductible applies for preventive and diagnostic services. A Deductible is an amount you are responsible for each Plan Year before the plan starts paying benefits.
- **Coinsurance** – Option B pays a percentage of the costs for basic and major restorative services, as well as eligible orthodontic care. Under that option, you pay only the remaining portion of the cost not covered by the plan.
- **Services that are not covered** – All three dental options help you pay for services you need to maintain sound dental health. Some services are not covered by the Dental Plan (see [Exclusions and Limitations](#) in this section). You pay the full cost for those services.

Under Options B and C, you will also have out-of-pocket costs if you use an out-of-network Dentist and he/she charges amounts that exceed Reasonable and Customary Charges or the annual maximum benefit.

Remember that you can reduce your out-of-pocket costs by using a Health Care Flexible Spending Account to pay for Eligible Expenses with before-tax dollars. See the [Flexible Spending Accounts](#) section for more information.

An Ounce of Prevention

The Dental Plan Options provide important benefits for preventive services. That is because preventive services, such as regular check-ups and cleanings, encourage good dental health. By brushing and flossing daily, and following your Dentist's instructions, you play an active role in maintaining healthy gums and teeth. In the long run, that means less major – and costly – dental problems.

Make the Most of Your Benefits Dollar

Your benefits are an important part of your total compensation at Hertz. You may select the dental coverage option that meets your needs, as basic or as comprehensive as you like, or even no

coverage at all. No matter which option you choose, here are some ways to help you make the most of your dental benefits:

1. Comparison Shop

Call or meet with Dentists in your area before beginning treatment. In addition to researching their education, training and office hours, ask about the Dentist's charges for common services. If you select a participating network Dentist, the charges will be pre-negotiated, and your benefits under the plan will be greater.

2. Take a Different Route

Some dental problems can be solved in different ways. Ask your Dentist about alternate procedures that may cost you less.

3. Keep Your Dentist in the Know

If you changed dental coverage recently, be sure to tell your Dentist about your new plan. Your Dentist needs to know the benefits for which you are eligible.

4. Time is of the Essence

If you enrolled in Options B or C and use a network Dentist, claims will be filed for you. However, if you use an out-of-network Dentist, timely claims processing is in your hands. Complete your section of the claim form accurately and thoroughly before you visit the Dentist, and remember to bring the claim form with you!

5. Plan Ahead

Some features under Options B and C, such as annual benefit limits and Deductibles, renew at the beginning of each Plan Year (July 1). So plan ahead and schedule your dental work to get the most out of each Plan Year.

What the Plans Cover

Highlights and general information about your Dental Plan Options are provided below.

Highlights of the Hertz Dental Options					
Feature or Benefit		CDC Option A	Hertz Dental Option B		Hertz Dental Option C
		In-Network* Only	In-Network**	Out-of-Network***	In- or Out-of-Network
Annual Deductible	<i>Individual</i>	None	\$75 (does not include amounts applied to out-of-network Deductible)	\$150 (does not include amounts applied to in-network Deductible)	None
	<i>Family</i>	None	3 individuals max	3 individuals max	None
Diagnostic and Preventive Services		Plan pays 100%*	100% - No Deductible; Maximum 2 exams and cleanings and one set of bite-wing x-rays per Plan Year	100% - No Deductible; Maximum 2 exams and cleanings and one set of bite-wing x-rays per Plan Year	100% - No Deductible; Maximum 2 exams and cleanings and one set of bite-wing x-rays per Plan Year
Basic Restorative Services		Plan pays any amount over fixed fee in Patient Charge Schedule*	80% after Deductible	70% after Deductible	No coverage
Major Restorative Services		Plan pays any amount over fixed fee in Patient Charge Schedule*	50% after Deductible	40% after Deductible	No coverage
Orthodontia		Plan pays any amount over fixed fee in Patient Charge Schedule	50% after Deductible	40% after Deductible	No coverage
Maximum Benefit per Plan Year (for services other than Orthodontia)		No dollar maximum	\$1,500 per person		\$1,500 per person
Maximum Lifetime Benefit for Orthodontia		24 months of service	\$1,500 per covered dependent child		No coverage
Member Services		(800) CIGNA-24	(800) CIGNA-24		(800) CIGNA-24
Web site		www.mycigna.com	www.mycigna.com		www.mycigna.com

* You must have care coordinated by your Network General Dentist to receive the benefits shown. Also, see your Patient Charge Schedule for limits on the frequency of covered services, such as cleanings.

** In-Network benefits are based on negotiated fees for the services.

*** Out-of-Network benefits are based on reasonable and customary (R&C) charges for the services, as determined by CIGNA.

Reasonable and Customary (R&C) Charges

Under Option B or Option C, the Hertz Dental Plan pays a percentage of the amount determined to be “reasonable and customary” (R&C) charges for covered out-of-network services based on the use of nationally recognized statistical databases. Most Dentists practicing in the same geographic area with comparable training and experience charge similar fees to patients. Your Dentist’s fees may be different from R&C charges. You are responsible for paying the amount in excess of R&C charges. Costs beyond R&C charges will not count toward your Deductible. Occasionally, you may experience special circumstances or complications requiring more time or a different course of treatment, which may be more costly than normal R&C charges. You may provide supporting documentation, such as treatment notes, to the Claims Administrator for their consideration when determining the amount of benefits the Hertz Dental Plan will pay.

Alternative Benefit Provision

Certain dental conditions can be properly treated in more than one way. Benefits under Hertz Dental Plan Options B and C are based on the most cost-effective covered service appropriate to produce a professionally satisfactory result, as determined by the Claims Administrator. Suitable treatment is based upon generally accepted professional standards of dental practice. If you and your Dentist decide you want to pursue a more expensive treatment, you will be responsible for paying the additional charges. For example, if you have a cavity and would like a gold filling rather than an amalgam filling, you will be responsible for the difference in the cost between the gold filling and the less expensive amalgam filling.

By requesting a pre-determination of benefits review of any proposed dental procedure (see [Know Before You Go: Estimate Your Dental Expenses](#) later in this section), you and your Dentist will know in advance what the plan will cover before any treatment begins. You can then make the right decision for your personal circumstances.

Option A – CIGNA Dental Care (CDC)

Your Patient Charge Schedule will show you:

- What services are covered under CDC,
- How often the services will be covered, and
- The fees associated with covered services.

The Patient Charge Schedule can be found in your CDC enrollment kit. Under this option, there are no Deductibles and no Plan Year dollar maximums.

The fees shown on the Patient Charge Schedule apply as long as you receive care through your Network General Dentist. Services performed by an out-of-network Dentist and services that are not listed on the Patient Charge Schedule are not covered. You will be responsible for paying the Dentist’s fees for such services.

When you need the care of a specialist, your Network General Dentist will refer you to a Network Specialist with the approval of CIGNA Dental. The fees in the Patient Charge Schedule apply to services received from a Network Specialist, as well as services from your Network General Dentist, provided CIGNA Dental approves the specialist care.

Finding a CDC Network General Dentist

When you enroll in the CDC option, you must select a Network General Dentist for yourself and each of your covered dependents. Your Network General Dentist provides or coordinates all of your care. You may choose a different Network General Dentist for yourself and for each of your dependents.

Call CIGNA Dental's automated Dental Office Locator at (800) CIGNA-24 to receive an up-to-date listing of participating Network General Dentists in your area or to inquire about a particular Dentist, free of charge. You can also find a list of CDC providers on CIGNA Dental's web site: www.mycigna.com. CDC participating dental offices are subject to capacity limitations and therefore, may not be accepting new patients. You will need to take this into consideration when making your dental office choices.

Changing Your Dentist

You may change your designated Network General Dentist by calling CIGNA Dental's Member Services at (800) CIGNA-24. The transfer request will take approximately five business days to process. The changes normally take effect on the first day of the following month.

In general, it is a good idea to complete any dental procedure in progress before changing your Dentist.

Exclusions and Limitations

Your benefits under CDC are subject to certain exclusions and limitations as outlined below.

Limitations on Covered Services

Listed below are limitations on services covered by CDC (Option A):

- **Frequency** – The frequency of certain covered services, such as cleanings, is limited. The Patient Charge Schedule lists any limitations on frequency.
- **Specialty Care** – Except for pediatric dentistry, endodontics and orthodontics, payment authorization is required for coverage of services by a network specialist.
- **Pediatric Dentistry** – Coverage for treatment by a pediatric Dentist ends on your child's seventh birthday; however, exceptions for medical reasons may be considered on an individual basis. The Network General Dentist will provide care after the child's seventh birthday.
- **Oral Surgery** – The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

Exclusions

Listed below are services or expenses that are not covered under CDC. You are responsible for the full cost of:

- Services not listed on the Patient Charge Schedule.
- Services provided by a non-network Dentist without CDC's prior approval (except in emergencies, as described below under [Emergencies](#) in this section).
- Services related to an Injury or illness covered under Workers' Compensation, occupational disease or similar laws. (Florida – this exclusion relates to such services paid under Workers' Compensation, occupational disease or similar laws.)

- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or public program, other than Medicaid.
- Services relating to injuries which are intentionally self-inflicted. (Texas and Ohio – services related to self-inflicted injuries are not excluded.)
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war.
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance).
- General anesthesia, sedation and nitrous oxide, unless specifically listed on your Patient Charge Schedule. When listed on your Patient Charge Schedule, general anesthesia and IV sedation are covered when Medically Necessary and provided in conjunction with covered services performed by an oral surgeon or periodontist. (Maryland residents: General anesthesia is covered when Medically Necessary and authorized by your Physician.)
- Prescription drugs.
- Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact) or (2) diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed on the Patient Charge Schedule.
- The completion of crown and bridge, dentures or root canal treatment already in progress on the date you become covered by CDC. (Texas – this exclusion does not apply.)
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect.
- Services associated with the placement or prosthodontic restoration of a dental implant.
- Services considered unnecessary or experimental in nature. (Pennsylvania – services considered experimental in nature. California and Maryland – services considered unnecessary.)
- Procedures or appliances for minor tooth guidance or to control harmful habits.
- Hospitalization, including any associated incremental charges for dental services performed in a Hospital.
- Services to the extent the participant is compensated for them under any group medical plan, no-fault auto insurance policy or insured motorist policy. (Arizona and Pennsylvania – this exclusion does not apply. Kentucky and North Carolina – services compensated under no-fault auto or insured motorist policies are not excluded. Maryland – services compensated under group medical plans are not excluded.)

Except as set forth in this section, pre-existing conditions are not excluded.

Emergencies

Emergency Care Away From Home

If you have an Emergency while you are out of your service area or are unable to contact your Network General Dentist, you may receive Emergency covered services as defined above from any general Dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered Emergency care. You should return to your Network General Dentist for these procedures. For Emergency covered services, you will be responsible for the patient charges listed on your Patient Charge Schedule. CIGNA Dental will reimburse you the difference, if any, between the Dentist's usual fee for Emergency covered services and your patient charge, up to a total of \$50 per incident. To receive reimbursement, send appropriate reports and x-rays to CIGNA Dental.

Emergency Care After Hours

There is a patient charge listed on your Patient Charge Schedule for Emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges.

Options B and C – PPO Dental Plans (Administered by CIGNA)

Dental Option B

Option B pays the following benefits up to a combined maximum benefit for diagnostic and preventive, basic, and major services of \$1,500 per covered participant each Plan Year. Option B also pays benefits for orthodontia up to a separate lifetime benefit maximum of \$1,000 per eligible participant.

100% of R&C charges or negotiated PPO discounted fees for eligible Diagnostic and Preventive Services (no Deductible), including:

- Office visits for oral examinations, cleaning or scaling of teeth (prophylaxis), routine comprehensive or recall examinations, and problem-focused examinations. The plan covers two routine preventive exams and cleanings (prophylaxis) per Plan Year.
- Up to two periodontal cleanings (in addition to the two routine cleanings covered in the first bullet), if the patient has a history of prior periodontal treatment.
- Bite-wing x-rays. The plan covers one set per Plan Year.
- Topical fluoride treatments, limited to once each Plan Year, for dependent children under age 19.
- Full-mouth x-ray series, panoramic x-rays, or vertical bite-wing x-rays, limited to once every 36 consecutive months.
- Sealants, for dependent children under age 14, limited to one treatment per permanent molar or bicuspid every three Plan Years.

In-Network: 80% of negotiated PPO fees for Basic Restorative Services; Out-of-Network: 70% of R&C charges for Basic Restorative Services (after you meet the Deductible), including:

- Basic restorative – amalgam, resin, silicate, plastic or composite fillings.

Note: Fillings other than amalgam may be subject to the alternative benefit provision (see the [Alternative Benefit Provision](#) information box in this section for more details) and benefits exclusions for cosmetic dentistry,

- Full Mouth Debridement, limited to once per lifetime.

- Endodontics – prevention and treatment of diseases of dental pulp, Periodontics – treatment of gum disease,
- Oral surgery – including surgical extractions and administering general anesthesia (not covered under the Medical Plan),
- Surgery or treatment for correction of damage caused by accidental Injury (except for those services received while confined in a Hospital as an inpatient at the time of an accident),
- Root canal therapy,
- Extractions, and
- Occlusal guards for Bruxism, limited to one set every three Plan Years.

In-Network: 50% of negotiated PPO fees for Major Restorative Services; Out-of-Network: 40% of R&C charges for Major Restorative Services (after you meet the Deductible), including:

- Major restorative – including inlays, onlays and crowns, and
- Prosthodontics – services to replace teeth (i.e., bridges and dentures).

In-Network: 50% of negotiated PPO fees for certain Orthodontic Services; Out-of-Network: 40% of R&C charges for certain Orthodontic Services (after you meet the Deductible), including:

- Braces and other orthodontic treatment, for your covered dependent children. Orthodontic services are eligible for benefits if the work was not already in progress on the date your eligible dependent child(ren) became covered under Dental Plan Option B.
- Space maintainers, including all adjustments within six months after installation, whether fixed (unilateral or bilateral) or removable (unilateral or bilateral).

Paying for Orthodontia

In general, orthodontic treatment occurs in stages. Before your dependent child(ren) begins treatment, the orthodontist will outline how long the treatment will last and how much it will cost. Once you agree to a cost, the orthodontist will expect an up-front payment based on the estimated treatment duration.

The plan will make an initial installment based on 25% of the overall treatment fee, once the initial banding is complete. The balance will be prorated and paid in monthly installments over the course of the proposed treatment plan. The plan will make payments until the maximum benefit of \$1,000 or 50% of the fee charged, whichever is less, has been paid.

Your orthodontist will usually work out a schedule of payments for your portion of the cost.

Know Before You Go: Estimate Your Dental Expenses

If you are enrolled in the Hertz Dental Plan Option B and are facing major dental work, it is a good idea to obtain an estimate of your dental expenses before you begin treatment. To receive a pre-treatment estimate, ask your Dentist to complete the pre-treatment section of the claim form. Submit this estimate to the Claims Administrator and you will receive an Explanation of Benefits describing which services and amounts are covered by the Hertz Dental Plan. Your Dentist should review this information with you before treatment begins.

Pre-treatment estimates are not required, however, it is recommended that you receive a pre-treatment estimate if you expect charges for dental services of \$350 or more.

A pre-treatment estimate does not guarantee payment; rather, it helps you make important decisions and plan ahead for your dental expenses.

Dental Option C

Option C provides payment for diagnostic and preventive services only. Option C pays the following benefits up to a maximum benefit of \$1,500 per covered participant each Plan Year.

100% of R&C charges or negotiated PPO discounted fees for Diagnostic and Preventive Services (no Deductible), including:

- Office visits for examinations, cleaning or scaling of teeth (prophylaxis), routine comprehensive or recall examinations, and problem-focused examinations. The plan covers two routine preventive exams and cleanings (prophylaxis), per Plan Year
- Up to two periodontal cleanings (in addition to the two routine cleanings covered in the first bullet), if the patient has a history of prior periodontal treatment.
- Bite-wing x-rays. The plan covers one set per Plan Year,
- Topical fluoride treatments are limited to once each Plan Year for dependent children under age 19, Full-mouth x-ray series or panoramic x-rays, limited to once every 36 consecutive months, and
- Sealants, for dependent children under age 14, limited to one treatment per permanent molar or bicuspid every three Plan Years.

Exclusions and Limitations

Exclusions under the Hertz Dental Plan Options B and C include, but are not limited to:

- Dental Plan Option C – basic restorative, major restorative and orthodontia services,
- Treatment other than by a Dentist, unless it is scaling or cleaning of teeth or topical application of fluoride performed by a licensed dental hygienist under the supervision and guidance of the Dentist, or an X-ray ordered by a Dentist,
- Replacement of amalgam fillings for purposes of eliminating mercury exposure or for cosmetic reasons,
- Topical applications of fluoride applied more than once each year, under age 19 and/or any topical fluoride application applied to an individual age 19 or older,

- Surgery or treatment while an individual is confined as an inpatient in a Hospital for correction of damage to the teeth caused by accidental Injury at the time of the accident (such expenses may be covered under the Medical Plan),
- Expenses related to the use of individual crowns, inlays, fixed bridges, removable partial dentures or any appliance or restorative means for the purpose of altering vertical dimension to restore occlusion, or correcting attrition, abrasion or erosion,
- Veneers or similar properties of crowns and pontics placed on or replacing teeth, posterior to the second bicuspid,
- Surgery or treatment for cosmetic purposes including charges for personalization or characterization of dentures,
- Repair or replacement of a lost, missing or stolen prosthetic or orthodontic appliance,
- Replacement of an existing partial denture, full removable denture or fixed bridgework if the existing denture or bridge is less than seven years old or can be made serviceable,
- Charges related to your failure to keep a scheduled appointment with the Dentist,
- Charges for services or supplies that the Covered Person is not legally obligated to pay, or for which no charge would be made in the absence of dental insurance,
- Services or supplies which are not necessary in terms of generally accepted dental standards,
- Charges in connection with experimental procedures or treatments not approved by the American Dental Association or the appropriate dental specialty society,
- Educational or training programs, dietary instruction, plaque control programs, mouth guards and myofunctional therapy,
- Charges in connection with any dental work already in progress on the effective date of coverage,
- Extra sets of dentures or other appliances,
- Any services rendered before the insurance became effective or after the coverage ceases. A service will be considered rendered on the date it is completed,
- Periodontal splinting,
- Replacement of teeth that were extracted or missing before the member became covered under a Hertz dental plan option.
- Treatment of temporomandibular joint disorders/syndrome (TMJ),
- A temporary dental service not included in the allowance for the final dental service (it is not considered a separate dental service),
- Dental services provided by a relative, including your spouse, parent, parent-in-law, child, brother, sister, brother-in-law or sister-in-law,

- Services or supplies which are compensable under a Workers' Compensation or Employers' Liability Law or similar law,
- Work that is furnished or paid for by any government plan, or is otherwise free of charge to patients,
- To the extent allowed by the law of the jurisdiction where the contract is delivered, service and supplies furnished, paid for, or for which benefits are provided, or required, by reason of past or present service of any person in the armed forces of a government,
- Completion of any insurance forms,
- Sealants applied to teeth other than permanent molars or bicuspid,
- The portion of any charge exceeding the R&C charge as determined by the Claims Administrator,
- Occlusal guards for Bruxism are limited to one set every three years, and
- If any eligible dental expense is also covered under a Medical Plan provided through Hertz, the Medical Plan benefits shall always be primary, and the Dental benefits will be coordinated. Refer to [Coordination of Benefits With Other Coverage](#).

Claiming Benefits

CDC

You will not need to worry about filing claims if you belong to CDC, provided you use your designated Network General Dentist. You will simply pay your Network General Dentist the appropriate Copayment outlined in the Patient Charge Schedule and your Network General Dentist will be reimbursed directly from CIGNA Dental. If you need to seek Emergency care from a provider outside the network, call CDC's Member Services for information on procedures and claim forms. If you have a Health Care Flexible Spending Account, remember to submit your uncovered expenses (including CDC patient charges) for reimbursement from your account.

Hertz Dental Plans – Options B and C

A claim must be filed in order to receive payment under the Hertz Dental Plan Options B and C. In-Network Providers will always file claims for you. In many cases, Out-of-Network Providers will also file claims for you. However, if you must file the claim, follow this procedure to file a claim for eligible dental services:

- After you or your covered dependents receive dental services, complete a Dental Benefits Claim Form in its entirety including an itemized list of services. Claim forms are available from:
 - The BenefitsPlus website; or
 - The Claims Administrator, CIGNA Dental, at (800) CIGNA-24.
- Mail the claim form and itemized bills to the Claims Administrator at the address on the form.

- You will receive an Explanation of Benefits (EOB) summarizing how the claim was processed. If the claim is eligible for payment, the payment will be sent to you or your provider – depending on whether or not you assigned benefits on the claim form.
- If you disagree with the payment decisions, see the [Claims and Appeals – Health Care Plans and Health Care FSA](#) section in [Administrative and Legal Information](#) for more information about appeal procedures and the timeframes in which your appeal will be reviewed.
- You should submit your claim to the Claims Administrator as soon as possible. You must submit your claim within 24 months of when the expense was incurred. Health Care Flexible Spending Account (FSA) participants should refer to the [Flexible Spending Accounts](#) section for information on submitting the uncovered portion of your dental expenses.

Termination of Coverage

Please refer to the [General Information About Health Care Plans](#) section for information on termination of coverage, continuing coverage through COBRA and conversion privileges.

Vision Plan

Good vision is important to your total well-being; regular Eye Exams may also detect other health problems, such as high blood pressure, before symptoms appear. The Vision Plan under the Hertz Custom Benefit Program is offered through EyeMed Vision Care, LLC, and provides you and your covered dependents with benefits for common vision expenses. If you elect to participate in the Vision Plan, it will help you pay for regular Eye Exams, lenses or contact lenses, and a frame.

What the Plan Covers

The Vision Plan features the EyeMed provider network. You may choose an EyeMed participating provider, or you may use any licensed Out-of-Network Provider of your choice. The following chart explains the available benefits.

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Exam	\$20 co-pay	Up to \$30
Dilation as necessary	\$0	
Refraction	\$0	
Exam Options – Contact Lenses		
Standard Fit and Follow-Up	Up to \$55	N/A
Premium Fit and Follow-Up	90% of retail price	N/A
Frames	\$0 copay, plus 80% of balance over \$140	Up to \$70
Standard Plastic Lenses		
Single Vision	\$25 copay	Up to \$20
Bifocal	\$25 copay	Up to \$30
Trifocal	\$25 copay	Up to \$40
Lenticular	\$25 copay	Up to \$40
Standard Progressive	\$90 copay	Up to \$30
Premium Progressive	\$90 copay plus (80% of charge less \$120 allowance)	Up to \$30
Standard Lens Options		
UV coating	\$15	N/A
Tint (solid and gradient)	\$15	N/A
Standard scratch resistance	\$15	N/A
Standard polycarbonate – Adults	\$40	N/A
Standard polycarbonate – Kids Under 19	\$25	Up to \$8
Standard anti-reflective coating	\$45	N/A
Polarized	80% of retail price	N/A
Other add-ons and services	80% of retail price	N/A
Contact Lenses**		
Conventional	\$0 copay, plus 85% of balance over \$105	Up to \$105
Disposable	\$0 copay, plus 100% of balance over \$105	Up to \$105
Medically necessary	\$0 (paid in full by Plan)	Up to \$210

	Your In-Network Cost	Your Out-of-Network Reimbursement*
LASIK or PRK from US Laser Network	85% of retail price or 95% of promotional price Whichever is lesser	N/A
Frequency - based on Plan Year		
Exam	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 24 months

**You are responsible for paying the Out-of-Network Provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.*

*** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.*

Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

Additional Benefits of Using an EyeMed Provider

EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by at Network Providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to an EyeMed provider’s professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered

Medically Necessary Contact Lenses

Medically Necessary Contact Lenses are covered when one of the following conditions exists:

- Anisometropia of 3D in meridian powers
- High Ametropia exceeding –10D or +10D in meridian powers
- Keratoconus where the member’s vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses
- Vision Improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

Laser Vision Correction

Discounts are available for LASIK and PRK. You receive a discount when using a Network Provider in the U.S. Laser Network. For additional information or to locate a Network Provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

After you have located a U.S. Laser Network Provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 1-877-5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded. You are responsible for scheduling any required follow-up visits with the U.S. Laser Network Provider to ensure the best results from your laser vision correction procedure.

Make the Most of Your Benefit Dollars

Here are a few tips to help you get the most from your vision benefits:

1. Use Your Network, Again and Again

By using an EyeMed participating provider, you pay low Copayments for covered services and benefit from reduced out-of-pocket costs for additional services and materials.

2. Classic Fashion is a Frame of Mind

The Vision Plan covers a new pair of frames once every two Plan Years. You will pay less if you make your frame selection from a participating provider. Alternatively, if you are happy with your current frames, you may be able to save money by limiting your purchase to new lenses.

3. Ring in the New Year – in July

Covered vision care benefits renew at the beginning of the Plan Year (July 1). Plan ahead and schedule your vision care appointments to get the most out of each Plan Year.

4. Be Flexible

By planning ahead and using a Health Care Flexible Spending Account, you can pay for eligible out-of-pocket vision expenses that are not covered by the Vision Plan with before-tax dollars.

Exclusions and Limitations

The Vision Plan excludes certain expenses. These include, but are not limited to, charges relating to the following:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Any vision examination, or any corrective eyewear required as a condition of employment.

- Safety eyewear.
- Services provided as a result of any Workers' Compensation law, or similar legislation.
- Services required by any governmental agency or program whether federal, state or subdivisions thereof.
- Plano (non-prescription) lenses and/or contact lenses.
- Non-prescription sunglasses.
- Two pair of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered before or after your coverage is effective, except when materials ordered before coverage ended are delivered and the services rendered are within 31 days from the date of such order.
- Replacement of lost, stolen or broken lenses, frames and/or contact lenses, except at the normal intervals when services are otherwise available.
- Fees charged by a provider other than those fees for a covered benefit.

Claiming Benefits

Call the doctor to schedule an appointment and identify yourself as an EyeMed member. The doctor will verify your eligibility and plan coverage with EyeMed.

Using an EyeMed Participating Provider

Before you receive vision care services, follow these steps:

- To find an EyeMed Network Provider, contact EyeMed's Customer Care Center at 1-866-723-0513. EyeMed's Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 7:00 pm EST. You can also visit www.eyemed.com and choose the Access Network.
- When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or plan number, located on the front of your ID card. Confirm the provider is an in-Network Provider for EyeMed. (While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the Vision Plan.)
- Following your appointment, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-Covered Expenses (for example, vision perception training).

Using an Out-of-Network Provider

An Out-of-Network Provider is any licensed optometrist, ophthalmologist, and/or dispensing optician who is not a member of the EyeMed network. If you receive services from an Out-of-Network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums provided above.

To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed:

FAA/EyeMed Vision Care, LLC.
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

An out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-866-723-0513.

You have the right to an appeal if you disagree with the payment decisions. See the [Claims and Appeals – Health Care Plans and Health Care FSA](#) section under [Administrative and Legal Information](#) for information about the appeal process and the timeframes in which your appeal will be reviewed.

Termination of Coverage

Please refer to the [General Information About Health Care Plans](#) section for information on termination of coverage, continuing coverage through COBRA and conversion privileges.

General Information About Health Care Plans

This section applies to all Program participants electing coverage under any of the Medical, Dental or Vision Plans.

Important Terms You Should Know

Alternate Facility – A health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services,
- Emergency Health Services,
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Ambulatory Surgical Center – an institution or facility, either free-standing or as a part of a Hospital, with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to, and discharged from, within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an Ambulatory Surgical Center.

Autism Spectrum Disorders – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Birthing Center – a specialized facility, which is not a Hospital, or in a Hospital, staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located, which is primarily a place for the delivery of children, following a normal uncomplicated pregnancy.

Brand-name Drug – a prescription drug which is protected by trademark registration.

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by UnitedHealthcare Insurance Company. The CRS program provides:

- Specialized consulting services to employees and enrolled dependents with cancer,
- Access to cancer centers with expertise in treating specific forms of cancer – even the most rare and complex conditions, and
- Guidance for the patient on the prescribed plan of care and the potential side effects of radiation and chemotherapy.

Certified Nurse Midwife (CNM) – a licensed Registered Nurse that has passed the educational requirements and certification examination administered by the American College of Nurse Midwives for providing normal maternity, newborn and gynecological care.

Claims Administrator – the organization(s) contracted with to provide services in conjunction with claims review, processing and payment for self-insured plans under the Program.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – Consolidated Omnibus Budget Reconciliation Act of 1986, as amended, is federal legislation requiring most employers providing group health insurance, to provide the opportunity for employees and their covered dependents to continue their coverage when it would otherwise end.

Copayment – the pre-set fee you pay for a service, supply, or prescription.

Coinsurance – the portion of Covered Expenses you pay after the Deductible has been met, up to the out-of-pocket maximum.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth, Congenital heart defects may:

- Be passed from a parent to a child (inherited),
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substance during her pregnancy, or
- Have no known cause.

Covered Expenses – the expenses that are eligible for reimbursement under a health plan.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Medically Necessary;
- Included in [What the Plans Cover](#);
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described in this Summary Plan Description; and
- Not identified as an Exclusion or Limitation.

Custodial Care – services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (including, for example, feeding, dressing, bathing, transferring and ambulating),
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence, or
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – the amount of Covered Expenses you pay each Plan Year before the plan starts to pay benefits.

Dentist – an individual who is a duly licensed doctor of dental surgery (DDS) or doctor of medical dentistry (DMD), practicing within the scope of his or her license. This includes dental specialists like periodontists, endodontists, pediatric Dentists and other specialists.

Designated Facility (Designated United Resource Networks Facility) – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions. The fact that a Hospital is a network Hospital does not mean that it is a Designated Facility.

Doctor/Physician – a lawfully licensed medical practitioner who is practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or to perform surgery.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- Ordered or provided by a Physician for outpatient use,
- Used for medical purposes with respect to treatment of a Sickness, Injury or symptom,
- Not consumable or disposable,
- Not of use to a person in the absence of a Sickness, Injury or symptom,
- Durable enough to withstand repeated use,
- Is not implantable within the body, and
- Is appropriate for, and is primarily used, within the home.

Elective Contact Lenses – contact lenses that are not Medically Necessary. The Vision Plan provides a set allowance towards the contact lens evaluation, fitting fees, material costs and follow-up care.

Eligible Expense or Eligible Expenses – a charge or charges for Covered Health Services that are provided while the plan is in effect, determined as follows with respect to the Medical Plans:

- For in-Network Providers, Eligible Expenses are based on the contracted rates with that provider.
- For Out-of-Network Providers, Eligible Expenses are determined as follows:
 - For Emergency services, the charges billed by the provider, unless the Claims Administrator negotiates lower charges.
 - For non-Emergency services, negotiated rates agreed to by the non-Network Provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator, or if rates have not been negotiated, then one of the following amounts:
 - 140% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
 - When a rate is not published by CMS for the service, the Claims Administrator uses an alternate methodology to determine a rate for the service, using a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the

service. The relative value scale currently used is created by Ingenix. If the Ingenix relative value scale becomes no longer available, a comparable scale will be used. The Claims Administrator and Ingenix are related companies through common ownership by UnitedHealth Group.

- When a rate is not published by CMS for the service and the alternate methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or the alternate methodology, the Eligible Expense is based on 50% of the provider's billed charge, except that certain Eligible Expenses for Mental Health and Substance-Related and Addictive Disorder services are based on 80% of the billed charge.
- The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copayment and/or Coinsurance.

Emergency – a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following::

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to Emergency, the following:

- A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd*) that is within the capability of the Emergency department of a Hospital, including ancillary services routinely available to the Emergency department to evaluate such Emergency, or
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Experimental and 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 UnitedHealthcare and Hertz make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and 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, or

- 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 is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under [Clinical Trials](#).
- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, UnitedHealthcare must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- The benefits provided,
- The allowable reimbursement amounts,
- Deductibles or Copayments,
- Coinsurance,
- Any other adjustments taken,
- The net amount paid by the plan, and
- The reason(s) why the plan did not pay for a service.

Eye Exam – an examination of the eyes and related structures to determine the presence of any vision problems or other abnormalities.

Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Diagnostic criteria for adults and adolescents:
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
 - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics.

- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- Diagnostic criteria for children:
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
 - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
 - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 - A strong preference for cross-gender roles in make-believe play or fantasy play.
 - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
 - A strong preference for playmates of the other gender.
 - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
 - A strong dislike of one's sexual anatomy.
 - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
 - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Generic Drug – a prescription drug which is not protected by a trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency – an agency or organization which provides a program of home health care and which meets one of the following requirements:

- Medicare approves it as a Home Health Care Agency,
- It operates in accordance with applicable licensing and other laws, or
- It meets all of the following criteria:
 - Primary purpose is to provide a home health care delivery system by bringing supportive services to the home,
 - Has a full-time administrator,
 - Maintains written records of services provided to the patient,
 - Staff includes at least one Registered Nurse or it has available nursing care by a Registered Nurse, and
 - Employees are bonded and it maintains malpractice insurance.

Hospice – an organization or a facility that meets all of the following:

- The standards established by the National Hospice Organization,
- If required by a state, is licensed, registered or certified by that state,
- Provides a Hospice care program coordinated through any:
 - Hospital or related institution,
 - Home Health Care Agency,
 - Hospice, or
 - Other similar licensed facility.
- Is a free-standing facility, and
- Provides inpatient care for persons who:
 - Have no reasonable chance for cure, as determined by a doctor, and
 - Have a life expectancy of less than six months.

A Hospice care team is made up of health care professionals such as:

- Registered nurses,
- Licensed clinical social workers,
- Psychologists, and
- Physical and occupational therapists.

Hospital – a legally constituted and operated institution, which is an accredited Hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and/or, a facility which meets all of the following criteria:

- It is primarily engaged in providing acute care and treatment of sick or injured persons for compensation from its patients, and on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians. If primarily a facility for the treatment of mental and/or nervous conditions, or substance abuse, such facility must be duly licensed, if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if such licensing is not required.
- It continuously provides twenty-four (24) hours per day nursing service by registered nurses under the supervision of Physicians, and
- It is not, other than incidentally, a place for the aged, or a nursing home, a convalescent care facility, a rehabilitation center, an extended care facility or a hotel or the like.

Injury – bodily damage from trauma other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – A long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Intensive Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment – a structured outpatient Mental Health or Substance-Related and Addictive Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermediate Care – Mental Health or Substance-Related and Addictive Disorder treatment that encompasses the following:

- Care at a Residential Treatment Facility;
- Care at a Partial Hospitalization/Day Treatment program; or
- Care through an Intensive Outpatient Treatment Program

Medically Necessary – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;

- Not mainly for your convenience or that of your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled Clinical Trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion. UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medically Necessary Contact Lenses – contact lenses are considered Medically Necessary when prescribed for one of the following conditions:

- Following cataract surgery,
- To correct visual acuity problems that cannot be corrected with spectacle lenses, certain conditions of anisometropia, and
- Certain conditions of keratoconus.

Medicare – the U.S. federal government plan under Title XVIII of the Social Security Act of 1965, as amended, that pays certain Hospital and medical expenses for those who qualify, primarily those over age 65.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*.

Mental Health/Substance-Related and Addictive Disorders Administrator - the organization or individual designated by Rose Associates, Inc. who provides or arranges Mental Health Services and Substance-Related and Addictive Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless they are listed as an exclusion under the Medical Plan.

Network Provider – a health care provider who has:

- Entered into an agreement with the Claims Administrator or an affiliate, and
- Agreed to accept specified reimbursement rates for Covered Health Services.

Neonatal Resource Services (NRS) – a program administered by UnitedHealthcare or its affiliates. The NRS program provides guided access to a network of credentialed Neonatal Intensive Care Unit (NICU) providers and specialized nurse consulting services to help manage NICU admissions.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Out-of-Network Provider – any licensed provider who is not a member of the network.

Personal Health Support – programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Plan Year – the 12-month period beginning each July 1 through the following June 30.

Reasonable and Customary Charges (R&C charges) with respect to the Dental plans – charges for covered services based on the use of nationally recognized statistical databases. Most providers and facilities practicing in the same geographic area with comparable training and experience charge similar fees to patients.

Residential Treatment – treatment in a facility which provides a program of effective Mental Health Services or Substance-Related and Addictive Disorders treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs;
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Services;
- It has or maintains a written, specific and detailed treatment program requiring full-time residents and full-time participation by the patient; and
- It provides at least the following basic services in a 24-hour per day, structured milieu: room and board; evaluation and diagnosis; counseling; and referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Sickness – physical illness, disease or pregnancy. The term “sickness” as used in this SPD includes Mental Illness and substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.

Skilled Nursing Facility – A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility.

Transitional Living – Mental Health Services/Substance-Related and Addictive Disorders that are provided through living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, and alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- Supervised living arrangement which are residences such as living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and Kettering Health Network may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and Kettering Health Network must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and Kettering Health Network's discretion. Other apparently similar promising but Unproven Services may not qualify.

Coordination of Benefits With Other Coverage

Coverage through the Hertz Medical Plans and the Hertz Dental Plans of this Program will be coordinated with any other coverage you or a covered dependent has.

When you or a covered dependent is eligible to receive benefits for the same service under more than one plan, the order the plans pay benefits is as follows:

- The primary plan pays its benefits first without consideration of any other plan, and

- The secondary plan(s) adjusts its benefit based on the amount paid by the primary plan. Under the Program's Hertz Medical Plan and Hertz Dental Plan, the combined total benefits paid will not be greater than if the secondary plan(s) was the only plan. In general, if the Hertz Medical Plan or Hertz Dental Plan is secondary, your total reimbursement from both the primary and secondary plans will not exceed what the Hertz Plan would have paid if it was the only plan, unless the primary plan already paid a greater amount. In the event your other plan's benefits meet or exceed what would have been payable under the Program's plan, no payment will be made by the Program's plan. This is referred to as a coordination/non-duplication of benefits provision.
- A plan without a coordination/non-duplication provision is always the primary plan. If all plans have a coordination/non-duplication provision, then:
- The plan covering the patient directly, rather than as a dependent, will be the primary plan.
- A plan covering a person as a laid-off or retired employee (or as a dependent of a laid-off or retired employee) is secondary to a plan that covers the person as an employee who is neither laid-off nor retired.
- If an individual is covered as an employee under more than one plan, the plan that has covered the employee longer is the primary plan.

If a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in a calendar year is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan.

The following are exceptions to the rule:

- If the other plan does not have the above noted "birthday" rule, the other plan's rule will be used to decide which plan is primary.
- If a child is covered under both parents' plans and the parents are separated or divorced, the plans pay in the following order:
 1. If the court (i.e., divorce decree) has established one parent as financially responsible for the child(ren)'s health care, the plan of the parent with that responsibility is primary, and the insurance company or Claims Administrator must be informed of the court decree/divorce.
 2. If the court (i.e., divorce decree) does not establish financial responsibility for the child(ren)'s health care, then the plan of the parent with custody of the child is primary, while the plan of the parent without custody is secondary.
 3. If the parent with custody has remarried, then a plan covering the child as a dependent of the step-parent with custody will determine its benefits before the plan of the natural parent without custody.

If none of the rules above apply, the plan that has covered the patient longer is primary.

How Coordination of Benefits Works		
The following chart illustrates how coordination of benefits work when your spouse has medical coverage through his or her employer and also participates in the Hertz Medical Plan as your dependent. When your spouse visits the doctor, here is how the benefits payable would be calculated assuming Deductibles have been met under both plans:		
	Spouse's Plan	Hertz's Plan
Doctor's fees	\$125	\$125
Eligible Expenses	\$100	\$100
Medical Plan co-insurance	50% of Eligible Expenses	80% of Eligible Expenses
Benefit payable before coordination of benefits	\$50	\$80
Amount paid by each Plan	\$50	\$30 (\$80 - \$50)

If your spouse had coverage only through his or her employer's plan, the out-of-pocket cost in the example shown above would have been \$75. With secondary coverage under the Program, the out-of-pocket cost is reduced to \$45.

Benefits under the following types of plans will be coordinated with benefits from the Hertz Medical and Hertz Dental Plans:

- Governmental benefit program provided or required by law (other than Medicaid, also refer to the [Coordination with Medicare](#) section),
- No-fault automobile insurance plans (Personal Injury Protection Coverage), and
- Other group health care plans to which you or your covered dependents belong, including student coverage provided through a school above the high school level, or by any other method of coverage for persons in a group.

The coordination/non-duplication of benefits provision does not apply to individual or private insurance plans.

Coordination of Benefits Under HMOs and CDC

Each HMO and the CDC Dental Plan may follow different rules for coordinating coverage with any other coverage you or a covered dependent has. Using the telephone number on your identification card, contact your HMO for coordination of benefits information.

Coordination with Medicare

When you or your dependent reaches age 65, you may be eligible to receive Medicare benefits. Medicare generally provides coverage for individuals age 65 and over, as well as for people entitled to Social Security disability benefits and those with end-stage renal disease. The Hertz Medical Plan provides primary coverage for you and your dependents if you are in any of the following categories:

- Active employees and their spouses who are age 65 and over and entitled to Medicare Part A benefits,

- Disabled employees for a maximum of 24 months while on an approved medical leave of absence, Covered disabled dependents who are entitled to Medicare Part A benefits, and
- Active employees and their dependents for a maximum period of 18 months if they are entitled to Medicare benefits solely on the basis of end-stage renal disease.

If you or your dependent is covered by Medicare, but do not meet the categories listed above, the Program's Hertz Medical Plan is coordinated with Medicare and provides secondary coverage. Contact your local Social Security office before your 65th birthday for further information about Medicare and your eligibility.

Subrogation and Reimbursement

The Plan does not cover the following:

- Expenses for which another party may be responsible as a result of liability for causing or contributing to the Injury or illness of you or your Dependent, or
- Expenses to the extent they are covered under the terms of any automobile liability, medical payments, automobile no-fault, personal Injury protection, uninsured or underinsured motorist, homeowner's, umbrella, workers compensation, government insurance other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent.

This section describes the Plan's rules and your obligations when the situations above apply.

Subrogation applies when the plan has paid benefits on your behalf for an Injury or illness for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Injury or illness for which a third party is alleged to be responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused an Injury or illness for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that Injury or illness.

Reimbursement - Example

Suppose you are injured in a boating accident that is not your fault, and you receive benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer an Injury or illness, or who is legally responsible for the Injury or illness;

- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Injury or illness;
- The Plan Sponsor (for example workers' compensation cases);
- Any person or entity who is or may be obligated to provide benefits or payments to you, including, for example, benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable;
 - Providing any relevant information requested by the Plan;
 - Signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
 - Responding to requests for information about any accident or injuries;
 - Making court appearances;
 - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
 - Complying with the terms of this section.

Your failure to cooperate with the Plan 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 injury or illness alleged to have been caused or 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 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 will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- 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. If you die as a result of your injuries and a wrongful death or survivor claim is asserted against any third party, the Plan's subrogation and recovery rights will still apply. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right. Under no circumstances will the Plan be obligated to pay a fee or costs to your attorney.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," "Rimes Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of Injury or illness, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those 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.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the Injury or illness.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs an injury or illness caused by a third party. If a parent or

guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused 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 covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- Made in error;
- Due to a mistake in fact;
- Advanced during the time period of meeting the calendar year Deductible; or
- Advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery. 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 you or your Dependent by the amount of the overpayment. If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the 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.

Termination of Coverage

Your coverage will terminate under the Medical, Dental and Vision Plans on the first of the following that occur:

- The day/date that you leave the Company's employment for any reason other than a retirement,
- The day/date that you stop making the required contributions,

- The day/date in which you remain an employee, but change from an eligible to an ineligible class under the Program,
- The last day of the month in which the Program ceases to be in force, and
- In the event of a retirement, coverage will continue until the last day of the month in which the retirement occurs.

Coverage ceases for a dependent when your coverage ends, or on the last day of the month when he/she no longer meets the eligibility requirements for a dependent, or when the required contribution is not paid.

The loss of coverage date will be used for determining eligibility for continuation of coverage under COBRA. Refer to [Continuing Health Care Coverage Through COBRA](#) in this section for information about continuing coverage.

Termination of Domestic Partner Relationship

If your domestic partner relationship terminates for any reason, you are required to remove them from coverage using BenefitsPlus within 31 days after the termination of the relationship.

Continuing Health Care Coverage Through COBRA

In certain circumstances, you may elect to continue medical, dental and vision coverage for you and your dependents, and continue participation in the Health Care Flexible Spending Account through the Program when your coverage would otherwise end. The Consolidated Omnibus Budget Reconciliation Act, as amended, is a federal law known as COBRA, which provides you with this opportunity. Under COBRA, you and your covered dependents may continue health care coverage for a period of up to 18, 29, or 36 months, based on the “event” that caused you and/or your dependent(s) to lose eligibility under the Program. This “event” is referred to as your COBRA qualifying event. Refer also to [Continuing Flexible Spending Account Coverage If You Leave Hertz](#) in the [General Information About Flexible Spending Accounts](#) section for special rules on continuing Flexible Spending Accounts under COBRA.

COBRA Costs

Generally, the cost to purchase COBRA coverage for you and your dependents is the full group premium rate plus a 2% administration fee. The full group premium rate was the total amount you and Hertz paid for such coverage prior to your termination of coverage. The premium rates are subject to change, usually at the beginning of each Plan Year. If you become eligible for an extension of COBRA coverage due to a disability, as explained below, your COBRA premium will be 150% of the applicable premium for the 19th through 29th month of COBRA coverage.

How to Elect COBRA Coverage

Shortly after you lose Program eligibility, for example through termination of employment or reduction of work hours, a COBRA notice will be sent via first class mail to your last known address as it appears in the Hertz payroll system. The notice will inform you of your right to elect COBRA coverage, and what you need to do to continue coverage. You have 60 days from the later of the date you would lose coverage or the date of your COBRA Notification Form to elect to continue coverage. You do not have to provide evidence of good health to receive coverage under COBRA. If you are still eligible to participate in the Program, but a dependent you have been covering is no longer eligible for coverage, you or your dependent must notify the COBRA Administrator within 60 days of the loss of eligibility to protect your dependent's right to COBRA continuation coverage.

When Your Dependents Are No Longer Eligible for Coverage

Sometimes, your dependents may lose eligibility to participate in the Program even though you are a participant. This may happen if you become divorced, or if your child reaches age 26 or otherwise loses eligibility under the Program. If your dependent loses eligibility, you must notify the COBRA Administrator within 60 days to request a COBRA notice for your dependent. If you do not notify the COBRA Administrator within 60 days after the date your dependent becomes ineligible for coverage, your dependent will not be entitled to COBRA coverage. In addition, you will need to remove your ineligible dependent(s), and change your coverage level if appropriate, on the BenefitsPlus website, as described in the [Changing Your Coverage](#) section.

If you elect COBRA within the 60-day period and pay the required premium on a timely basis, your coverage will be retroactively reinstated without penalty. Your initial premium payment is due 45 days after the date you elect COBRA continuation coverage. Your initial premium payment must be sufficient to cover all premiums due as of the date your payment is made. Subsequent premium payments are due on the first of each month. Your monthly premium will be considered timely if it is made within 30 days of the date due.

Even if you do not elect to continue your coverage through COBRA, any or all of your covered dependents can elect to continue their coverage. If you do not choose to continue coverage, your coverage under the Program will end as of the first day you were no longer eligible to participate in the Program.

Length of Time Coverage Can Be Continued

You can continue coverage under COBRA, depending on your situation, up to the following limits:

- **If you are covered as an employee** and your coverage under the Program ends because of termination of employment (except for gross misconduct) or a reduction of work hours, coverage for you and your covered dependents can be continued for 18 months. If you or a covered dependent is disabled (as determined by the Social Security Administration) at any time during the first 60 days of continuation coverage, you are entitled to a total of 29 months of continued coverage (at 150% of the full group premium rates for the additional 11-month period) if you notify the COBRA Claims Administrator of the Social Security determination within 60 days after receipt of the determination and within the initial 18 months of COBRA coverage.
- **If you are covered as a dependent spouse of an employee** and your coverage ends because you become divorced or legally separated, your coverage can be continued for 36 months.
- **If you are covered as a dependent child of an employee** and your coverage ends because you cease to be considered a qualified dependent child according to the Program's eligibility requirements, your coverage can be continued for 36 months.
- **If you are covered as a dependent of an employee** and your coverage ends because the employee is deceased, coverage can be continued for 36 months. When this applies and your dependent(s) elects COBRA, Hertz will provide any medical, dental, and vision coverage in effect at the time of your death at no cost for the first six months. Your covered dependents must pay premiums in full each month for the remaining 30 months in order to continue coverage.

If you and your covered dependents are eligible for an 18-month COBRA continuation period and elect to continue coverage, if during that period, your dependents experience another qualifying event (such as loss of dependent status), they will be eligible for continued coverage for up to 36 months starting from

the date of the original qualifying event. You must notify the COBRA Claims Administrator within 60 days after the second qualifying event to be eligible for this extension.

Your coverage may end before the times indicated above if any of the following occurs:

- The Company ceases to provide a group health care plan for any employee,
- You cease to pay any required payments for the continued health care coverage,
- You become covered under any other group health care plan that does not contain any exclusion or limitation with respect to any pre-existing condition that applies to you or a covered dependent,
- You become entitled to Medicare benefits, or
- If there has been a final determination under the Social Security Act that you are no longer disabled during the 11-month period of extended coverage.

As a COBRA participant, you are entitled to the same plan coverage as a similarly situated active employee. For example, if you experience a qualifying event for a status change, you are entitled to make the change under the same terms that apply to active employees. You also have the right to modify your coverage options during open enrollment periods that occur during your period of continuation coverage.

If during your period of COBRA continuation coverage you add a newborn or a child placed for adoption, the child will be treated as a “qualified beneficiary” with independent rights to continue COBRA coverage until the end of your maximum COBRA coverage period.

Domestic Partner Coverage

The Company has elected to extend COBRA benefits to covered domestic partners and their covered children. In general, all of the COBRA rules applicable to covered persons apply equally to covered domestic partners and the covered children. Thus, if your domestic partnership ends or if the children of your domestic partner cease to be eligible for coverage under the Program as your dependents, they may be able to temporarily continue coverage under the Medical, Dental and/or Vision Plans. In order to be eligible for such continuation coverage, if your domestic partner relationship ends or if your domestic partner’s children cease to satisfy the eligibility criteria to be covered under the Program as your “dependent,” you, your domestic partner, or your domestic partner’s children must notify the COBRA Administrator within 60 days of their change in status.

Conversion Privileges

You may be able to convert medical coverage under an HMO option or the CDC dental coverage option to individual policies after your COBRA continuation of coverage ends. You should contact the insurance companies for further details. There are no conversion privileges to individual policies under the Medical Plan Options administered by UnitedHealthcare, or Hertz Dental Plan Options B and C.

Family Protection

No one likes to think about tragic events – a death or a serious accident or injury – much less the unexpected financial implications they bring. The Hertz Custom Benefit Program offers you various opportunities to provide financial protection for you and your family, including numerous coverage alternatives under Life Insurance, Accidental Death and dismemberment, and Long-Term Disability Plans.

Family Protection

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Life Insurance Plan

The financial future of your family or other beneficiary may depend on how well you plan ahead. Life insurance should be an important part of your financial plan. It can give you peace of mind knowing you are helping to protect the people relying on you for financial support in the event of your death. As an added benefit, you are automatically enrolled in the Travel Assistance Program (see [Travel Assistance Program](#) in this section).

Coverage Amounts

The Hertz Custom Benefit Program offers several life insurance coverage options which will pay a benefit to your designated beneficiary in the event of your death.

Basic Life Insurance: You are automatically enrolled in the basic life insurance, at 1 times your base pay. Hertz pays the premium on the basic life insurance.

Supplemental Life Insurance: You have the option of electing supplemental life insurance in an amount between 1 and 6 times your base pay (i.e., 1, 2, 3, 4, 5 or 6 times your base pay). If you elect supplemental life insurance, you pay the full cost of that coverage.

You choose the coverage that is right for your family's protection.

What Is Base Pay?

Base pay is your annual pay excluding overtime, incentive pay, bonuses and any other forms of special compensation.

For Commission Salespersons with over one year of service, base pay equals 80% of your prior year's annualized Hertz W-2 earnings, but not less than your base pay.

Your coverage amount will be automatically adjusted as your base pay changes during the Plan Year.

Proving Your Good Health

You may be required to provide evidence of insurability (proof of your good health) when you enroll on and after July 1, 2017 (special evidence of insurability rules applied to the one-time enrollment period prior to the 2017 Plan Year). Evidence of insurability is only required for supplemental life insurance. You are automatically enrolled in basic life insurance.

Whether or not evidence of insurability is required will depend on when you enroll and the amount of coverage you elect. **Evidence of insurability is always required if you elect life insurance coverage in an amount greater than 5 times your base pay or \$300,000 (whichever is less).** This coverage amount is called a *guaranteed issue (GI) amount*.

New Hires: If you enroll when you are first eligible, you may elect life insurance coverage up to the GI amount (up to 5 times your base pay or \$300,000 (whichever is less)) without evidence of insurability. If you elect life insurance above the GI amount, evidence of insurability is required. For example, if you are a new hire, your base pay is \$85,000, and you want to elect coverage of 4 times your base pay (\$340,000), evidence of insurability will be required.

During Annual Enrollment or Following a Status Change (With Supplemental Life Already in Place): If you are already enrolled in supplemental life insurance, and you want to increase that coverage during annual enrollment or within 31 days after a status change, evidence of insurability is required to increase your coverage by an amount exceeding 1 multiple of base pay. Evidence of insurability is also

required for any increase that would exceed the GI amount (up to 5 times your base pay or \$300,000 (whichever is less)). This means that you can increase your supplemental life insurance coverage by 1 times your base pay without evidence of insurability, unless that increase would exceed the GI amount. For example, if your base pay is \$50,000, and you have supplemental life insurance of 2 times your base pay, evidence of insurability would not be required if you increased your coverage during annual enrollment to 3 times your base pay, but it would be required if you increased your coverage to 4 times your base pay. Evidence of insurability would also be required, for example, if your base pay was \$120,000, and you wanted to increase your coverage from 2 times your base pay to 3 times your base pay (because it would exceed the GI amount).

During Annual Enrollment or Following a Status Change (Without Supplemental Life Already in Place): If you elect supplemental life insurance for the first time during annual enrollment or within 31 days after a status change, evidence of insurability is required for any election. For example, if you have no supplemental life insurance, and you want to elect supplemental life insurance in an amount equal to 2 times your base pay during annual enrollment, evidence of insurability will be required no matter the amount of your base pay.

If you enroll during any other time, evidence of insurability will always be required.

You may need to provide additional documentation following the insurance company's initial review of your health statement. Any coverage that requires evidence of insurability will become effective only after it has been by the insurance company. The insurance company will inform you in writing if your application has been approved or denied.

A Word About Smoking

Have you smoked, chewed, or used tobacco products in the last 12 months? If not, then you qualify as a non-smoker under the Life Insurance Plan. As a non-smoker, you are eligible to take advantage of lower premium rates than those used for employees who smoke.

Naming a Beneficiary

Your beneficiary is the person(s) you designate to receive a benefit under the Life Insurance Plan in the event of your death. You may designate anyone as your beneficiary or you may designate more than one beneficiary when you enroll. When designating more than one beneficiary, you will need to indicate the percentage of the benefit you want to allocate to each person. If you do not specify a certain percentage, all beneficiaries listed will share the benefit equally. You may change your beneficiary at any time.

In the event you do not designate a Life Insurance Plan beneficiary or your beneficiary dies before you do, benefits will be paid to the first of the following who survive you:

1. Your spouse,
2. Your children, in equal shares,
3. Your parents, in equal shares,
4. Your siblings, in equal shares, or
5. Your estate.

Be sure to keep your beneficiary choices up-to-date. You may want to review your choices as you and your family experience key life changes, such as marriage, divorce, birth or death.

If You Continue Working After Reaching Age 65

If you continue working after you reach age 65, your life insurance coverage will continue at a reduced amount. The amount of coverage you will have depends on your age, as shown in this chart:

Your Age	Continued Percentage of Elected Life Insurance Coverage
65 but less than 70	65%
70 but less than 75	40%
75 or older	25%

How to Calculate Your Coverage After Age 65

The following example will help you to calculate your life insurance coverage. Suppose you are age 66, your current base pay is \$30,000, and you elected coverage equal to two times your base pay.

<p>Calculate your life insurance using your current base pay and the benefit option you elected</p>	<p>Two times base pay = $(\\$30,000 \times 2) = \\$60,000$</p>
<p>Identify the continuation of coverage percentage for your age using the previous table.</p>	<p>Age 66 but less than 67 continuation percentage = 84.6%</p>
<p>Multiply your life insurance coverage by the appropriate continuation percentage. Your reduced coverage amount is the result rounded to the nearest \$1,000.</p>	<p>Coverage amount x continuation percentage = $(\\$60,000 \times 84.6\%) = \\$50,760$</p> <p>Reduced coverage amount = \$51,000</p>

Exclusions and Limitations

No life insurance benefit will be paid if your death is caused by suicide or self-destruction, or any attempt at suicide or self-destruction, within 24 months after you are first covered by the Programs's life insurance.

Terminal Illness

Your life insurance coverage features a terminal illness benefit. If you are diagnosed by a physician as terminally ill, with less than six months to live, you may choose to receive a one-time advance payment of a portion of your life insurance benefit. The money may be used for any purpose.

The amount of your terminal illness benefit will be 75% of your life insurance coverage amount in force on the date you are determined by the insurance company to be terminally ill, and this amount, after the scheduled reduction, must be at least \$20,000 to qualify for this provision. The maximum advance benefit payment amount will be \$250,000. Receiving payment of this benefit may affect your eligibility for public assistance programs such as Medicaid.

At the time of your death, your beneficiary(ies) will receive the remaining portion of your life insurance coverage amount, taking into consideration the terminal illness payout and any scheduled benefit reduction due to age (see the [If You Continue Working After Age 65](#) section for details).

Log on to BenefitsPlus for instructions on applying for this terminal illness benefit.

Tax Implications

If your life insurance coverage is in excess of \$50,000, federal tax law requires that the cost of the life insurance exceeding \$50,000 is taxable to you (whether or not the Company pays the premiums or you pay the premiums). The amount included in your income is determined by guidelines and tables established by the IRS, and is subject to change. As a result, your paycheck will reflect the payment of taxes on the “value” of your life insurance coverage over \$50,000. Imputed income also will be reported on your IRS Form W-2 as taxable income. If you have questions about imputed income and associated tax obligations, you should consult a tax specialist.

There are no tax consequences if your life insurance coverage does not exceed \$50,000. This tax does not apply to dependent life insurance, which you pay for on an after-tax basis.

Claiming Benefits

Please refer to the [General Information About Family Protection Plans](#) section for details about how to claim benefits.

Coverage After You Retire

You may be eligible for post-retirement life insurance provided by the Company if you were hired before 1990. Your age and years of service as of January 1, 1990 determine the amount of coverage. Contact the Corporate Employee Benefits Department for details.

Travel Assistance Program

The Travel Assistance Program provides access to information and referral services to all members 24 hours a day, 365 days a year by contacting:

Outside the United States (collect calls accepted)	312-935-3704
Within the United States (toll-free)	877-935-3704
Anywhere email	aetnatravelassistance@axa-assistance.us

As a participant in the Life Insurance Plan you are automatically a member of the Travel Assistance Program. The Travel Assistance Program is available to you and your immediate family members who are traveling more than 100 miles away from home, for up to 120 consecutive days.

The Travel Assistance Program provides you with the opportunity to learn about:

- Visa and passport information
- Immunization requirements
- Currency
- Safety
- Local customs

The following services are available:

Medical Support and Emergencies:

- **Medical/Dental Referrals and Hospital Admission:** Contact information for local physicians, dentists and/or hospital/clinics is provided to members upon request. If needed, you will receive coordinated support with your hospital admission, including help with precertification and outpatient surgery, and you can receive assistance and coordination with your primary medical insurance. If you'll be hospitalized for more than seven days, you can request a family member or companion join you. *Medical costs are your responsibility.*
- **Critical Care Monitoring:** A member's condition may be monitored while the member is hospitalized away from home.
- **Prescription Assistance:** This service helps you replace lost or forgotten prescriptions, medical devices and eyeglasses.

Evacuation Services:

- **Emergency Medical Evacuation:** Medical professionals will help arrange the right personnel and transportation to the nearest facility that can provide care to you in a medical emergency.
- **Political Evacuation:** If the government calls for political evacuation, you can get assistance to get home.

General Travel Services:

- **Emergency Messages:** You can send emergency messages to someone at home.
- **Lost Document and Item Assistance:** This includes help obtaining replacements and canceling original documents and help recovering lost or stolen items.
- **Legal Referral:** Name and contact information if the need for a local attorney arises while traveling.
- **Emergency Cash Advance:** You can get an emergency cash advance or bail bond assistance.
- **Vehicle Return:** Arrangements to return a personal rental vehicle if you are unable to do so due to illness, accident, etc.

You are covered for up to \$150,000 per occurrence for costs associated with medical evacuation, repatriation or return of mortal remains. Additional costs are your responsibilities. You must arrange all services through the Travel Assistance Program. No reimbursement claims for out-of-pocket expenses will be accepted.

The Travel Assistance Program does not provide cover for any covered injury, loss or expense that is caused by or results from:

- Suicide, attempted suicide or any intentional self-inflicted injury while sane or insane.
- Act of declared or undeclared war (political evacuation not subject to this exclusion).
- Participating in, or practicing for, professional sports.
- Piloting or learning to pilot or acting as a member of the crew of any aircraft.

- The commission of or attempt to commit a felony by the insured person or the insured person's being engaged in an illegal occupation.
- Normal childbirth, normal pregnancy (except complications of pregnancy) or voluntary induced abortion.
- Mental or nervous condition, unless hospitalized.
- Participating in maneuvers or training exercises of an armed service, except while participating in weekend or summer training for the reserve forces of the United States.

Dependent Life Insurance Plan

Benefits for your family give you security in knowing that you can pay for necessary expenses in the event of the death of your spouse or domestic partner, or dependent child(ren).

Coverage Amounts

The Hertz Custom Benefit Program offers you the choice of various coverage amounts for eligible family members. You decide how much protection is right for you. You may also elect to waive coverage.

Option Coverage Amount

	Spouse or Domestic Partner	Child
A	\$100,000	\$15,000
B	\$50,000	\$15,000
C	\$40,000	\$15,000
D	\$30,000	\$15,000
E	\$20,000	\$10,000
F	\$10,000	\$5,000

Proving Your Spouse's or Domestic Partner's Good Health

You may be required to provide evidence of insurability (proof of your spouse's or domestic partner's good health) when you enroll on and after July 1, 2017 (special evidence of insurability rules applied to the one-time enrollment period prior to the 2017 Plan Year). Evidence of insurability is only required for spouse or domestic partner life insurance. Evidence of insurability is not required for child life insurance.

Whether or not evidence of insurability is required for your spouse or domestic partner will depend on when you enroll and the amount of coverage you elect. **Evidence of insurability is always required if you elect spouse or domestic partner life insurance coverage in an amount greater than \$50,000.** This coverage amount is called a *guaranteed issue (GI) amount*.

New Hires: If you enroll your spouse or domestic partner when you are first eligible, you may elect life insurance coverage up to the GI amount (\$50,000) without evidence of insurability. If you elect life insurance above the GI amount, evidence of insurability is required. For example, if you are a new hire and you want to elect coverage of \$100,000 for your spouse or domestic partner, evidence of insurability will be required.

During Annual Enrollment or Following a Status Change: If you enroll or increase your spouse or domestic life insurance coverage during annual enrollment or within 31 days after a family status change, evidence of insurability is required for any amount exceeding the GI amount (\$50,000). For example, if your spouse or domestic partner is currently enrolled in coverage in the amount of \$10,000, and you want to increase that coverage to \$50,000 during annual enrollment, evidence of insurability would not be required, but if you want to increase the coverage to \$100,000, evidence of insurability would be required.

If you enroll your spouse or domestic partner during any other time, evidence of insurability will always be required.

Beneficiary Information

In the event of the death of a covered eligible dependent, you, the employee, are the beneficiary of any benefit payable under this Dependent Life Insurance Plan. If an eligible dependent dies within six months after your death, a death benefit will still be paid.

If you are not living at the time your spouse or domestic partner dies, payment is made to your spouse's or domestic partner's estate. If a dependent child dies, payment will be made to the first of the following who survive the child:

1. Child's parent,
2. Child's siblings, in equal shares, or
3. Child's estate.

Limitations

If your spouse or domestic partner is a Hertz employee, special rules apply. Please refer to the [General Information About Family Protection Plans](#) section for details.

Claiming Benefits

Please refer to the [General Information About Family Protection Plans](#) section for details on how to claim benefits.

Accidental Death and Dismemberment Plan

Accidents can happen to anyone, at any time. Accidental Death and Dismemberment (AD&D) insurance provides you and your family financial protection in the event of an accidental injury or death.

Coverage Amounts

The Hertz Custom Benefit Program offers you the choice of several AD&D coverage options for you and your eligible dependents. You decide how much protection is right for you. You may elect coverage for yourself only, or for you and your family.

You may elect employee coverage up to the lesser of 10 times your annual base pay or \$750,000, or you may waive coverage. When you elect family coverage, your spouse or domestic partner's benefit is 50% of your coverage, and your child(ren)'s benefit is 10% of your coverage.

Option	Employee Coverage	Family Coverage (Spouse or Domestic Partner and Child)	
		Spouse or Domestic Partner	Child
A	\$750,000	\$375,000	\$75,000
B	\$500,000	\$250,000	\$50,000
C	\$350,000	\$175,000	\$35,000
D	\$250,000	\$125,000	\$25,000
E	\$150,000	\$75,000	\$15,000
F	\$100,000	\$50,000	\$10,000
G	\$50,000	\$25,000	\$5,000
H	\$25,000	\$12,500	\$2,500
I	\$10,000	\$5,000	\$1,000

The family coverage amounts increase if you only have a spouse or domestic partner or child(ren), but not both. In that case, your spouse or domestic partner's benefit will be 60% of your coverage, or your child(ren)'s benefit will be 20% of your coverage. For example, if you elect Option D (\$250,000) and have a spouse or domestic partner, but no children, your spouse or domestic partner's benefit is \$150,000; if you elect Option D (\$250,000) and have child(ren) but no spouse or domestic partner, your child(ren)'s benefit is \$50,000.

What Is Base Pay?

Base pay is your annual pay excluding overtime, incentive pay, bonuses and any other forms of special compensation.

For Commission Salespersons with more than one year of service, base pay equals 80% of your prior year's annualized Hertz W-2 earnings, but not less than your base pay.

How to Determine Your Maximum Coverage Amount

The following example will help you determine the maximum amount of coverage available to you under the AD&D Plan. For this example, assume your annual base pay is \$30,000.

 Multiply your base pay by 10.	$(\$30,000 \times 10) = \$300,000$
 Identify the coverage option on the chart closest to, but not in excess of, 10 times your base pay.	\$250,000 for yourself, \$125,000 for your spouse or domestic partner and \$25,000 for each child.

Beneficiary Designations

Unless you request otherwise, your beneficiary under the AD&D Plan will be the same beneficiary or beneficiaries you named under the Life Insurance Plan. You are the beneficiary for any elected dependent coverage.

How Your Benefit Is Determined

If you or a covered dependent is injured or dies in an accident, the AD&D Plan pays benefits based on your elected coverage amount, and the extent of the loss. Benefits may be paid under any of the following categories:

- Accidental death and dismemberment;
- Total loss of use.

Additional benefits may be paid in the event of your death, a child's dismemberment and when a seatbelt is used.

Accidental Death and Dismemberment (AD&D) Benefits

If the loss is of...	The plan pays this portion of the elected coverage amount
Life	100%
Brain Death	100%
Both hands, both feet, sight in both eyes, or a combination of any two	100%
Speech and hearing in both ears	100%
Speech or hearing in both ears	100%
One hand, one foot, or sight in one eye	100%
Thumb and index finger of the same hand	30%
Four fingers of the same hand	30%
Hearing in one ear	100%

An eligible loss must occur within one year of a covered accident, and is defined as:

- Hand or foot – complete severance through or above the wrist or ankle joint,
- Sight, speech or hearing – total and irrevocable loss of the function,
- Thumb and index finger – complete severance through or above the metacarpophalangeal joint, or
- Brain Death – irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, although the heart is still beating.

If you experience more than one loss as a result of the same accident, you will be paid for the loss that pays you the greatest amount. For example, if you lose your left hand and the thumb and index finger of your right hand, the AD&D Plan would pay you the greater benefit associated with the loss of your left hand.

Total Loss of Use Benefits

Total loss of use is the loss of the ability to function because of incurable paralysis or stiffening. In addition, total loss of use must affect the entire arm or leg from the shoulder or hip, including the hand or foot attached to it.

When the total loss of use is of...	The plan pays this portion of the elected coverage amount
Both arms and both legs	200%
Both arms or both legs	100%
One arm and one leg	100%
One arm or one leg	100%

Benefits will be paid for total loss of use if:

- You or your dependent suffers total loss of use within one year of the accidental injury,
- Total loss of use continues for 12 consecutive months after the onset,
- It is shown by proper medical authority at the end of 12 months that the total loss of use has been continuous and will be permanent, and
- No accidental death and dismemberment benefit is payable for such loss.

The total of all benefits paid for any one accident, through both the total loss of use benefit and the accidental death and dismemberment benefit, will not exceed the elected coverage amount.

Additional Benefits

Seat Belt Benefit

Hertz recognizes the importance of consistent seatbelt use, both on the job and in your personal vehicle. Consequently, the AD&D Plan will pay an additional 20% benefit if you or a covered dependent dies while using a seatbelt (as defined in the Policy). The additional 20% benefit will be paid if:

- Death occurs within one year of a covered accident,

- Appropriate use of the seat belt was established in the police report of the accident,
- The participant was operating a self-propelled private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highways of any state or country. Automobile includes, but is not limited to, a sedan; station wagon; sport utility vehicle; pick-up; panel; van; camper; or motor home. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transit.

This benefit is not payable for any loss sustained if the covered participant was sharing a seat belt or if the covered participant was not wearing a seat belt, regardless of the reason.

Air Bag Benefit

If a Seat Belt Benefit is payable and if the insured person is positioned in a seat protected by a properly functioning, original, factory-installed Supplemental Restraint System that inflates on impact, the AD&D Plan will pay an additional 20% benefit.

Verification of the actual use of the seat belt at the time of the accident, and that the Supplemental Restraint System inflated properly upon impact must be part of an official report of the accident or be certified, in writing, by the investigating officer(s).

“Supplemental Restraint System” means an air bag which inflates for added protection to the head and chest areas.

Increased Dismemberment Benefit for Children

The AD&D Plan benefit will be doubled for a dismemberment loss suffered by an insured dependent child.

Survivor Benefit

If you die in a covered accident, the AD&D Plan will pay your spouse or domestic partner an additional monthly benefit for six months. This monthly benefit is equal to 1% of your covered amount. If your spouse or domestic partner is no longer living, the additional benefit will be paid to your surviving dependent children, in equal shares.

Other Benefits

AD&D benefits also include:

- Bereavement and trauma counseling,
- Burial and cremation,
- Child care,
- Child survivor,
- Coma coverage,
- Common accident,
- Family plan,
- Group medical and dental premium reimbursement,

- Spouse or Domestic Partner retraining,
- Education,
- Home alteration and vehicle modification,
- Rehabilitation, and
- Emergency medical.

Exclusions and Limitations

The AD&D Plan does not pay benefits for a loss or death resulting from the following:

- Suicide or attempted suicide, self-destruction or attempted self-destruction, while sane or insane,
- Service, training or active duty in the armed forces, National Guard, military naval, or air service, or organized reserve corps of any country or international organization.

Exposure

Any loss that is due to exposure to the elements will be covered as if it were due to an injury (as defined in the Policy).

Disappearance

If the body of an insured person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant while covered under the Policy, then it will be deemed, subject to all other terms and provision of the Policy, that the insured person has suffered accidental death within the meaning of the Policy.

Hijacking and Air Piracy

Coverage for the hijacking of an aircraft, air piracy, or unlawful seizure or attempted seizure of an aircraft begins with the onset of the hijacking or air piracy and continues while subject to the hijacking or air piracy. Coverage ends when you return to your residence or originally scheduled destination, whichever occurs first. Any loss must take place while you are in the course of performing your job for Company business.

War Risk

You are covered for war risks due to or contributed by declared or undeclared war. No coverage is provided if you are a resident of and travelling in your country of origin or citizenship or if you are travelling within the designated hazardous war risk countries (as defined in the Policy).

If Your Spouse or Domestic Partner Is a Hertz Employee

If your spouse or domestic partner is a Hertz employee, special rules apply. Please refer to the [General Information About Family Protection Plans](#) section for details.

Claiming Benefits

Please refer to the [General Information About Family Protection Plans](#) section for details on how to claim benefits.

Long-Term Disability Insurance Plan

Your ability to produce a consistent income is one of your greatest assets during your working years. Long-term disability (LTD) coverage assists in protecting your financial security if you are not able to work for more than 26 weeks due to a covered illness or injury that results in “disability.” LTD coverage works together with other disability plans, like Social Security and Workers’ Compensation, to replace a portion of your income.

Coverage Amounts

The Hertz Custom Benefit Program offers you a choice of LTD coverage options to provide the level of security that meets your needs, or you may elect to waive coverage. Your choices for coverage are as follows:

Coverage Amount Options	Monthly Benefit Ranges	
	Minimum	Maximum
60% of your base pay	\$100	\$16,000
50% of your base pay	\$100	\$13,000

While you are actively at work, your LTD coverage amount will reflect your current base pay.

What Is Base Pay?

Base pay is your annual pay excluding overtime, incentive pay, bonuses and any other forms of special compensation.

For Commission Salespersons with over one year of service, base pay equals 80% of your prior year’s annualized Hertz W-2 earnings, but not less than your base pay.

Proving Your Good Health

If you enroll in LTD coverage when you first become eligible, you automatically qualify for coverage. If you waive or end coverage and want to enroll or re-enroll, you will have to wait until a future open enrollment period. At that time, you will be required to provide proof of your good health to the insurance company.

Following your election of LTD coverage under these circumstances, a Statement of Health for Employee Enrollment Form will be sent to your home. You must complete and submit this form to the insurance company.

You may also need to provide additional documentation or have a medical examination following the insurance company’s initial review of your health statement.

Your coverage amount and related payroll deductions will become effective once the insurance company approves your coverage. The insurance company will inform you in writing if your application has been approved or denied.

What Is Disability?

You will be considered disabled, and eligible for benefits by the LTD insurance company, if you are unable to perform each of the material duties of your regular occupation, and unable to earn 80% or more of your pre-disability earnings from working in your regular occupation, and are under the continuous care of a physician. After disability benefits have been payable for 24 months, you may continue to qualify for disability benefits. However, to qualify for continued benefits, you must be unable to perform for wage or profit each of the material duties of any gainful occupation for which you are reasonably suited by education, training or experience, and unable to earn 60% or more of your Indexed Earnings.

When Payments Begin

You may be eligible for LTD benefits when you have been disabled due to an illness or injury for 26 weeks. This is called your elimination period. Once you have completed this elimination period and your application has been approved by the insurance company, payments will be provided on a monthly basis.

How Your Benefit is Determined

Your LTD benefit will be calculated using the LTD option you elected — either 50% or 60% of your base pay on the day prior to the commencement of your disability. If you receive income from certain other sources during your disability, your LTD benefit will be reduced by the amount of this other income so that your total disability income does not exceed 50% or 60% of your monthly base pay, depending on your elected option. The LTD insurance company has the right to recover any overpayment resulting from retroactive awards (from the sources listed below), fraud or any error made in determining your LTD benefit. Income that will reduce your LTD payments includes, but is not limited to, amounts that you or your dependents receive (or are assumed to have received) under any of the following:

- Pension plan or annuity payments from Hertz, or any labor management trustee or union plan that is contributed to by Hertz,
- Social Security or other benefits provided under any local, state, provincial or federal government disability or retirement plan,
- The Railroad Retirement Act or Canada and Québec Pension Plans,
- Workers' Compensation, occupational disease, unemployment compensation, compulsory benefit, or other similar benefits,
- Disability income from any other franchise or group income replacement insurance or mandated state benefits (including No-Fault auto insurance),
- Any settlement, judgment, arbitration or otherwise which provides benefits for loss of earnings, where a third party may be liable, regardless of whether liability is determined, or
- Income from any employment or other retirement plan.

Note: The LTD policy contains a Return to Work Incentive provision under which you can have earnings from employment during your disability (Disability Earnings) and still receive LTD benefits. Such Disability Earnings will be taken into consideration in calculating the amount of your monthly LTD benefit.

Once your monthly LTD benefit is calculated, cost of living adjustments will not be made.

Taxation of LTD Benefits

If you elect LTD coverage, you have the option to have your premium contributions deducted on either a before-tax or after-tax basis. See the box below for information about the tax consequences associated with these choices.

Taxation of LTD Benefits
Your contributions to the LTD plan may be made on either a before-tax or after-tax basis. Generally, contributions made on a before-tax basis would make any benefits you receive from the LTD plan taxable. However, contributions made on an after-tax basis would make any LTD benefits you receive non-taxable. Please consult your own tax advisor if you have any questions.

Social Security Disability Benefits

You may be eligible to receive primary or family Social Security disability benefits if you become disabled. Social Security disability benefits can start after five months of disability if your disability is determined to be permanent, or is expected to last 12 or more consecutive months.

Additional Social Security disability benefits may be payable for each of your dependent children under age 18 (or age 19, if the dependent is a full-time high school student). In addition, your spouse may be eligible for a benefit if he or she is caring for a dependent child under age 16. Total family benefits are subject to a maximum established by Social Security.

You must apply for Social Security benefits; they are not paid automatically. The insurance company will assist you in applying for Social Security benefits, or you may begin the process earlier, by contacting your local Social Security office. To locate the Social Security office nearest you, call 800-772-1213 or access the Social Security Administration's Internet web site at www.ssa.gov. If you do not apply and the insurance carrier receives no denial of benefits through Social Security, Social Security benefits are assumed and your LTD benefits are reduced accordingly.

How to Determine Your LTD Benefit if You Have Other Income

Suppose your annual base pay is \$36,000 (\$3,000 per month), you elected LTD coverage to continue 60% of your base pay and you are disabled. Also assume you are eligible to receive a \$750 monthly benefit from Social Security. Your monthly LTD benefit would be calculated as follows:

Determine your total monthly LTD income by multiplying your monthly earnings by your LTD coverage percentage.	$(\$3,000 \times 60\%) = \$1,800$
Determine your LTD benefit by subtracting your other income from your total monthly LTD income.	$(\$1,800 - \$750) = \$1,050$

In this example, your monthly LTD benefit is \$1,050. Your total monthly income from all sources is \$1,800.

How Long Benefits Continue

As long as you are considered disabled under the LTD Plan, you will continue to receive LTD benefits up to a specified period. This period is based on your age when you first become disabled as shown in the following chart. (Additionally, see [If You Are Disabled Due to a Mental Illness](#).)

If you become disabled at age...	LTD benefits may continue up to...
59 or younger	Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

When Benefits End

Your LTD benefits will immediately end when the earliest of the following events occur:

- You return to active work,
- You earn more from any occupation, than the percentage of indexed earnings as set forth in the definition of disability,
- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis but you do not;
- After 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you do not;
- You are no longer considered disabled under the plan,
- You refuse, without good cause, to cooperate in all required phases of the Rehabilitation Plan and assessment (Benefits may be resumed if you begin to cooperate fully with the Rehabilitation Plan within 30 days of the date benefits terminated.),
- You no longer receive appropriate care,
- You fail to cooperate with the insurance company in the administration of your claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due,
- Your coverage ends according to the above age-based guidelines, or
- You die.

If You Are Disabled Due to a Mental Illness

If you are disabled due to a mental illness, alcoholism, or drug addiction or abuse, you may receive LTD benefits for a maximum of 24 months. A mental illness is any type of mental, nervous, or emotional disease or disorder. If, before reaching the 24-month maximum, you are confined for at least 14 consecutive days in a hospital, institution or other facility licensed to provide care and treatment for your mental illness, alcoholism or drug addiction or abuse, that period of confinement will not count against the 24-month maximum. In no event will LTD benefits be paid beyond the maximum shown in the chart above.

If Your Disability Returns

If you receive LTD payments, recover and return to work, and then become disabled again due to the same or a related injury or illness within six consecutive months of returning to work, your LTD payments will resume immediately. You will not be required to complete a new 26-week elimination period.

If your second disability is due to a different illness or injury, or if you have returned to work for more than six consecutive months, you must fulfill another 26-week elimination period before receiving additional LTD payments.

Survivors Benefit

In the event you die after receiving monthly disability payments for three months, the LTD Plan will pay a benefit to your "Eligible Survivor(s)" (your spouse or domestic partner, if applicable, otherwise your child(ren) under age 25).

The benefit will be equal to three times your monthly LTD benefit before reductions for other income benefits. The amount of survivors benefit payable may be reduced by any outstanding overpayment. If payment becomes due to your child(ren), payment will be made to your child(ren), or the person legally appointed to receive payments on the child(ren)'s behalf. When the benefit is payable to more than one child, it will be paid in equal shares. If there is no spouse or domestic partner and no children, benefits will be paid to your estate.

Exclusions and Limitations

The LTD Plan does not cover any disability caused by or resulting from:

- Pre-existing conditions,
- Intentionally self-inflicted injuries while sane or insane, suicide or attempted suicide,
- War, any act of war, whether or not declared,
- Committing a felony, for which you have been convicted,
- Operation of any motorized vehicle while intoxicated,
- Active participation in a riot, or
- The revocation, restriction or non-renewal of a license, permit or certification necessary to perform the duties of your occupation, unless due solely to injury or sickness otherwise covered by the plan.

In addition, the plan will not pay benefits for any period of disability during which you are incarcerated in a penal or corrections institution.

What Is a Pre-existing Condition?

A pre-existing condition is a sickness or injury for which you incurred expenses, received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines within three months of your coverage effective date.

LTD benefits will not be paid if you become disabled during the first 12 months after your coverage effective date and your disability is the result of a pre-existing condition.

General Provisions

Incontestability

All statements made by Hertz or by you are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to you. In the event of death or legal incapacity, your beneficiary or representative must receive the copy.

After two years from your effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Misstatement of Age

If your age has been misstated, the insurance company will adjust all benefits to the amounts that would have been purchased for the correct age.

Certificates

A certificate of insurance is available from BenefitsPlus upon request. The certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits

The Insurance Company will not be affected by the assignment of your certificate until the original assignment or a certified copy of the assignment is filed with the insurance company. The insurance company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnished, or otherwise taken for your debts. This prohibition does not apply where contrary to law.

Clerical Error

Your insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Important Terms You Should Know

Consumer Price Index (CPI-W)

The Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the index is discontinued or changed, another nationally published index that is comparable to the CPI-W will be used.

Disability Earnings

Any wage or salary for any work performed for any employer during the employee's disability, including commissions, bonus, overtime pay or other extra compensation.

Indexed Earnings

For the first 12 months that monthly benefits are payable, indexed earnings will be equal to base pay. After 12 months benefits are payable, indexed earnings will be an employee's base pay plus an increase applied on each anniversary of the date monthly benefits became payable. The amount of each increase will be the lesser of:

- 10% of the employee's indexed earnings during the preceding year of disability, or
- The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

Rehabilitation Plan

A written plan designed to enable the employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:

- Rehabilitation, under which the insurance company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services,
- Work, which may include modified work and work on a part-time basis.

Claiming Benefits

Please refer to the [General Information About Family Protection Plans](#) section for details on how to claim benefits.

General Information About Family Protection Plans

If Your Spouse or Domestic Partner Is a Hertz Employee

If both you and your spouse or domestic partner are Hertz employees, you and your spouse or domestic partner cannot be insured as both an employee and a dependent. You and your spouse or domestic partner must each elect your own employee coverage. Eligible children may be insured dependents of either you or your spouse or domestic partner, not both. Duplicate coverage is not permitted.

Claiming Benefits

Life Insurance, Dependent Life Insurance and AD&D

Life insurance and AD&D benefits are based on your elected coverage amounts and are generally paid as a lump sum.

In the event of a covered loss, you (or your beneficiary, in the event of your death) should notify your local Human Resources Business Partner and submit proof of the loss (such as a police report to document the accident and/or death certificate, as appropriate) within 30 days of the loss or as soon as reasonably possible. Information about filing a claim will be provided by the Employee Benefits Department after notification of the loss is received.

You have the right to appeal if you disagree with the insurance company's payment decision. See the [Claims and Appeals - Life Insurance, AD&D and Dependent Care FSA](#) section under [Administrative and Legal Information](#) for information about the appeals procedure and the timeframes in which your appeal will be reviewed.

LTD

LTD benefits are paid monthly while you are disabled and eligible to receive benefits. You must file a claim to receive LTD benefits. You may receive claim forms automatically if you are receiving short-term disability benefits. If you do not have a copy of the claims forms, call the Claims Administrator to request the LTD forms needed to file a claim. You must complete and return any required LTD forms as requested or required by the Claims Administrator.

- The LTD claim form has sections to be completed by you, your physician and a management representative of your work location. The insurance company needs this information to process your claim and to understand your disability and your job duties. Complete the employee section of the form and forward the physician's statement to your attending physician.
- All sections of the claim form must be returned to the LTD carrier within 90 days after your 26-week elimination period or as soon as reasonably possible. Incomplete forms cannot be processed and will be returned to you. Failure to submit a completed claim form within 90 days after the elimination period may result in a loss of LTD benefits for the entire period of disability. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Claims Administrator, must be given no more than six months after that 90-day period.
- The Claims Administrator may need to gather additional medical information related to your disability in order to process your claim. If the LTD Claims Administrator requests proof of your disability and continuous care by a licensed physician, you must provide proof within 30 days of the date of the request. Proof of your disability includes the initial date of disability, the cause of the disability and details on the extent of the disability.

You have the right to appeal if you disagree with the Claims Administrator's payment decision. See the [Claims and Appeals – Long-Term Disability](#) section under [Administrative and Legal Information](#) for information about the appeals procedure and the timeframes in which your appeal will be reviewed.

Termination of Coverage

Your coverage will terminate under the Life, Dependent Life, AD&D and LTD Plans on the first of the following that occur:

- The day/date you retire or leave the Company's employment for any reason other than a layoff,
- The last day of the month in which you remain an employee, but change from an eligible to ineligible class under the Program (except that LTD coverage ends on the date you transfer out of an eligible class),
- The end of the period for which premium has been paid for your coverage, or
- The date the Policy terminates, or the Program ceases to be in force.
- In the case of LTD, the date benefits end for failure to comply with the terms and conditions of the Policy.
- In the case of AD&D, the date you enter full-time active duty in the armed forces of any country or international authority or the date you are no longer actively at work.

If you are on an approved leave of absence, Life and Dependent Life coverage will continue for up to 24 months from the date of leave, provided the required premium continues to be paid. For AD&D coverage, coverage continues for up to 24 months only in the event of an authorized family or medical leave; for all other leaves of absence, continued coverage will not exceed 3 months. LTD coverage will terminate immediately after three months of an approved leave of absence or paid vacation. Life, Dependent Life, AD&D and LTD coverage terminates immediately upon a layoff.

Insurance ceases for a dependent when your coverage ends, or on the last day of the month when he/she no longer meets the eligibility requirements for a dependent, or when the required premium is not paid. After this date, your dependents will no longer be eligible and any claim for an ineligible dependent will be denied. If you no longer have eligible dependents, you must discontinue your coverage.

Converting & Portability

If your life insurance coverage ends as a result of your employment termination (either due to your voluntary or involuntary termination, retirement, or disability) or other event (your failure to meet the eligibility terms, layoff, or leave of absence), you may be able to convert or port your life insurance coverage. You can also convert or port your life insurance coverage if the coverage is reduced (as a result of your age or retirement). Dependent coverage can also be converted or ported if the dependent is no longer eligible (due to a divorce or similar event or if your child reaches the eligible age limit).

When you convert your coverage to an individual whole life policy, the new policy remains in effect as long as you continue to pay the premiums. You will pay your premiums directly to the insurer, rather than having premiums deducted from your payroll. You can continue to cover yourself and your family members (or you can convert just your own or your dependent's coverage).

If you choose to port your life insurance coverage, you can continue to cover yourself and your family, but you must port your coverage in order to port your dependent's coverage. Your premiums under a ported

policy will change as you age, and you pay the premiums directly to the insurer. Ported coverage will reduce as your age, and coverage will end at a certain time.

You must apply and pay for the converted coverage during the 31-day period following your coverage termination. You and your dependents are not required to provide proof of good health in order to convert your coverage. Conversion and portability is not available if your coverage ends due to non-payment of premium. For instructions on portability and conversion of your life insurance, call Aetna at 877-503-3448. When calling, you will need the Hertz policy number (285660).

If life insurance coverage ends because the Policy is terminated or amended to terminate any class of insureds, or the Company cancels participation under the Policy, coverage can only be converted if the individual has been insured under the Policy for at least five years. In this case, the amount of conversion insurance will be the lesser of the coverage in force under the Life Insurance Plan, or \$10,000.

Conversion is not available under the AD&D Plan. In order to port your AD&D coverage, your coverage must end before our reach age 60. You must elect and pay for coverage within 45 days after the end of your coverage in order to take advantage of the portability option. To obtain a portability application and/or a quote, contact Arch at 201-743-4612. When calling, you will need the Hertz policy number (11ADV8335800).

There are no conversion or portability privileges under the LTD Plan.

Flexible Spending Accounts

We all share some of the same benefit needs, and the Hertz Custom Benefit Program provides you with many options to help meet those needs. However, you may still have some health-related expenses that are not covered by a benefit plan, as well as dependent day care expenses that enable you to work. Through automatic pre-tax payroll contributions, the Health Care and Dependent Care Flexible Spending Accounts (FSAs) can help you budget for these expenses while producing considerable tax savings.

Flexible Spending Accounts

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Flexible Spending Account Basics

The Hertz Custom Benefit Program offers Flexible Spending Accounts (FSAs) to help you budget and pay for certain predictable health and dependent care expenses while you save on taxes. There are two types of FSAs:

- Health Care, and
- Dependent Care.

How FSAs Work

When you make your personal choices for benefits, you decide how much you want to deposit into the FSAs for the Plan Year. Since FSA participation is an annual election, you must (re)elect to contribute to the FSAs each Plan Year. In other words, you will not be “defaulted” to your previous Plan Year’s contribution amount if you do not make a new election.

The Health Care and Dependent Care FSAs are maintained separately. Health care expenses can only be reimbursed from your Health Care FSA, while dependent care expenses can only be reimbursed from your Dependent Care FSA. Additionally, you cannot transfer funds between the accounts.

Use It or Lose It
According to IRS rules, you will forfeit any account balance for which you have not incurred eligible expenses during the Plan Year (July to June), or during the two-and-one-half months immediately following the end of the Plan Year (through September 15th). In other words, you must use it or lose it. However, you will have until December 31 to file a claim for expenses incurred during the prior Plan Year, including those incurred during the two-and-one-half months immediately following the end of the Plan Year. Any balance in your prior Plan Year account on December 31 will be forfeited. Estimate your expenses carefully! See also Special Distribution Rule for Reservists below.

Special Distribution Rule for Reservists

Pursuant to provisions of the Heroes Earnings Assistance and Relief Tax Act of 2008 (the HEART Act), a Reservist called up for active duty for at least 180 days, or for an indefinite period of time, may withdraw unused funds from a Health Care FSA. Employees who believe they may qualify, may request this special “Qualified Reservist Distribution” by contacting BenefitsPlus.

The FSA Tax Advantage

FSAs can help you pay less in taxes. When you participate in an FSA, your contributions come out of your paycheck before taxes are calculated. Consequently, you lower your taxable income and increase your take-home pay by paying less in taxes. Here is an example. Suppose that:

- You have \$1,000 in eligible health care expenses,
- You have \$2,000 in eligible dependent care expenses,
- You and your spouse have a combined annual income of \$50,000, and
- You and your spouse file taxes jointly and claim four exemptions.

	Without Flexible Spending Accounts	With Flexible Spending Accounts
Combined annual income	\$50,000	\$50,000
Before-tax contribution to the <ul style="list-style-type: none"> • Health Care FSA • Dependent Care FSA 	-\$0 -\$0	-\$1,000 -\$2,000
Taxable income	\$50,000	\$47,000
Taxes (assumes 22% federal and state tax)	-\$11,000	-\$10,340
Take-home pay	\$39,000	\$36,660
After-tax health and dependent care expenses	-\$3,000	\$0
Take-home pay remaining	\$36,000	\$36,660
Tax Savings	\$0	\$660

As you can see from this example, you would save \$660 on your taxes. You come out ahead since you would have to spend money on these expenses anyway. Your actual savings may vary based on your personal situation. You may wish to consult your tax advisor to discuss whether the FSAs are right for you, or if in your personal situation, the dependent care tax credit would provide you with a greater tax savings than the Dependent Care FSA. Refer to the [Dependent Care FSA or Dependent Care Tax Credit?](#) information box later in this section for more information.

Limit on Contributions by Highly Compensated Employees

The federal government imposes certain limitations to make sure that a reasonable cross-section of employees takes advantage of tax-savings programs such as this Plan. To comply with those restrictions, Hertz may be required to limit the contributions of Highly Compensated Employees. You are considered a Highly Compensated Employee if your prior year W2 compensation from Hertz and all its Affiliates was in excess of \$120,000. If you are a Highly Compensated Employee, your regular before-tax contributions to an FSA may be limited. If you are impacted by this limitation, you will be notified shortly after Open Enrollment, and will be informed of the adjusted maximum amount you may contribute.

Health Care Flexible Spending Account

The Health Care FSA allows you to pay for eligible health care expenses not covered by your (or your spouse's) medical, dental, vision or other health care insurance plans. You do not need to be enrolled in this Program's health care plans to take advantage of the Health Care FSA.

How Much You Can Contribute

If you elect to participate in the Health Care FSA, the minimum annual contribution is \$100. Currently, the maximum amount you can contribute annually is \$2,600.* The IRS may increase this limit in the future.

Your elected before-tax contribution amount will be made in equal amounts each pay period.

*Highly compensated employees may be subject to limited contributions. Refer to the [Limits on Contributions by Highly Compensated Employees](#) information box under [Flexible Spending Account Basics](#).

Eligible Expenses

You may be reimbursed through your Health Care FSA for eligible out-of-pocket health care expenses incurred by you, your spouse or your eligible dependents.

Some of the health care expenses that are eligible for reimbursement through the Health Care FSA include:

- Deductibles and Copayments,
- Acupuncture,
- Birth control pills,
- Chiropractic services, if Medically Necessary,
- Infertility treatments,
- Routine physical exams,
- Prescription eyeglasses or contact lenses,
- Dental services,
- Over-the-counter drugs or vitamins, if prescribed by your doctor,
- Smoking cessation programs,
- Cosmetic surgery, if the surgery is necessary to promote the proper function of the body or to prevent or treat illness or disease, and
- Weight loss programs, when used to treat a disease or ailment, including obesity.

Eligible Expenses for Your Health Care FSA

In general, eligible health care expenses are:

- Those relating to expenses incurred during the Plan Year (including the two-and-one-half month grace period ending on September 15) or, if you were not participating during the entire Plan Year, the part in which you participated in the FSA. You incur an expense on the day the service is provided or the supply is received, not when you are billed or when you pay for it; and
- Not reimbursed or un-reimbursable under any health care plan sponsored by Hertz, an affiliate or participating company, or by any other source (such as your spouse's health care plan).

Exclusions and Limitations

Some health care expenses are not eligible for reimbursement from your FSA. Here are some examples of ineligible expenses:

- Before-tax contributions you pay for health care coverage,
- Expenses paid by a health insurance plan,
- Over-the-counter drugs and supplies, unless prescribed by a Physician,
- Cosmetics,
- Cosmetic surgery, if it does not meaningfully promote the proper function of the body or prevent or treat illness or disease (e.g., face lifts, hair transplants),
- Electrolysis,
- Marriage or family counseling,
- Custodial care in an institution,
- Weight loss programs which are not being undertaken to treat a disease,
- Health club dues,
- Illegal operations, treatments, or controlled substances whether rendered or prescribed by licensed or unlicensed practitioners, and
- Prescribed drugs from a foreign country, unless you can provide documentation satisfactory to the Program to support that a prescription was legally brought in or shipped from a foreign country, or purchased in and used in a foreign country.

Many health care expenses are covered by medical, dental and vision benefit plans. You need to claim benefits under all plans in which you or your dependents participate, before you seek reimbursement from your FSA. The Claims Administrator determines which expenses are eligible for reimbursement under your FSA by following IRS guidelines. For further information on Eligible Expenses, refer to IRS Publication 502, "Medical and Dental Expenses" – available online at www.irs.treas.gov or by calling 800-829-4477.

Claiming Benefits

Please refer to the [General Information About Flexible Spending Accounts](#) section for details on how to claim benefits.

Dependent Care Flexible Spending Account

The Dependent Care FSA allows you to use tax-free income to pay for dependent day care expenses that allow you and your spouse (if you are married) to work or your spouse to attend school full time.

Who Is an Eligible Dependent?

- Your eligible dependents for the purposes of filing claims through your Dependent Care FSA may be different than your eligible dependents for other benefit plans. Eligible dependents must live in your home for at least eight hours a day and include:
- Your children under age 13,
- Your spouse, if physically or mentally incapable of self-care, and
- Any other person who is a dependent for tax purposes who is physically or mentally incapable of self-care, regardless of age.
- A disabled parent, if the disabled parent is not receiving pension or other income in excess of the income limitation (this amount is subject to change each year – refer to IRS Publication 503).

How Much You Can Contribute

If you elect to participate in the Dependent Care FSA, the minimum annual contribution is \$100. The maximum amount you can contribute annually is \$5,000*, unless you are married and fall into one of the following categories:

- If you and your spouse file separate federal income tax returns, your annual contribution limit is \$2,500.
- If both you and your spouse participate in Dependent Care FSAs, your combined maximum annual contribution is limited to \$5,000*.
- Your annual contributions cannot be greater than your earned income, or your spouse's earned income, whichever is less. For example, if your spouse's earned income is \$4,000 per year, your maximum annual Dependent Care FSA contribution would be \$4,000.
- If your spouse has no earned income because he or she is a full-time student, or is disabled and not able to work, your maximum annual Dependent Care FSA contribution is \$5,000*.

If you enroll after the beginning of the Plan Year (July 1), the \$5,000 maximum will be reduced to ensure your calendar year contribution does not exceed IRS limitations.

**Highly compensated employees may be subject to limited contributions. Refer to the [Limits on Contributions by Highly Compensated Employees](#) information box under [Flexible Spending Account Basics](#).*

Changing Your Contribution Amount

You may change your contribution amount only during the annual open enrollment, unless you have a qualified change in family status. If you have a qualifying event that affects your use of the Dependent Care FSA, you may make a change that is consistent with the qualifying event to either increase or decrease your contribution during the Plan Year. Qualifying status changes for the Dependent Care FSA are:

- Divorce or legal separation,
- Loss of a dependent,

- Loss of your spouse's employment,
- Change in your dependent care provider, or
- Change in your dependent's eligibility under this account.

Eligible Expenses

You may be reimbursed through your Dependent Care FSA for eligible day care expenses incurred during the Plan Year*, in which you participated in the Dependent Care FSA (not when you are formally billed, charged for or pay for the services). Examples of Eligible Expenses include:

- Day care provided in your home by a provider who is not your dependent, and
- Day care provided outside your home at a qualified facility (such as a pre-school, day camp, day care center or before- or after-school program) that provides care for more than six individuals.

* Includes a two-and-one-half month grace period through September 15th.

Dependent Care FSA or Dependent Care Tax Credit?
<p>Instead of using the Dependent Care FSA, you may be eligible to receive a federal tax credit for dependent care expenses. The federal tax credit allows you to deduct a percentage of Eligible Expenses from your taxes. You may wish to consult your tax advisor for guidance on whether or not you would receive a better benefit using the dependent care tax credit. You may not use both a Dependent Care FSA and the dependent care tax credit for the same expenses. If you use both programs, your dependent care tax credit will be reduced by the amount you contributed to the Dependent Care FSA.</p>

Exclusions and Limitations

Expenses for dependent care which are not eligible for reimbursement under the Dependent Care FSA include:

- The cost of sending your child to an overnight camp,
- The cost of transportation for your dependent to get to and from the care location or the cost of transportation for your care provider to get to and from your home, including bus, taxi, subway or private car,
- Expenses incurred when you, or your spouse (if you are married) are not working or attending school full time.
- Expenses for 24-hour custodial care, such as nursing home services,
- The amount you pay your child under age 19 (at the end of the calendar year) to provide care for another dependent, or the amount you pay a dependent you can claim as an exemption,
- The amount you pay a provider for the care of an ineligible dependent (see the [Who Is an Eligible Dependent?](#) information box), and

- The amount you pay a provider for care of a disabled parent, if the disabled parent is receiving pension or other income in excess of the income limitation (this amount is subject to change each year – refer to IRS Publication 503).

The Claims Administrator determines which expenses are eligible for reimbursement under your FSA by following IRS guidelines. IRS Publication 503, “Child and Dependent Care Expenses” describes Eligible Expenses. This publication is available online at www.irs.treas.gov or by calling 800-829-4477.

Claiming Benefits

Please refer to the [General Information About Flexible Spending Accounts](#) section for details on how to claim benefits.

General Information About Flexible Spending Accounts

Claiming Benefits

The procedures for claiming reimbursement differ for the Health Care and Dependent Care FSAs. See below under [Health Care FSA](#) and [Dependent Care FSA](#) for details on how to claim reimbursement from the respective accounts.

The following apply to both the Health Care FSA and Dependent Care FSA:

- You have until six months following the end of the Plan Year in which to file for reimbursement of Eligible Expenses incurred during the Plan Year (including the two-and-one-half month grace period ending September 15), or during the period in which you participated. For example, any expense incurred between July 1 and June 30 can be submitted for reimbursement if received by the Claims Administrator on or prior to December 31. The FSA Claim Form can be downloaded from the BenefitsPlus website.
- All reimbursements from your FSA(s) will be made to you. If you prefer, you can elect Direct Deposit of your reimbursement into your bank account. Log into www.myuhc.com to make that election.
- You can submit for reimbursement as often as you like. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least \$25, except for :
 - Reimbursement with respect to the last month of the Plan Year.
 - Reimbursements resulting from the Auto-Rollover feature (see [Automatic Reimbursement \(Auto-Rollover\)](#) under [Health Care FSA](#) in this section).
 - Reimbursements debited against your account by use of the Consumer Account Card (see [Consumer Account Card](#) under [Health Care FSA](#) in this section).

Amounts below \$25 will be accumulated and processed with future payments.

- In accordance with IRS regulations, amounts contributed to your Health Care or Dependent Care FSA during the Plan Year, but remaining in your account at the end of the processing period (December 31 following the end of the Plan Year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited. Refer to the [Use It or Lose It](#) box in the [Flexible Spending Account Basics](#) section for further details.

Health Care FSA

If your health care expense is covered by your medical, dental or vision plan (regardless of whether it is a Hertz-sponsored plan), you must file a medical, dental, or vision claim first. Then you can make a claim for reimbursement from your Health Care FSA for the amount not paid by the health care plan. The Explanation of Benefits (EOB) you receive details what is covered and what the insurance company or Claims Administrator pays on behalf of the health care plan. You then must submit this EOB as supporting documentation for your Health Care FSA claim. Original receipts for health care services can be submitted when you have no insurance coverage for a specific service.

In order for your eligible claims to be processed efficiently, they must include:

- The provider's name and address,
- The paid receipt indicating the dates of the services and corresponding amounts,
- Name or description of the service provided, and
- Any other information that the Claims Administrator may from time to time require.

Automatic Reimbursement (Auto-Rollover)

If you are enrolled in one of the Hertz-sponsored medical plans administered by UnitedHealthcare, and you submit a medical claim, any eligible charge balance not paid by the medical plan will automatically roll over and be reimbursed to you from your Health Care FSA, if you have a balance in your account. You will not have to file an FSA claim form.

Consumer Account Card

When you enroll in the Health Care FSA, you will automatically receive two Consumer Account Cards that may be used to pay for certain Eligible Expenses directly from your Health Care FSA. The Consumer Account Card allows for direct payment to certain qualified providers that accept MasterCard®. Use of the Consumer Accounts Card is voluntary.

- **Qualified Providers**
The Consumer Account Card may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard®, or your Consumer Account Card number can be entered online or on an order form, similar to using a credit card number. Examples of qualified providers include dental offices, vision care providers, and retail or mail-order pharmacies.
- **Using the Consumer Accounts Card**
When you use the Consumer Accounts Card, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Once you swipe the Consumer Account Card through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your FSA account based on the guidelines established by the IRS. If you use the Consumer Accounts Care and your purchase cannot be substantiated, you must provide documentation supporting your expense. If you fail to do so, the Program may recoup any improper payments in accordance with IRS guidance.

Under the Health Care FSA, you may be reimbursed for Eligible Expenses up to the total amount you elected for the Plan Year, even if you have not yet contributed that amount to your account at the time you submit your claim.

If you disagree with a payment decision, see the applicable ***Claims and Appeals*** section under the [***Administrative and Legal Information***](#) section.

Dependent Care FSA

If you have dependent care expenses, you must first pay for the expenses. Then you must make a claim for reimbursement from your FSA by completing and submitting an FSA Claim Form along with your receipt, clearly marked as paid, as supporting documentation for your claim.

Under the Dependent Care FSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account,

you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

In order for your eligible claims to be processed efficiently, they must include:

- The name and address of the dependent care provider,
- The provider's Social Security number or taxpayer identification number (TIN),
- Your dependent's name(s) and date(s) of birth,
- The paid receipt indicating the dates of the services and corresponding amounts,
- The type of dependent care provided, and
- Any other information that the Claims Administrator may from time to time require.

How Dependent Care FSA Reimbursement Works

Here is an example of how Dependent Care FSA reimbursement works. Suppose that in July you begin contributing \$100 per month to the Dependent Care FSA and in September you request reimbursement of dependent care expenses totaling \$500. You will be reimbursed for \$300 of that bill, because your account then had only a \$300 balance (your contributions from July, August and September) at the time you submitted your claim. If your contributions continue, you automatically will be reimbursed \$100 in November and another \$100 in December, to bring your total reimbursement to \$500. If you submit more claims before your first claim has been reimbursed in full, the additional claims will be processed in the order they were submitted as long as you made sufficient contributions to your Dependent Care FSA.

Non-Discrimination Testing

The Flexible Spending Accounts are subject to Non-Discrimination Testing. Under rare circumstances, in order to fulfill the testing requirements, you may be required to make an election change.

For more information, refer to the [Limits on Contributions by Highly Compensated Employees](#) information box under [Flexible Spending Account Basics](#).

Continuing Flexible Spending Account Coverage If You Leave Hertz

You can continue to file claims for reimbursement under both the Health Care and Dependent Care FSAs for expenses incurred while you were employed and participating. You may also be eligible to continue to participate in the Health Care FSA as a terminated employee under the Consolidated Omnibus Budget Reconciliation Act, as amended (COBRA) through the end of the current coverage period, in the same manner as an active employee, provided you continue to make the required contributions. You cannot continue the Dependent Care FSA on COBRA. Contact the COBRA Administrator within 60 days of your employment termination for details. (Refer to the [General Information About Health Care Plans](#) section for more information on continuing coverage through COBRA.)

Administrative and Legal Information

Information about your rights as a participant, and other important legal information about the Program are provided in this section.

Administrative and Legal Information

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About This Guide

This document is the Summary Plan Description (SPD), required by the Employee Retirement Income Security Act of 1974, as amended (ERISA), for the Hertz Custom Benefit Program (Program) as in effect as of July 1, 2017. While there are references in this SPD to “plans,” these references are to the various benefit coverage options offered under the Program. The Program is, for legal purposes, a single plan consisting of various benefit coverage options.

The Program’s Plan document (Program Document) for purposes of ERISA consists of a document titled the Hertz Custom Benefit Program, as well as:

- This SPD with respect to eligibility to participate in each of the benefit coverage options available under the Program,
- This SPD with respect to benefits under any self-insured benefit coverage options,
- Insurance contracts, and
- Insurance booklets, and/or certificates of insurance, provided by the insurance carriers to participants under the insured benefit coverage options.

If there is any conflict or a discrepancy between the Program Document and any other part of the SPD, the Program Document will govern. Also remember that the SPD is a summary and does not address all the details included in the Program Document.

Neither the Program Document nor any part of the SPD constitutes a contract of employment between you and Hertz or any of its participating affiliates.

General Information

Limitation on Assignment

Your rights and benefits under the Program cannot be assigned, sold, transferred, or pledged by you or reached by your creditors or anyone else, subject to applicable law.

Disclaimer

As a matter of prudent business planning, Hertz is continually reviewing and evaluating various proposals for changes to this Program. When Hertz is acting in this manner, it is not acting in its capacity as fiduciary or the Plan Administrator, but as the settlor of the Program. When acting in its capacity as the settlor of the Program, Hertz has no fiduciary obligations to the Program or to any participant or beneficiary of the Program. You should understand that in some cases while performing its settlor responsibilities, Hertz's interests and actions will be adverse to the continuation of this Program and to the financial interests of you (as well as to any beneficiary). In acting as settlor of the Program, Hertz will indemnify its officers and employees from any and all personal liability arising out of any actions taken by them in good faith and in the course and scope of their employment and responsibilities with respect to the Program.

Because of the need for confidentiality, decisions regarding changes in the Program are not discussed or evaluated below the highest levels of management. Until a Program amendment is actually adopted by Hertz, lower-level managers and other employees of Hertz (as well as third-party service providers) do not know whether Hertz will change the Program and are not in any position to advise any individual about possible changes. Any such speculation or statements about future changes should be disregarded and may not be relied upon. Unless and until changes in the Program are formally announced by Hertz, no one is authorized to give assurance that a change will or will not occur.

In the event of a discrepancy between any statements (written or oral) given to you and the legal documents comprising the Program, the Program Document as interpreted within the sole discretion of the Plan Administrator will control.

Future of The Program

Hertz reserves the right to amend or terminate the Program (and the benefits it provides) in whole or in part, at any time (including at any time during the Plan Year), in its sole discretion and without the prior consent of, or prior notice to, Program participants or beneficiaries, by action of the Chief Human Resources Officer and/or the Chief Executive Officer, or other authorized persons. Hertz may make changes to the Program including, but not limited to, changes to eligibility requirements, employee costs/premiums, benefit exclusions, benefit limitations, benefit coverages or the choice of insurance carriers, or whether benefits should be insured or self-insured. Changes made may affect all employees or participants, or only some groups of employees or participants. Hertz will inform employees and participants about substantial changes or the termination of the Program as the law requires. If the Program is terminated, in whole or in part, benefits will be paid for all Covered Expenses incurred prior to the termination date. Participation in the Program confers no rights (legal, equitable, or otherwise) on participants or beneficiaries that are not otherwise conferred by law or applicable collective bargaining agreement. No one has a vested right to benefits under this Program; participants and beneficiaries may not rely on any statement or promise to the contrary.

Amendments may be retroactive to the extent necessary or desirable to comply with applicable law. No amendment or termination will reduce the amount of any benefit otherwise payable under the Program for eligible charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of Hertz, the Program will terminate, unless the Program is continued by a successor to Hertz.

Plan Administration

Hertz sponsors the Program for its eligible employees and for eligible employees of its participating affiliates. The Program includes benefit plans that are subject to the provisions of Section 125 of the Internal Revenue Code (Code). Code Section 125 permits employee contributions to such plans to be made on a before-tax basis. Under this Program, the benefits currently subject to the Code Section 125 requirements are the Medical, Dental, Vision, Life Insurance, Accidental Death and Dismemberment (AD&D) and Long-Term Disability Plans, as well as the Health Care and Dependent Care Flexible Spending Accounts (FSAs). The Program also includes benefits that are not subject to Section 125 of the Code, such as the Dependent Life Insurance Plan.

Plan Funding

Employees may make contributions toward the cost of their elected Program options. These employee contributions are combined with employer contributions to fund the overall Program.

The Choice Plan A, Consumer Health Account Plans, and Economy Medical Plan, the Dental Plan Options B and C, and the FSAs are self-insured. Claims and administrative expenses for the self-insured health plans and the Health Care and Dependent Care FSAs are paid out of the general assets of Hertz and its participating affiliates, and are administered through one or more third party administrators (TPAs).

For the self-insured plans, Hertz and the Program reserve the right to negotiate discounted rates, directly or indirectly through a third party, for health care services and supplies.

The Program also pays premiums to insurance carriers for various coverages offered under the Program. When a claim is filed under an insured plan, the insurance company is responsible for processing and approving or denying that claim, and for paying an approved claim.

In the event an insurance carrier under the Program grants a reduction or abatement of premium payment, a dividend, a refund or other such return, such funds will be applied toward future premium payments, to improve benefits, to offset administrative expenses of the Program or in such other manner as determined by the Plan Administrator.

Plan Administrator and Committee

The Plan Administrator is the Company. The Plan Administrator supervises the day-to-day operation of the Program, processes enrollment and compensation reduction elections, files government reports and performs other administrative tasks. In addition, the Plan Administrator delegates some of its routine administrative duties under the Program to the Human Resources Department of the Company.

The authority to administer the Program has been delegated to the Hertz Benefits Committee (Committee), the individual members of whom are appointed by the Board of Directors of Hertz. The Committee supervises the operation of the Program and has the authority to exercise discretion where necessary or appropriate in its administration and its interpretation of Program provisions. The Committee has the power to make any factual determination, resolve factual disputes and decide all matters in connection with the interpretation, administration and operation of the Program or the determination of eligibility for benefits. Such discretionary authority is intended to include, without limitation, the determination of eligibility of a person desiring to claim benefits under the particular plan, the determination whether a person is entitled to benefits and the computation of any and all benefit payments. The Committee also may delegate some of its responsibility and powers to subcommittees, employees, third party and Claims Administrators or insurance companies.

Currently, the Committee delegates to the TPAs the discretionary authority to interpret and apply Program terms and to make factual determinations in connection with the review of claims under the self-insured

Medical Plan Options, Dental Plan Options B and C, and the Health Care and Dependent Care FSAs. The Committee also has delegated to the TPAs the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his or her duly authorized representative. Refer to the [Administrative and Legal Information](#) sections for additional information.

The Committee has delegated the discretionary authority to interpret and apply Program terms and to make factual determinations in connection with the review of claims and appeals under the insured plans maintained by the Program to the applicable insurance companies and HMOs. The interpretations and constructions of the Committee and its delegates are final, binding and conclusive as to all interested parties.

Your Rights Under Federal Law

As a participant in the Program you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). However, the Dependent Care FSA and the before-tax contribution (Code Section 125) features of the Program are not subject to ERISA.

ERISA provides that all Program participants have certain rights as described below.

Receive Information About Your Program and Benefits

You have the right to examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Program, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Program with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You have the right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Program, including insurance contracts and collective bargaining agreements, and copies of the latest annual report and updated Summary Plan Description (the Plan Administrator may charge a reasonable fee for the copies).

You have the right to receive a summary of the Program'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

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Program as a result of a qualifying event. You or your dependents may have to pay for such coverage.

You have the right to review this SPD and the documents governing the Program regarding the rules governing your COBRA continuation coverage rights.

Prudent Actions by Program Fiduciaries

In addition to creating rights for Program participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people responsible for operating the Program, called "fiduciaries" under ERISA, have a duty to do so prudently and in the interest of you and other Program 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 Program benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Program 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 above rights. For instance, if you request a copy of Program documents or the latest annual report from the Program and do not receive them 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 a fine of up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a timely claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting your rights of appeal described in the sections of this SPD relating to Claims and Appeals. In addition, if you disagree with the Program's decision or lack thereof, concerning the qualified status of a medical child support order, you may file suit in federal court. As described below, such suits must be brought in a federal court in Bergen County, New Jersey.

If it should happen that Program fiduciaries misuse Program funds, 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, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about the Program, 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Confidentiality and Security of Your Health Information Related to Health Care Plans and Health Care FSA

Protected Health Information

Consistent with the privacy rule (the “Privacy Rule”) under the federal Health Insurance Portability and Accountability Act (“HIPAA”), only certain people at Hertz can, without written authorization from a Program participant or beneficiary, use or disclose individually identifiable health information deemed “protected health information” (“PHI”), which is maintained by or for the Program. Also, such PHI is to be used or disclosed only for Program administrative purposes, principally those described as “payment” and “health care operations” under the Privacy Rule. More information is available in the group health plans’ Notice of Privacy Practices, which has been furnished to you. A copy of this document is available from the Corporate Employee Benefits Department or on BenefitsPlus (the Hertz benefits website) at www.hertz.com/benefitsplus.

The job functions or positions of Hertz employees who can use or disclose PHI for these purposes are:

- The Committee,
- Benefits Administration,
- Human Resources,
- Risk Management,
- Legal Counsel, and
- Certain other positions described in the Program Document.

Consistent with the security rule (the “Security Rule”) under HIPAA, the Program also contains provisions which require Hertz to reasonably and appropriately safeguard electronic PHI created, received, maintained or transmitted to or by Hertz on behalf of the Program.

If you know that employees of Hertz have used and disclosed PHI inappropriately, or have inappropriately obtained PHI, you may contact the Company’s HIPAA Privacy Officer through the Corporate Employee Benefits Department.

Hertz is committed to maintaining the privacy and security of your PHI and will only use and disclose PHI as is necessary for Program administrative purposes and in compliance with the Privacy Rule or as required by law. Hertz employees will not use your PHI in making employment-related decisions about you or in connection with any benefits that are not related to health benefits.

Claims and Appeals – Limitations and Venue

Unless a Program document expressly provides for a different period, all claims for benefits under the Program must be submitted within one (1) year after the earlier of (i) the date on which a communication from the Program, the Plan Administrator or a Program fiduciary (or one of their delegates or agents) contains the information contested or challenged by the claim or (ii) the date when the expenses to which the claim relates first were incurred. You may not institute any action or proceeding in any state or federal court of law or equity, or before any administrative tribunal or arbitrator, for a claim for benefits under the Program unless and until you have exhausted the claim appeal procedures set forth in this SPD or the applicable certificate or brochure. All such claims and appeals must be brought within the timeframes set forth in the Program documents for the particular type of claim.

If you have complied with and exhausted the appropriate claims and appeals procedures under the Program and you intend to exercise your right to bring civil action under ERISA Section 502(a), you must bring such action within one (1) year following the date of the denial of your last required appeal (or voluntary appeal, if offered and you file a voluntary appeal). If you do not bring such action within such one (1) year period, you will be barred from bringing an action under ERISA related to your claim. All action(s) or litigation arising out of or relating to the Program must be commenced and prosecuted in the federal district court whose jurisdiction includes Lee County, Florida. Each participant, beneficiary, claimant or other person consents and submits to the personal jurisdiction over him or her of the federal district court whose jurisdiction includes Lee County, Florida in respect of any such action(s) or litigation. Each participant, beneficiary, claimant or other person consents to service of process upon him or her with respect to any such action(s) or litigation by registered mail, return receipt requested, and by any other means permitted by rule or law.

Claims and Appeals – Eligibility

If your claim relates to your eligibility for a particular coverage (for example, whether you are a full-time employee eligible for Long Term Disability coverage or whether you timely elected a particular benefit), send the claim directly to the Corporate Employee Benefits Department. In that event, the Corporate Employee Benefits Department and, if there is an appeal, the Committee will follow the procedures applicable to the type of coverage that is being sought (see below) except that, with respect to requests for coverage under a group health plan, questions regarding medical necessity, experimental treatment, expert advice, etc. will not apply. Also, if facts about your employment are relevant to your claim, you should submit with your claim any information regarding such employment that you believe to be pertinent.

If there is a final adverse determination of your claim, you generally would have the right to bring a civil action under ERISA. Refer to [Your Rights Under Federal Law](#) for additional information.

Claims and Appeals – Health Care Plans and Health Care FSA

The following procedures will apply to the processing of benefit claims and claim appeals submitted for the Medical Plans, Dental Plans, Vision Plan and Health Care FSA benefits, unless otherwise stated in a booklet provided by an HMO or insurer with respect to a specific insured benefit.

For Medical benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim. These rules would not apply to standalone dental or vision claims or to Health Care FSA claims.

Claim Procedure

Submission of Claim

Your claim for benefits should be submitted in accordance with the procedures described in the [Health Care](#) and [Flexible Spending Accounts](#) sections.

Definitions

For this claims procedure the following definitions apply:

Concurrent care decision – a decision made with respect to a course of ongoing treatment.

Pre-service claim – a claim that must be filed before any services are rendered or you obtain any supplies in order for you to receive the maximum benefits available under the plan (e.g., pre-certification of a hospital admission).

Urgent care claim – any pre-service claim for medical care or treatment that if not processed as an urgent care claim could:

- Seriously jeopardize the life or health of the claimant, or the claimant's ability to regain maximum function, or
- According to a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Post-service claim – any claim for a benefit for which advance approval is not required. Claims under the Health Care FSA are in this category.

Adverse Benefit Determination – An adverse benefit determination is any denial reduction or termination of, or a failure to provide or make payment (in whole or in part), for a benefit. An adverse benefit determination includes, for example, a decision to deny benefits based on:

- An individual being ineligible to participate in the Plan;
- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate;
- A concurrent care decision; or

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- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time.

Claim Review

When your claim is received, the Claims Administrator or applicable insurance company will evaluate whether a determination can be made on the claim or additional information is needed.

If your claim is complete, and no additional information is required, the Claims Administrator, or insurance company, will inform you of the approval or denial of the claim within:

- 72 hours after receipt of the claim for an urgent care claim (urgent care claims are generally responded to as soon as possible taking into account the medical exigencies),
- 24 hours after receipt of a request to extend a concurrent care decision involving urgent care (if made at least 24 hours prior to the end of the initially approved period of treatment)
- 15 days after receipt of the claim for a pre-service claim, or
- 30 days after receipt of a post-service claim.

If additional information is needed before a determination can be made, the Claims Administrator or applicable insurance company will notify you of the need for additional information within:

- 24 hours after receipt of the claim for an urgent care claim,
- 15 days after receipt of the claim for a pre-service claim, or
- 30 days after receipt of a post-service claim.

You will be provided with a description of the information that is needed, and an explanation of why it is needed before a claims determination can be made.

In the event that additional information is needed for an urgent health care claim, or an urgent health care claim is being denied in whole or in part, unless you have requested written notification, the Claims Administrator or applicable insurance company may notify you or your authorized representative orally. Written or electronic notice will be sent within three days after any oral notification.

If you wish to appeal a denied per-service request for Benefits, post-service claim or a rescission of coverage, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card;
- The provider's name;
- The date of medical service;
- The reason you disagree with the denial; and

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- Any documentation or other written information to support your request.

Concurrent Care Decision

- **Reduction in Approved Treatment** – In the event that the Claims Administrator or applicable insurance company determines that a previously approved ongoing course of treatment should not be covered at the level previously approved (for a reason other than amendment or termination of the plan under which you are covered) you will be provided with written or electronic notice of that determination. You will receive the notice sufficiently in advance of the effective date of the reduction in or termination of benefits so that you will have the opportunity to appeal, and obtain a decision on the appeal of the reduction or termination before it becomes effective.
- **Extension of Approved Treatment** – If you request an extension of an approved course of treatment (i.e., an increased number of treatments, or treatment over a longer period of time) at least 24 hours in advance of the conclusion of the previously approved treatment period, and the request constitutes an urgent care claim, you will be advised of the decision on your request in no more than 24 hours after your request is received. You may be advised of the determination on your request orally, unless you requested written notification. Any oral notification provided by the Claims Administrator or applicable insurance company will be followed by a written or electronic notice. If your request for extended treatment is denied in whole or in part, whether or not it involved urgent health care, you may appeal the determination as if it were a claim involving urgent care as described under [Benefit Denials and Appeal Procedure](#) in this section.

Submission of Additional Information

After you receive a notice that additional information is required, you must submit the necessary information within:

- 48 hours after receipt of the notice for an urgent care claim,
- 45 days after receipt of the notice for a pre-service claim, or
- 45 days after receipt of the notice for a post-service claim.

Review After Receipt of Additional Information

After the required additional information is received, the Claims Administrator or applicable insurance company will notify you of its decision to accept or deny your claim within:

- 48 hours after receipt of the additional information required for a determination on an urgent care claim,
- 30 days after initial receipt of the pre-service claim, or
- 45 days after initial receipt of the post-service claim.

Benefit Denials and Appeal Procedure

Benefit Denials

In the event of an adverse benefit determination in whole or in part, you will receive written or electronic notification of the denial. The notification will include:

- The date of service;

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- The health care provider;
 - The claim amount (if applicable);
 - The specific reason(s) for the adverse determination, including the denial code and its meaning;
 - Reference to the specific Plan provisions on which the determination is based;
 - A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
 - A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
 - In addition to the description of the Plan's internal appeal procedures, a description of the external review processes;
 - The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes;
 - A request for any additional information needed to reconsider the claim and the reason this information is needed;
 - If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
 - If the claim is incomplete, a description of any additional material or information necessary and an explanation of why such material or information is necessary;
 - For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical reasons for the determination, or a statement that the explanation is available, upon request, without charge;
 - A statement that you can receive reasonable access to, and copies of, all documents, records, or other information that is relevant to the claim, without regard to whether these documents, records and information were considered or relied upon by the insurance company or Claims Administrator, including any reports;

Note: A document, record, or information is relevant to the claim if it:

- Was relied upon in making the benefit determination,
- Was submitted, considered or generated in the course of making the determination whether or not it was relied upon,
- Demonstrates compliance with administrative processes or safeguards, or

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- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit, whether or not it was relied upon in making the determination.
 - For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice;
 - A description of the plan's review procedures and time limits, and
 - A statement of your rights to bring a civil action under ERISA following an adverse benefit determination on review.

Review on Appeal

The following section generally describes the Plan's internal claim appeals process.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. If your claim is denied in whole or in part, regardless of whether the claim was an urgent health care claim, a pre-service claim, or post-service claim, you will have 180 days after receiving the denial to appeal the decision on the claim. If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Program will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

When an appeal involves an urgent care claim:

- The appeal may be submitted orally, or in writing, and
- All necessary information, including the determination on review, will be transmitted by telephone, facsimile or other method available to ensure prompt receipt.

In connection with your appeal:

- You will be able to review your file and present evidence as part of the review,
- You may submit written comments, documents, records or other information relating to the claim,
- You may receive, free of charge, upon request, access to and copies of all documents, records, or other information relevant to your claim for benefits,
- You will be afforded a full and fair review that takes into account all such comments, documents, records, and other information, whether or not it was submitted or considered in the initial benefit determination and without deference to the initial benefit determination, and
- A health care professional with appropriate training and experience in the applicable field of medicine, who was not consulted in the original benefit determination, will be consulted with regard to the review of your appeal of a benefit denial based on a medical judgment, such as a determination that a particular treatment, drug or other item is experimental or investigational or not medically necessary or appropriate.

Decision on Appeal

You will be notified of a decision on your appeal within:

- 72 hours after receipt of the appeal of an urgent care claim,
- 30 days after receiving the appeal of a pre-service claim, or
- 60 days after receiving the appeal of a post-service claim.

You will receive a written or electronic notification of the decision on your appeal. In the event your appeal is denied, the notification also will include each of the items that are included in a notice of a claim denial.

External Review Program

If, after exhausting two levels of appeal, you are not satisfied with the final determination, you may choose to participate in the external review program. This program applies only if the adverse benefit determination is based on:

- Medical judgment; or
- Rescission of coverage.

To be eligible, you must:

- Be covered under the plan at the time the claimed health care item or services was requested or provided,
- Have exercised your available rights under the above claim and appeal procedures, and
- Provide all the information and forms necessary to process the external review.

The external review program is not available if the adverse benefit determination is based on explicit benefit exclusions or defined benefit limits. You must request an external review within 4 months after the date of receipt of an adverse benefit determination.

If your claim is eligible for external review, documentation provided during the internal review process will be provided to the independent review organization. The independent review organization may also review additional documentation. The independent review organization will not be bound by any decision or conclusions made during the plan's internal review process. The independent review organization will generally issue a detailed written decision within 45 days of receiving your claim. If the independent review organization reverses an earlier plan decision, the plan will provide coverage or payment.

An expedited external review is available if:

- A claimant receives an initial internal adverse benefit determination and following the generally applicable timeframes for the completion of an internal appeal would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function.
- A claimant receives a final internal adverse benefit determination following the generally applicable timeframes for the completion of a standard external review would seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function; or concerns the admission, availability of care, continued stay, or health care

item or service for which the claimant received emergency services and the claimant has not been discharged from a facility.

For additional details and specifics about standard and expedited external reviews, contact the Claims Administrator at the toll free number on your ID card for more information.

Important Information

No interest is payable on any benefits that are delayed or paid late.

During the internal appeals process you must raise all issues and legal theories you wish to have considered at any time during the internal or external administrative claims review process or any subsequent lawsuit.

For medical claims, the Claims Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claims Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claims Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications. Prior to making a benefit determination on review, the Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the medical Program (or at the direction of the Program) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Program's internal appeals process has been completed.

Exhaustion of Remedies

You cannot institute any action or proceeding for a claim for benefits under the Program until you have exhausted the procedures described in the sections of this SPD, or in the applicable brochures and certificates, relating to claims and appeals. See also [Claims and Appeals – Limitations and Venue](#) above.

Claims and Appeals – Long-Term Disability

Claim Procedure

The following procedures apply for long-term disability benefit claims and appeals.

Submission of Claim

Your claim should be submitted in accordance with the procedures described in the [Family Protection](#) section of this SPD.

Claim Review

You will be notified of a determination on your claim for LTD benefits within 45 days after your claim is received. If a decision cannot be made within 45 days after the claim is received, the time for a benefit determination may be extended for an additional 30-day period. In such case, you will be provided with a notice of the need for the extension and a description of the unresolved issues and any additional information required so that a resolution can be reached.

You will have at least 45 days from the date of the notice, advising you that additional information is required, to submit additional information.

Benefit Denials and Appeal Procedure

Benefit Denials

If your claim is denied in whole or in part, you will receive written notification of the denial. The notification will include each of the items specified, under the heading “Benefit Denials” in the section called [Claims and Appeals – Health Care Plans and Health Care FSA](#), with the exception of information relating to medical necessity and/or Experimental treatment.

Review on Appeal

If your claim for long-term disability benefits is denied in whole or in part, you will have 180 days after you receive notification of the denial in which to appeal the determination on your claim.

In connection with your appeal:

- You may submit written comments, documents, records or other information relating to the claim,
- You may receive, free of charge, upon request, access to and copies of all documents, records, or other information relevant to your claim for benefits, and
- You will be afforded a full and fair review that takes into account all such comments, documents, records, and other information, whether or not it was submitted or considered in the initial benefit determination and without deference to the initial benefit determination.

Decision on Appeal

You will receive a written notification of the decision on your appeal within 45 days after your appeal has been received. In certain circumstances, an extension of time may be required for the processing of your appeal. If an extension is required, you will be notified of the need for the extension within 45 days after your appeal has been received by the insurance company or Claims Administrator. The extension of time will not exceed 45 days from the end of the initial period. In the event your appeal is denied, the notification will include each of the items included in a notice of claim denial.

Exhaustion of Remedies

You cannot institute any action or proceeding for a claim for benefits under the Program until you have exhausted the procedures described in the sections of this SPD, or in the applicable brochures and certificates, relating to claims and appeals. See also [Claims and Appeals -- Limitations and Venue](#) above.

Claim Fiduciary

The Plan Administrator appoints the insurer as the Claim Fiduciary of the Long-Term Disability Plan. Under this appointment, Claim Fiduciary shall be responsible for adjudicating claims for benefit under the plan, and for deciding any appeals of adverse claim determinations. The Claim Fiduciary shall have the authority, in its discretion, to interpret the terms of the plan, including the Policies; to decide questions of eligibility for coverage or benefits under the plan; and make any related findings of fact. All decisions made by such Claim Fiduciary shall be final and binding on participants and beneficiaries of the plan to the full extent permitted by law.

Claims and Appeals – Life Insurance, AD&D and Dependent Care FSA

Submission of Claim

You, your covered dependent or your beneficiary may claim Program benefits by following the guidelines provided in the [Family Protection](#) and [Flexible Spending Accounts](#) sections of this SPD.

Decision of Claim

After you file a claim, you will receive a written or electronic explanation of your benefit payments from the insurance company or Claims Administrator. If your claim is denied in full or in part, the insurance company or Claims Administrator will notify you in writing (or electronically) within a reasonable period of time, but not later than 90 days after receipt of your claim.

- If special circumstances require an extension of time, you will be notified before the end of the 90-day period. This notice will indicate the special circumstances requiring an extension and the date within the additional 90-day period by which you can expect a decision.
- If you have not provided sufficient information to make a determination, you will be notified within 45 days of the specific information needed to complete the claim. You will then have 180 days to provide the information. The insurance company or Claims Administrator will then notify you of its determination within 45 days of the earlier of the Program's receipt of the additional information or the expiration of the 180-day period.

Benefit Denials and Appeal Procedure

Benefit Denials

If your claim is denied, the written notice of this denial will contain the following information:

- The specific reason or reasons for the denial,
- Specific reference to those Program provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the denial is based,
- If the claim is incomplete, a description of any additional information or material necessary for you to complete your claim and an explanation of why this material or information is necessary,
- A statement that you can receive reasonable access to, and copies of, all documents, records and other information relevant to the claim, without regard to whether the documents, records and information were considered or relied upon by the insurance company or Claims Administrator, including any reports and identities of any experts whose advice was obtained,

Note: A document, record or information is relevant to the claim if it:

- Was relied upon in making the benefit determination,
- Was submitted, considered or generated in the course of making the determination whether or not it was relied upon,

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- Demonstrates compliance with administrative processes or safeguards, or
 - Constitutes a statement of policy or guidance with respect to the Program concerning the denied treatment option or benefit, whether or not it was relied upon in making the determination.
 - An explanation of the Program's claim review procedure and the time limits applicable to this procedure, and
 - A statement of your right to bring a civil action under section 502(a) of ERISA if your claim is denied following appeal.

Review on Appeal

If your claim payment is not explained to your satisfaction, please contact your local Human Resources Representative or the Corporate Employee Benefits Department who will attempt to answer your inquiry. If you feel that you have not received an adequate explanation concerning the benefits paid, you have a legal right to appeal the denial of your claim.

If you disagree with a decision and you wish further consideration of your claim, you may make a written request for a review of the claim. Send your appeal to the Claims Administrator, or to the appropriate insurance company, at the address listed under [Important Names, Numbers and Addresses](#). The request must be made within 60 days after the original claim decision is received. Your written request may also include:

- A request for reasonable access to, and copies of, all documents, records and other information relevant to the claim, without regard to whether these documents, records and information were considered or relied upon by the insurance company or Claims Administrator, and
- Written comments, documents, records or other information relating to your claim for benefits.

Decision on Appeal

You will receive a written or electronic notice of the final decision within 60 days after a timely-filed written request for a review is received. If special circumstances require an extension of time for determining your appeal, the insurance company or Claims Administrator will render its decision as soon as possible, but not later than 120 days after receipt of your original appeal request.

- If your appeal is denied, the written notice of this denial will contain the following information: The specific reason or reasons for the denial,
- Specific reference to those Program provisions (including any internal rules, guidelines, protocols, criteria, etc.) on which the denial is based,
- A statement that you can receive reasonable access to, and copies of, all documents, records and other information relevant to the claim, without regard to whether these documents, records and information were considered or relied upon by the insurance company or Claims Administrator, including any reports, and identities of any experts whose advice was obtained; and

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- A statement of your right to bring a civil action under section 502(a) of ERISA if your claim is denied following appeal. However, this does not apply to claims under the Dependent Care FSA.

Exhaustion of Remedies

You cannot institute any action or proceeding for a claim for benefits under the Program until you have exhausted the procedures described in the sections of this SPD, or in the applicable brochures and certificates, relating to claims and appeals. See also [Claims and Appeals – Limitations and Venue](#) above.

Important Names, Numbers and Addresses

Legal Plan Name

Hertz Custom Benefit Program

Plan Number

505

Plan Year

The Plan Year is the 12-month period beginning each July 1 and ending the following June 30.

Plan Administrator

Hertz Benefits Committee
The Hertz Corporation
8501 Williams Road
Estero, FL 33928
239-301-7000

Employer

The Hertz Corporation
8501 Williams Road
Estero, FL 33928
239-301-7000

Participating Affiliates

A list of participating affiliates is available upon request from the Plan Administrator.

Employer Identification Number

Hertz is identified by EIN 13-1938568, which is the employer identification number assigned to the Company by the Internal Revenue Service for tax purposes.

Agent for Service of Legal Process

Executive Vice President and Chief Human Resources Officer
The Hertz Corporation
8501 Williams Road
Estero, FL 33928

(Legal process may also be served on the Plan Administrator.)

Privacy Officer

Corporate Employee Benefits Department
The Hertz Corporation
8501 Williams Road
Estero, FL 33928

BenefitsPlus

The BenefitsPlus website can be found at www.hertz.com/benefitsplus.

COBRA Administrator

888-993-4646

AskHr

AskHR can be reached at 800-654-3373.

Hawaii Plan Information

The Program applies to residents of Hawaii. This section describes additional terms of the Program that apply to residents of Hawaii.

Eligibility and Enrollment

Except as provided below, the Program's eligibility and enrollment requirements are the same for residents of Hawaii. See the section titled [Program Membership](#) in the [General Information](#) section of this SPD.

Eligibility – Employee

If you reside in Hawaii, you are eligible to participate in the Hertz Custom Benefit Program if:

- You are an employee of the Company, or of an affiliate of the Company that has adopted the Program, and
- You are a full-time employee or part-time employee who works an average of at least **20** hours a week.

See the section titled [Program Membership](#) for more information about eligibility.

When Coverage Begins

If you meet the eligibility terms, your elected coverage takes effect on the first day of the month following 28 continuous days of employment. The period between your hire date and the date your coverage takes effect is called a "waiting period." For example, if you are hired on August 15 and work continuously, your elected coverage will take effect on October 1.

See the section titled [Program Membership](#) for more information about coverage.

Coverage If You Do Not Enroll — Default Coverage

If you do not enroll when you are initially eligible, you will be automatically enrolled in Life Insurance coverage of one times your base pay.

Transferring Into or Out of Hawaii

If you transfer into or out of Hawaii from another location (into or out of the HMO or Dental Plan service area), you will have the opportunity to make a new benefit election. If you are enrolled in medical or dental coverage before the transfer, you will be automatically enrolled in the lowest cost medical and/or dental option unless you make a change. If you did not have coverage, you will default to no coverage unless you make a change.

Declining Medical Coverage

For medical coverage, if you decide to decline coverage because you have medical coverage elsewhere, you must sign a State of Hawaii Department of Labor waiver form HC-5 when you become eligible and each calendar year thereafter that you decline coverage.

Working Spouse/Domestic Partner Additional Contribution

If your spouse or domestic partner is eligible to elect medical coverage through his or her employer but chooses not to enroll in that medical plan, you must pay an additional charge to enroll your spouse or domestic partner in the Medical Plan offered through this Program. The Working Spouse/Domestic

Partner Additional Contribution amount applicable to you will be communicated to you during your enrollment.

Benefit Options

Participants who reside in Hawaii have different medical, dental, and vision benefits and program options than those offered to other participants. You must read this SPD, together with the additional information provided by the Hawaii Claims Administrators (described below), in order to understand your benefits. The following coverage is available to Hawaii residents:

Coverage	Program Options	Where to Find More Information
Medical	Kaiser Permanente – HMO Kaiser Permanente – Added Choice	Benefits Summary (available on BenefitsPlus)
Dental	Hawaii Dental Plan 1 Hawaii Dental Plan 2	Group Plan Brochure & Summary of Benefits (available on BenefitsPlus)
Vision	The option described in this SPD applies to residents of Hawaii, but the benefits offered by the Vision Plan are different	Group Vision Insurance Certificate (available on BenefitsPlus) and the section titled Vision Plan in the Health Care section of this SPD
Life Insurance and Dependent Life Insurance	The options described in this SPD apply to residents of Hawaii	The sections titled Life Insurance Plan and Dependent Life Insurance Plan in the Family Protection section of this SPD
AD&D Insurance and Dependent AD&D Insurance	The options described in this SPD apply to residents of Hawaii	The section titled Accidental Death and Dismemberment Plan in the Family Protection section of this SPD
Long-Term Disability Insurance	The option described in this SPD applies to residents of Hawaii	The section titled Long-Term Disability Insurance Plan in the Family Protection section of this SPD
Health Care Flexible Spending Account	The option described in this SPD applies to residents of Hawaii	The section titled Health Care Flexible Spending Account in the Flexible Spending Accounts section of this SPD
Dependent Care Flexible Spending Account	The options described in this SPD applies to residents of Hawaii	The section titled Dependent Care Flexible Spending Account in the Flexible Spending Accounts section of this SPD

Third Party Administrator (TPA) and Plan Insurers

The following list is current as of July 1, 2017, and is subject to change. These are the addresses to which you should submit claims and appeals.

Plan Type	Provider Name	Address	Phone Number	Group Number
Choice Plan A, Consumer Health Account Plans and Economy Medical Plan	UnitedHealthcare	PO Box 740800 Atlanta, GA 30374-0800	800-440-5276	709759
Prescription Drug Plan	OptumRx	PO Box 968022 Schaumburg, IL 60196	Customer Service 855-871-6277	HERTZ
Specialty Prescription Drugs	Walgreens Specialty Pharmacy		866-823-2712	HERTZ
Hawaii Medical Plans (HMO & POS)	Kaiser - HI	711 Kapiolani Blvd. Honolulu, HI 96813	808-432-5955	313/11
Dental Plans B, C and DHMO	Cigna Dental	PO Box 188037 Chattanooga, TN 37422	800-CIGNA-24	3203424
Hawaii Dental Plans 1 & 2	Hawaii Dental Service (HDS)	700 Bishop Street Suite 700 Honolulu, HI 96813-4196	800-232-2533 ext 248	943
Flexible Spending Accounts	UnitedHealthcare (TPA)	PO Box 981506 El Paso, TX 79998	800-440-5276	709759
Vision	EyeMed	PO Box 8504 Mason, OH 45040-7111	866-723-0513	9718925
Life Insurance	Aetna	PO Box 14579 Lexington, KY 40512-4549	800-523-5065	285660
Accidental Death and Dismemberment (AD&D)	Arch Life Insurance Co. of America	Administrative Concepts, Inc. 994 Old Eagle School Road, Suite 1005 Wayne, PA 19087-1802	888-293-9229	11ADV8174000
Disability (STD and LTD)	Sun Life Financial	One Sun Life Executive Park Wellesley Hills, MA 02481	800-424-0929	244172

This Summary Plan Description is provided for informational purposes.
It is not a contract of employment between you and Hertz.
It does not cover all provisions, limitations and exclusions. There are official plan documents, policies and certificates of insurance that govern in all cases.