Retiree Benefits Guide

(For Retirees who retire on or after 11/01/12)

American Airlines provides retirees with a comprehensive benefits package designed to help you meet the health and insurance needs of you and your eligible dependents.

To help you make the most of your retiree benefits, this Guide describes the major provisions of the benefits and explains how you can use them effectively. In addition to the descriptions of the benefits provided and how each plan works, this Summary Plan Description also provides general and plan specific information.

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About This Guide

This Health & Life Benefits Guide for Retirees ("Guide") contains the legal plan documents and the summary plan descriptions (SPDs) for the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries and the American Airlines, Inc. Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries and the Long Term Care Insurance Plan for Employees of participating AMR Corporation Subsidiaries (the "Plans") as it pertains to retiree medical, supplemental medical, long term care and life insurance coverage.

The provisions of this Guide apply to eligible retirees of the participating subsidiaries of AMR Corporation (who were on the United States payroll), spouses, dependents and surviving spouses who are covered under the benefit program for Retirees. The Company reserves the right to modify, amend or terminate any of the Plans, any program described in this Guide, or any part thereof, at its sole discretion. Changes to the Plans generally will not affect claims for services or supplies received before the change.

Only the Pension Benefits Administration Committee (PBAC) and the Benefits Strategy Committee are authorized to change the Plans.

Voluntary Offerings Provided by American Benefits Consulting (ABC) American makes accessible for employees the opportunity to enroll in: Hyatt Legal, Group Homeowners' and Automobile Insurance, Veterinary Pet Insurance, LifeLock, Group Accident and Critical Illness Insurance at a discounted rate. At the request of the employee, American facilitates the post-tax payroll deductions to pay for these voluntary offerings. American does not assume any plan sponsorship for the Voluntary Offerings provided by American Benefits Consulting. The details of these offerings are not included or governed in this Employee Benefits Guide (Summary Plan Descriptions). Please go to www.AAaddedbenefits.com or call 1-855-550-0706 to contact ABC directly for information about these benefits

Am I eligible?

In this section, you will find information to help you determine if you (and any eligible dependents) are eligible for Retiree Medical Benefits. This guide is designed for former employees who retire(d) on or after 11/01/2012. If you retired prior to this date, refer to the Retiree Benefits Guide for former employees who retired on or before 10/31/2012.

Contents of "Am I Eligible?" Section:

Retiree Medical Benefits – General Eligibility

These general guidelines apply to retirees from ALL workgroups:

Universal Eligibility – All Workgroups

You may enroll yourself and request to enroll your eligible dependents in Retiree Medical Benefits effective the first day immediately following your last day on active payroll if you meet ALL of the criteria on the following checklist:

- ❑ At least age 55
- ❑ Under age 65
- ❑ Have at least 10 years of Company seniority

Specific universal eligibility questions and answers that may help you further determine your eligibility are provided below.

Can I enroll if I left the Company after my 50th birthday, but before turning 55?

You may be eligible for Retiree Medical Benefits to begin at age 55 and up to the attaining age (65), if you meet ALL criteria in the following checklist:

- ❑ Retired from any workgroup, other than Pilot
- ❑ Have at least 15 years of Company seniority
- ❑ Are between ages 50 and 55 when employment ends
- ❑ Have qualified to leave the company under the 50-55 Rule

What if I am eligible for Retirement, but not ready to enroll?

You may enter Retiree Medical Benefits when you first become eligible or you can defer enrollment to a later date…

- one time only
- from the date you are eligible until the first of the month of your 65th birthday
- if your 65th birthday is the first of the month, you may choose to defer until the first day of the previous month
- if you are covered as a dependent under your spouse's active medical coverage or you obtain active medical coverage from another employer

You will need to contact HR Services to initiate Retiree Medical Benefits enrollment, when you are in a deferred retiree medical status before you turn age 65.

Retiree Married to an Active AA or AE Employee

Specific Retiree Married to Active Employee questions and answers are provided below that may help you further determine your eligibility.

May I enroll if I am married to an active AA or AE employee?

You may decide to be covered as a dependent under your spouse or Company-recognized Domestic Partner's active medical benefit and defer your retiree medical enrollment, if you meet universal eligibility criteria.

Make sure you complete this checklist:

- ❑ The active employee (your spouse/DP) must complete a Life Event via the Benefits page of Jetnet within 60 days following your exit of the active medical benefits
- ❑ You must defer your entry into Retiree Medical Benefits (as described above)

If you lose your dependent status (e.g. if you divorce) or when your active-employee-spouse/DP retires or terminates employment, you may enroll and activate the retiree coverage you previously deferred by contacting HR Services before you turn age 65.

What if my spouse (who is an active employee) and I have a child who we cover as a dependent?
The child/ren are covered under the parent who is an active employee. Even if each parent carries separate benefit coverage (one on Active coverage and one on Retiree coverage), the child/ren may not be covered under both parents' health benefits.

Retiree Married to Retirees of Participating AMR Subsidiary
Specific Retiree Married to Active Employee questions and answers are provided below that may help you further determine your eligibility.

What if I am married to another Company Retiree (of a Participating AMR Corp. Subsidiary)?
Use the questions in the chart below to determine which situation applies for you.

1. Are you each a retiree of American Airlines and eligible for your own Retiree Medical Benefits?	
If YES,	You must each maintain your own individual coverage. By maintaining your Retiree Medical Benefits separately, the death of your spouse or a divorce will not jeopardize your eligibility.
If NO,	You may cover your spouse as a dependent under your Retiree Medical Benefits coverage, if either of the following apply: • Your spouse/DP's workgroup does not offer Retiree Medical Benefits coverage • Your spouse/DP worked for a subsidiary and did not meet the eligibility requirements for the Retiree Medical Benefit
2. Do you have eligible dependent children?	
If YES,	**Are both you and your spouse/DP concurrently covered by Retiree Medical Benefits?**
	The children are covered as dependents of the parent whose **birthday occurs first in the calendar year, unless the parents elect** otherwise (Contact HR Services to make this adjustment). Children may not be covered under both parents' health benefits.
NO	Children are not eligible for benefits under a parent who is not enrolled in benefits; does not apply

Retirees Age 65 or Over
Specific Retiree Age 65 or Over questions and answers are provided below that may help you further determine your eligibility.

What happens when I reach age 65?
If you retire on or after your 65th birthday, you are not eligible for Retiree Medical Benefits. Guaranteed-Issue Medicare Supplement Insurance may be available for you and/or your spouse to purchase upon reaching age 65.

Coverage is available until age 65. Use the chart below to answer questions for specific coverage situations.

If I retire before age 65…	
When will I no longer be eligible for Retiree Medical Benefits?	When Medicare becomes your primary coverage
	On the first day of the month in which you turn 65. Or, if your birthday falls on the first day of the month, Medicare becomes primary for you the month prior to your 65th birthday
But my spouse/DP is age 65 or over?	He/she is not eligible for coverage under Retiree Medical Benefits.
May my dependents continue coverage after I turn 65?	If your spouse/DP is under age 65…
	• Yes, he/she is eligible for coverage and can enroll in Retiree Medical Benefits (Split Coverage) under his/her own coverage
	• Your dependent child/ren will be eligible under the spouse's coverage until one of the following occurs… ❑ Spouse/DP turns 65 ❑ Spouse/DP reaches his/her Maximum Medical Benefit ❑ The dependent turns age 19 or age 23 if a full time student

Retiree Medical Benefits – Disability Eligibility

This section details your eligibility for the Retiree Medical Benefit, if you become disabled as an active employee.

All Workgroups Except Pilots – Medical Disability Benefits

If you become disabled as an active employee, you may also become eligible for Retiree Medical Benefits.

When your Company-sponsored active health coverage ends, you may be eligible to enroll in Retiree Medical Benefits if you meet ALL criteria on this checklist:

- ❑ You have at least 10 years of Company seniority
- ❑ You applied for Social Security disability benefits before the end of your one-year sick leave
- ❑ Your Social Security disability benefits were approved with an effective date that falls within your one-year sick leave
- ❑ A separation/resignation PTR has been processed
- ❑ You are current on your contribution payments

You will be billed for coverage and need to pay the appropriate monthly cost listed on your direct bill invoice by the specified deadline.

Pilots – Medical Disability Benefits

While remaining disabled and receiving disability benefits from the Pilot Long Term Disability (LTD) Plan, you may maintain the same health and welfare benefits you had while you were an active employee. If you retire and are eligible for Retiree Medical Benefits, you will go off of the active plan onto the retiree plan. When you reach age 65, the Pilot LTD Plan benefits terminate, and you are not eligible for the Retiree Medical Benefits.

Specific questions and answers that may help you further determine your disability eligibility are provided below.

What happens if I am able to resume being an active Pilot, after being enrolled in Retiree Medical due to a disability (pre-2/1/2004 disabled pilots only)?

You will be eligible for active medical as an active employee. Refer to the Employee Benefits Guide for active Pilots.

What happens if I become disabled while already enrolled in Retiree Medical?

Your eligibility is not affected by the disability, you will see a change in how claim payments are applied as Medicare now becomes your primary and Retiree Medical Benefits will be secondary to Medicare.

Retiree Medical Benefits – Workgroup Specific Eligibility

In addition to the general eligibility guidelines previously discussed, some workgroups have additional requirements and limitations to eligibility for Retiree Medical Benefits.

Am I eligible, if I am a…

- ❑ **Flight Attendant and terminate employment under Article 30 after 09/12/2012?**
  No, you are not eligible for Retiree Medical Benefits.
- ❑ **Pilot and retire on or after my 50th birthday?**
  Yes, you are eligible for Retiree Medical Benefits to begin at age 50 and up to attaining age (65), as long as you have at least 10 years of Company seniority

Retiree Medical Benefits – Dependent Eligibility

Within this section, you will find information to help you determine if any dependents you may have are eligible for coverage under the Retiree Medical Benefits.

The Plan considers an eligible dependent as any individual who is related to you (the retiree) in one of the following ways:

- Spouse or Company-recognized Domestic Partner not covered as an employee or retiree under a medical benefit sponsored by the Company
- Unmarried child under age 19
- Unmarried incapacitated child age 19 or over who meets all criteria as outlined later in this section
- Unmarried child up to age 23, if the child is:
  - ❑ Registered as a full-time student at an educational institution in a program of study leading to a degree or certification (proof of continued eligibility will be required by your claims administrator periodically)
  - ❑ AND either of these apply:
    - The child maintains legal residence with you
    - You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) issued by the court or a state agency

Specific Dependent Eligibility questions and answers follow that may help you further determine your eligibility is provided below.

What if my child, who is a full-time student, due to medical reasons, had to reduce or terminate his/her studies?

Provided he/she previously met all eligibility requirements to be covered as a dependent, coverage may continue for up to 12 months (one year), if both of the following criteria are met:

- ❑ The child must be under a physician's care.
- ❑ Statements confirming the child's medical condition and student status must be provided from the child's attending physician and educational institution to your Network/Claims Administrator.

After 12 months (one year), coverage will end unless the child returns to the education institution full-time or meets the definition of an incapacitated child.

Determining a Child's Eligibility

Use this chart to assist in determining if your child is eligible for dependent coverage under your Retiree Medical Benefits.

For the purposes of determining eligibility, when the term "child" is used throughout this guide it includes, all of the following:

<table>
<tr><td colspan="3">Natural child</td></tr>
<tr><td colspan="3">Legally adopted child</td></tr>
<tr><td colspan="3">Incapacitated child</td></tr>
<tr><td colspan="3">Natural or legally adopted child of a covered Company-recognized Domestic Partner(DP)</td></tr>
<tr><td>Stepchild</td><td rowspan="3">If all of the following requirements are met…</td><td>• the child lives with you, AND
• you (the retiree) either jointly or individually claim the stepchild as a dependent on your federal income tax return</td></tr>
<tr><td>Stepchild of your Company-recognized DP</td><td>• the child lives with you, AND
• your Company-recognized DP claims the child on his/her federal income tax return, AND
• the tax return indicates the same address as yours, AND
• your Company-recognized DP is enrolled as a dependent on your Retiree Medical Benefits</td></tr>
<tr><td>Special Dependent</td><td>• You have legal custody and legal guardianship of the child
• The child maintains legal residence with you and is dependent on you for maintenance and support
• You submit a Statement of Eligibility for Special Dependent form to HR Services
• HR Services approves the form (see details below)</td></tr>
<tr><td>Child you are required to provide coverage for</td><td>If either of the following apply</td><td>• under a Qualified Medical Child Support Order (QMCSO) issued by the court
• a National Medical Support Notice issued by a state agency</td></tr>
</table>

What do I need to do to show eligibility for a Special Dependent?
You must submit a Statement of Eligibility for Special Dependent form to HR Services and HR Services must approve the form. Follow these steps:

1. Complete and return the form to HR Services, along with copies of the official court documents awarding you custodianship or guardianship of the child.
    - This must be submitted within 60 days of the date that legal guardianship or legal custodianship is awarded by the court
    - If you submit the request after the 60-day timeframe, the child will not be added to your coverage for the current plan year, but you may add the child during Annual Benefits Enrollment for subsequent plan years.

2. Receive a confirmation letter from the claims administrator notifying you of its determination on eligibility
3. If approved, the notification letter will include an approval date
4. If approved, the child's coverage will be effective as of the date that legal guardianship or legal custodianship is awarded by the court

Coverage for an Incapacitated Child

How can I get coverage for an Incapacitated Child?
The child is eligible if ALL of the following criteria are met:

- ❑ The child was covered as your dependent under this Plan before reaching age 19 (or age 23 if registered as a full-time student before reaching age 23)
- ❑ The child is mentally or physically incapable of self-support
- ❑ You submit your request for Incapacitated Child status BEFORE the child's coverage under the Plan ends
- ❑ You submit a Statement of Dependent Eligibility for Incapacitated Child within the specified timeframe based on your Network/Claims Administrator:
  - For UnitedHealthcare: Within 60 days of the date coverage would otherwise end
  - For Blue Cross and Blue Shield of Texas: Within 45 days of the date coverage would otherwise end
  - For Aetna: Within 90 days of the date coverage would otherwise end
  - For the RHMO: Contact Humana. See "Contact Information" in the *Reference Information* section
- ❑ Your Network/Claims Administrator approves the application
- ❑ The child continues to meet the criteria for dependent coverage under this Plan
- ❑ You provide additional medical proof of incapacity as may be required by your Network/Claims Administrator from time to time
- ❑ And either of these apply:
  - The child maintains legal residence with you and is wholly dependent on you for maintenance and support
  - You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) issued by the court or a state agency.

If coverage is terminated for my Incapacitated Child, can it be reinstated?
No, if you do not provide proof of incapacity as may be required, if your Network/Claims Administrator determines the child is no longer incapacitated, or if you elect to drop coverage for your child, you may not reinstate at a later date.

Determining a Spouse (SP), Domestic Partner (DOMESTIC PARTNER (DP)) or Common Law Spouse Eligibility

Spouse (SP)

An opposite-sex spouse or same-sex spouse is referenced through this benefit guide as "Spouse". Please see the below definitions of opposite-sex spouse and same-sex spouse to understand eligibility requirements for spouse coverage under Americans benefits.

Opposite-Sex Spouse

Your opposite-sex spouse to whom you are legally married If you and your spouse were married outside the United States or the aforementioned territories/protectorates, you and your spouse must have been legally married to you in the country/jurisdiction where your marriage took place. Your marriage must be legally documented via marriage certificate from the state or country government that permitted and certified your marriage. You and your spouse must not be married to, or have a DOMESTIC PARTNER (DP), common law, or other spouse-like relationship with any other person(s) at the same time you are married to each other.

Same-Sex Spouse

As a result of change to the federal Defense of Marriage Act (DOMA), the Plan(s) now recognizes same-sex marriage for purposes of benefit eligibility, provided you and your same-sex spouse were legally married in one of the states, territories, or protectorates that recognize same-sex marriage. Adding your same-sex spouse to your benefits accords your same-sex spouse the same eligibility and coverage's available to any other company employee and his/her opposite-sex spouse. If you and your same-sex spouse were married outside the United States or the aforementioned territories/protectorates, you and your same-sex spouse must have been legally married in the country/jurisdiction where your marriage took place. Your marriage must be legally documented via marriage l/certificate from the state or country government that permitted and certified your marriage. Furthermore, you and your same-sex spouse must not be married to, or have a DOMESTIC PARTNER (DP), common law, or other spouse-like relationship with any other person(s) at the same time you are married to each other. Requirements for your same-sex spouse to be eligible for coverage under the Plan(s) are:

- You and your same-sex spouse were legally married in one of the U.S. states, districts, territories, protectorates or other countries or jurisdictions that has legalized same-sex marriage

Common Law Spouse

Common law spouses are eligible for enrollment in Plan benefits only if your common law marriage is recognized and deemed (certified) legal by the individual state where the employee resides, and only if the employee and spouse have fulfilled the state's requirements for common law marriage. To enroll your common law spouse for benefits, you must complete and return a Common Law Marriage Recognition Request and provide proof of common law marriage, as specified on the

form. You and your common law spouse must not be married to, or have a DOMESTIC PARTNER (DP), common law, or other spouse-like relationship with any other person(s) at the same time you are in a common law marriage to each other. Requirements for your common law spouse to be eligible for coverage under the Plan(s) are:

Although criteria vary by state, the following guidelines usually apply:

- The couple cohabitates for a specified period of time established by the state.
- The persons recognize each other as husband and wife.
- The persons hold each other out publicly as husband and wife.

Company-Recognized Domestic Partners (DOMESTIC PARTNER (DP))

Company-recognized Domestic Partners are defined by American Airlines, Inc. as two people in a spouse-like relationship who meet all of the following criteria:

- Are the same gender
- Reside together in the same permanent residence and have lived in a spouse-like relationship for at least six consecutive months
- Are both at least 18 years of age and are not related by blood in a degree that would bar marriage
- Are not legally married or the common law spouse or Company-recognized Domestic Partner of any other person
- Submit a complete and valid Declaration of Company-recognized Domestic Partnership from the Domestic Partner Enrollment Kit.

After reviewing the Company-recognized Domestic Partner Enrollment Kit, if you need additional information regarding benefits and privileges available to Company-recognized Domestic Partners, please contact HR Services (see “Contact Information” in the reference Information section).

Company-recognized Domestic Partners and their eligible dependent children are eligible to be covered under the following benefits or Plans:

- STANDARD, VALUE, CORE, and OUT-OF-AREA Medical Options

  Note: Home-Based Representatives or Level 84 Premium Services Representatives are only eligible for the CORE Medical Option.
- Dental Benefit
- Vision Insurance Benefits
- Spouse and Child Life Insurance Benefits
- Retiree Medical Benefits
- Accident Insurance Benefits

Under current laws, a Company-recognized Domestic Partner and his or her dependent children are not eligible for certain health and welfare benefits under an ERISA-governed plan. Company-recognized Domestic Partners are not eligible to participate in:

- Flexible Spending Accounts (your Company-recognized Domestic Partner's health care expenses may not be reimbursed from:
- Your Health Care FSA or your Limited Purpose Health Care FSA or Health Savings Account

Company-recognized Domestic Partners may be eligible to participate in Health Maintenance Organizations (HMOs). Contact your HMO directly for eligibility criteria. Home-Based Representatives or Level 84 Premium Services Representatives and their dependents are not eligible to enroll in an HMO.

Proof of Eligibility

What is Proof of Eligibility (POE)?

The Company reserves the right to request documented proof of dependent eligibility for benefits at any time. When first adding a new dependent you will be required to provide POE for that dependent. Coverage is considered "requested" until the correct documentation for Proof of Eligibility is received and approved. It is important to provide accurate and true documented proof when requested to ensure continued coverage for the dependent. If such proof is not provided, your dependent may lose coverage and you may be required to pay back any overpaid benefits. The details about what POE you should submit to prove your dependent meets the eligibility requirements can be found on Jetnet.

When do I need to provide POE?

You must submit, to HR Services, proof of the dependents' eligibility within 60 days of the date you request to enroll them. This applies to each of the following situations, when you:

- Enroll dependents while you are first eligible to enroll in benefits
- Enroll new dependents at annual enrollment
- Enroll new dependents as the result of a Life Event

What type of documentation is considered POE?

Acceptable documents for proof of dependent eligibility include (but are not limited to) official government-issued birth certificates, adoption papers, marriage licenses, court orders, etc. A detailed listing can be found on Jetnet, within the Proof of Eligibility Requirements.

What happens to coverage for my dependents if I die?

Eligibility will be different for your spouse, Domestic Partner and child/ren. Refer to the chart below to assist in determining eligibility in this situation.

Dependents of Deceased Retirees

If your dependent is a:

<table>
<tr><td rowspan="3">Surviving Spouse of a Retiree on Retiree Medical Benefits coverage
(with or without children)</td><td colspan="2">Coverage depends on your spouse’s age at the time of your death.</td></tr>
<tr><td>Spouse Under age 65</td><td>He/she may continue Retiree Medical Benefits coverage until one of the following first occurs, at which time coverage ends.
• Your spouse reaches age 65
• Your spouse becomes eligible for Medicare
• Your spouse remarries</td></tr>
<tr><td>Spouse Age 65 or over</td><td>There is no Retiree Medical Benefits coverage for retirees or surviving spouses/DPs age 65 or over</td></tr>
<tr><td rowspan="3">Surviving Spouse of an Active employee over age 55
(with or without children)</td><td rowspan="3">Spouse Under age 65</td><td>Your spouse/DP is eligible for Retiree Medical Benefits coverage, as long as you were otherwise eligible for this coverage at the time of your death</td></tr>
<tr><td>He/she may continue Retiree Medical Benefits coverage until one of the following first occurs, at which time coverage ends.
• Your spouse reaches age 65
• Your spouse becomes eligible for Medicare
• Your spouse remarries</td></tr>
<tr><td>When your spouse’s coverage ends, he/she may be eligible to elect Continuation of Coverage under COBRA*</td></tr>
<tr><td rowspan="2">Company-recognized Domestic Partner (DP)</td><td rowspan="2">Covered under Retiree Medical Benefits at the time of your death</td><td>He/she may continue coverage for the 90 days immediately following your death</td></tr>
<tr><td>At the end of the 90-day period, he/she may elect Continuation of Coverage under COBRA*</td></tr>
<tr><td>Child/ren
(without surviving spouse)</td><td rowspan="2">Covered under Retiree Medical Benefits at the time of your death</td><td rowspan="2">Coverage ends upon your death
Your children may elect Continuation of Coverage under COBRA*</td></tr>
<tr><td>Dependent children of your Company-recognized DP</td></tr>
</table>

*(See “COBRA Continuation of Coverage” in the Additional Health Benefit Rules section for more information.)

Parents and Grandchildren

If my parents or grandchildren live with me can I cover them as dependents on my Retiree Medical Benefits?
Neither your parents nor grandchildren are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchild's legal guardian as outlined above in "Determining a Child's Eligibility").

Additional Eligibility Requirements

This section provides a checklist to determine if you are eligible to participate in the Retiree Value Plus (RVP) or Retiree HMO (RHMO) options.

Retiree Value Plus Eligibility

May I voluntarily elect to participate in the RVP Option?
Yes, To be eligible for the RVP option, you must meet ALL requirements on the following checklist:

- ❑ Meet all other retiree eligibility requirements, as defined in the provisions of Retiree Medical Benefits
- ❑ Be under age 65
- ❑ Have not reached your Maximum Medical Benefit under a Company-sponsored medical benefit (this includes the Retiree Standard Medical Option)
- ❑ Reside where your Network/Claims Administrator offers a network
- ❑ Did not terminate employment under Article 30 (this applies to Flight Attendants only)
- ❑ Did not elect to waive or voluntarily and permanently opt out of Retiree Medical Benefits
- ❑ Did not retire under the 1995 SVEOP (Special Voluntary Early Out Program)
- ❑ Are not a TWA retiree

RHMO Eligibility
If you are eligible to enroll in the RHMO, it will appear as an option in Benefits Service Center when you enroll.

I live in Puerto Rico, can I voluntarily elect to participate in the RHMO Option?
To be eligible for the RHMO option, you must meet all requirements on the following checklist:

- ❑ Meet all other retiree eligibility requirements, as defined in the provisions of Retiree Medical Benefits
- ❑ Be under age 65
- ❑ Have not reached your Maximum Medical Benefit under a Company-sponsored medical benefit (this includes the RHMO)
- ❑ Reside where the RHMO offers a network
- ❑ Did not terminate employment under Article 30 (this applies to Flight Attendants only)
- ❑ Did not elect to waive or voluntarily and permanently opt out of Retiree Medical Benefits
- ❑ Did not retire under the 1995 SVEOP (Special Voluntary Early Out Program)
- ❑ Are not a TWA retiree

What does it mean to reside where a Network/Claims Administrator or RHMO offers a network?
These two voluntary Retiree Medical Benefits options (RVP and RHMO) are limited to networks in specific geographical areas. Therefore your eligibility for the RVP and RHMO is determined by the ZIP code of your alternate address on record.

Many retirees maintain more than one residence, you may list both addresses in Jetnet and your alternate address determines your geographical Retiree Medical Benefits eligibility. If you do not have an alternate address listed in Jetnet, your eligibility is based on your permanent address. If you do not reside where your Network/Claims Administrator offers a network, you will be offered the Retiree Standard Medical Option. Remember, within Jetnet you may list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence).

My covered dependent child does not live with me, how will the RHMO coverage work for him/her?
If your child does not live with you, either because the child is a student or because you are providing the child's coverage under a Qualified Medical Child Support Order (QMCSO), you must contact the RHMO to find out if your child can be covered. If the RHMO cannot cover your child, you may be required to select the Retiree Standard Medical Option or the Retiree Value Plus Option for your entire family.

The Company reserves the right to alter, amend, modify or terminate the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries (the "Plan") or any part thereof at its discretion. Changes will not affect valid claims incurred before the change(s) allowed under the appropriate plan or program terms. For more information, contact HR Services.

What am I eligible for?

In this section, you will find information about each of the Retiree Medical Benefit Options, plan administrators, and coverage levels. Utilize the Comparison Chart to learn the basics of each option and refer to the detailed summary pages for each benefit to better understand how the coverage works.

Contents of the "What Am I Eligible for?" Section:

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Retiree Medical Benefit Options Overview

Eligible retirees will be offered access to one of two Company-sponsored retiree medical options: the Retiree Standard Medical (RSM) or the Retiree Value Plus (RVP). In addition, Puerto Rico residents will be offered access to the Retiree HMO (RHMO) Option.

Overview Comparison Chart

The following chart provides an overview of features under the RSM and RVP Options. As you review the comparison charts, keep the following in mind:

- Benefits are available for eligible expenses that are medically necessary.
- The charts show the amount or percentage you pay for eligible expenses. You will be responsible to pay any amounts not covered by the plan.
- Out-of-network expenses incurred…
  - Under the RSM option, must also fall within the usual and prevailing fee limits.
  - Under the RVP option, must also fall within 140% of Maximum Out-of-Network Reimbursement Program (MNRP) fee limits.
- Visit your Network/Claims Administrator's website to determine if your physician is an in-network provider.
- The out-of-pocket max does NOT include any of the following:
  - Deductibles
  - Co-pays
  - Amounts not covered by the plan
  - Amounts exceeding the usual and prevailing fee limits
  - Amounts for services covered at 50% (RSM only)
  - Amounts exceeding 140% of MNRP limits (RVP only)
  - Mail Order pharmacy co-pays or co-insurance amounts (RSM only)
  - All pharmacy co-pays and co-insurance amounts (RVP only)

Overview Comparison Chart Overview Comparison Chart				
	Retiree Standard Medical (RSM)		**Retiree Value Plus (RVP)**	
Individual Maximum Medical Benefit	$300,000		$1,000,000	
	Amount you will pay if you are covered by…			
	RSM and utilize a		**RVP** and utilize a	
	In-Network Provider	**Out-of-Network** Provider	**In-Network** Provider	**Out-of-Network** Provider
Annual Deductible	$150 (individual) $400 (family)		$250 per person	$750 per person
Annual Out-of-Pocket Max	$1,000 (individual) $3,000 (family)		$1,750 per person for services that require you pay 15%	No Limit
Co-Insurance	20%	40%	15%	35%
	After deductible is met			
MEDICAL CARE All services must be medically necessary to be considered covered expenses.				
Annual Routine Physical Exam	Not Covered	Not Covered	$0	Not Covered
Primary Care Physician Office Visit	20%	40%	$30 co-pay per visit	35%
Specialist Office Visit	20%	40%	$40 co-pay per visit	35%
Urgent Care Clinic	20%	40%	$40 co-pay per visit	35%
Retail Clinic Visits Establishments such as CVS, Walgreens, Wal-Mart, etc.	20%	40%	$40 co-pay per visit	35%

Overview Comparison Chart Overview Comparison Chart				
	Retiree Standard Medical (RSM)		Retiree Value Plus (RVP)	
Emergency Room (when determined to meet the criteria that define an emergency)	20%	20%	15%	15%
Impatient Hospital (Preauthorization Required)	20%	40%	15%	35%
PHARMACY				
Retail Pharmacy (up to a 30-day supply)	20%	Drug reimbursement is based on in-network pricing.	Generic Drugs: $10 co-pay Formulary Drugs: 30% ($20 min/$75 max)* Non-Formulary Drugs: 50% ($35 min/$90 max)*	Drug reimbursement is based on in-network pricing.
Mail Order Pharmacy (up to a 90-day supply)	Generic Drugs: $25 co-pay Brand Name Drugs: 25%, when no generic available, $150 max	Not Covered	Generic Drugs: 20% (no min/ $80 max) Formulary Drugs: 30% ($40min/ $150 max)* Non-Formulary Drugs: 50% ($70min/ $180 max)*	Not Covered

* If you select a brand name drug (Formulary or Non-Formulary) when a generic is available, you will pay the appropriate generic co-pay or co-insurance, plus the cost difference between generic and brand prices. Maximums will not apply.

The above chart is a basic overview of the Retiree Medical Benefit options. Obtain additional coverage information by reviewing the detailed summary for each plan throughout the remainder for this section.

What are my Coverage Tier Options?
You may choose from the following coverage levels:

- Retiree
- Retiree + one
- Retiree + two or more

If you are married to another AA retiree or employee, be sure to review the appropriate Retiree Eligibility section for more information on coverage options.

How will I show I have coverage when my eligible covered dependents and I access care?
After you have enrolled, you will receive an ID card from your Network/Claims Administrator indicating which Retiree Medical Benefit option you are enrolled in. The ID card includes important phone numbers and should be presented each time you go to a in-network physician, hospital or other facility. RSM & RVP option members will also receive an Express Scripts/Medco pharmacy drug card for prescription drug services.

Retiree Standard Medical (RSM) Option – Detailed Summary

The Retiree Standard Medical (RSM) Option is available to all eligible retirees and their dependents. This option offers a preferred provider network of physicians, hospitals and other medical service providers (in-network) that have agreed to charge negotiated rates for medical services. Throughout this section, you will find questions and answers specific to the RSM Option that may help you further understand how this option works.

As you review the Retiree Standard Medical (RSM) Option Features Chart, keep the following in mind:

- RSM pays 80% of in-network eligible expenses up to the negotiated rate, after you and your covered dependents have met the annual deductible.
- You pay 20% co-insurance for in-network services with the exception of Mail Order pharmacy.
- Eligible out-of-network charges are paid at 60% of usual and prevailing fees.
- You may pay 40% co-insurance for out-of-network services.
- After you meet the annual out-of-pocket max, eligible expenses are covered at 100% for the remainder of the year, with the exception of Mail Order prescription drugs.

How can I find out if my doctor is in-network?

You can contact your Network/Claims Administrator or access the Network/Claims Administrator's website for more information and to obtain a list of the current in-network providers.

If my doctor is not in-network, can I still use him/her?

You may use any qualified licensed physician you wish. If you go to a provider who is not part of the network, you are covered for eligible medically necessary services; however, the charges will be subject to usual and prevailing fee limits and the RSM Option may pay your expenses at a lower level of benefit (see details above) Additionally, you must pay any amount of the provider's billed fee that exceeds the usual and prevailing fee limits. This amount could be significant, therefore, you may want to consider having a predetermination of benefits, using CheckFirst, prior to services being rendered. The following detailed RSM Features Chart details what you will pay for various services, both in- and out-of-network.

Retiree Standard Medical (RSM) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
Individual Maximum Medical Benefit	$300,000	
Annual Deductible • Deductible must be met, for most covered services with co-insurance, before benefits are payable • Co-pays are not subject to the deductible • Each covered individual must continue to meet his/her individual deductible until the family deductible has been met.	$150 (single) $400 (family)	
Annual Out-of-Pocket Max • Only each individual's portion of covered expenses can be used to meet the individual annual out-of-pocket maximum • Co-pays and deductibles cannot be used to meet the individual or family annual out-of-pocket maximum	$1,000 (single) $3,000 (family)	
PREVENTIVE CARE		
Annual routine physical exams	Not Covered	Not Covered
Well-child care	Not Covered	Not Covered
MEDICAL SERVICES		
Physician's office visit (including X-ray and lab work)	20%	40%
Specialist office (including X-ray and lab work)	20%	40%
Urgent/Immediate Care Clinic	20%	40%
Retail Clinic Visits Establishments such as CVS, Walgreens, Wal-Mart, etc.	20%	40%
Second surgical opinions • No cost if ordered by the plan or claims processor	20%	40%
Chiropractic care	20%	40%
Speech, physical, occupational, restorative, and rehabilitative therapy	20%	40%

Retiree Standard Medical (RSM) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
GYNECOLOGICAL CARE Preventive care not covered (except for mammograms)		
Pap tests • If medically necessary; routine pap tests are not covered	20%	40%
Mammograms – routine preventive or diagnostic • If medically necessary - refer to Mammograms in Covered Expenses for detailed information	20%	40%
Pregnancy	20%	40%
ALLERGY CARE		
Physician's office visit	20%	40%
Allergy testing, shots, or serum	20%	40%
OUTPATIENT SERVICES		
Diagnostic X-ray and/or lab • Performed in a physician's office, hospital or independent surgical facility	20%	40%
Outpatient surgery • Performed in a physician's office, hospital or independent surgical facility • Pre-authorization recommended to ensure medical necessity • See (CheckFirst)	20%	40%
Pre-admission testing • Performed in a physician's office, hospital or independent surgical facility	20%	40%
HOSPITAL SERVICES		
Inpatient room and board • Including intensive care unit or special care unit • Pre-authorization required	20%	40%
Ancillary services • Including radiology, pathology, operating room and supplies • Pre-authorization required	20%	40%

Retiree Standard Medical (RSM) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
Newborn nursery care • Preauthorization required • Considered under the baby's coverage, not the mother's. • Within 60 days of the birth, a Life Event must be processed for the baby to have coverage. • Payment of maternity claims does not automatically enroll the baby.	20%	40%
Surgery and related expenses • Such as anesthesia and medically necessary assistant surgeon	20%	40%
Blood transfusions	20%	40%
Organ transplants	20%	40%
Emergency ambulance • When determined to meet the criteria that define an emergency	20%	20%
Emergency room (ER) • When determined to meet the criteria that define an emergency	20%	20%
OUT OF HOSPITAL CARE		
Convalescent and skilled nursing facilities following hospitalization • Max of 60 days per illness for in-network and out-of-network combined	50%	50%
Home Health Care	20%	40%
Hospice care	20%	40%
OTHER SERVICES		
Tubal ligation or vasectomy • Reversals are not covered	20%	40%
Infertility treatment • Including in-vitro fertilization	Not Covered	Not Covered
Radiation therapy and chemotherapy	20%	40%
Kidney dialysis • **If the dialysis continues more than 12 months, participant MUST apply for Medicare**	20%	40%
Supplies, equipment, and durable medical equipment (DME)	20%	40%

Retiree Standard Medical (RSM) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
MENTAL HEALTH BENEFITS No Treatment Limit	**In-Network** Provider	**Out-of-Network** Provider
Inpatient mental health care	20%	40%
Alternative mental health care center – residential treatment	20%	40%
Alternative mental health care center – intensive outpatient and partial Hospitalization	20%	40%
Outpatient mental health care	20%	40%
CHEMICAL DEPENDENCY BENEFITS No Treatment Limit		
Detoxification	20%	40%
Inpatient chemical dependency rehabilitation	20%	40%
Outpatient chemical dependency rehabilitation	20%	40%
GENDER REASSIGNMENT BENEFIT (GRB)		
Surgery	Not Covered	Not Covered
Travel Expenses	Not Covered	Not Covered
Non-Surgical Treatments	Not Covered	Not Covered
PHARMACY		
Retail Pharmacy • Up to a 30-day supply • Express Scripts/Medco in-network pharmacies offer discounts on prescriptions	20% for most prescription drugs	Drug reimbursement is based on in-network pricing.
Mail Order Pharmacy • Up to a 90-day supply • If you select a brand name drug when a generic is available, you will pay the appropriate generic co-pay, plus the cost difference between generic and brand prices, with no maximum.	Generic Drugs: $25 co-pay Brand Name Drugs: 25% ($150 max)	Not Covered
Oral contraceptives • Oral contraceptives used for family planning or birth control are not covered, but are offered at a discounted price. • See Mail Order Prescription Drug Benefit	Not covered Unless prescribed as medically necessary treatment of a diagnosed illness or injury	
Fertility (infertility) medications • Medications used to treat infertility or promote fertility are never covered	Not Covered	
Over-the-counter medication (OTC)	Not Covered	

Special Provisions

The RSM option includes additional special provisions not outlined in the chart above.

Annual Individual/Family Deductible

- Each individual must satisfy his or her own deductible.
- The family annual deductible is applicable if three or more family members are covered.
    - After you have satisfied the family annual deductible, all covered individuals are eligible for reimbursement of eligible medical expenses, regardless of whether they have satisfied individual annual deductibles.

Annual Out-of-Pocket Maximum for all retirees …

- After you satisfy the annual out-of-pocket maximum for eligible expenses, the Plan pays 100% of eligible expenses for the rest of the calendar year (with the exception of Mail Order drugs).
- Co-insurance amounts, excluding mail order drugs, apply to the annual out-of-pocket maximum, except for expenses covered at 50%.

Negotiated Rates

RSM offers a voluntary network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for eligible medical services. Some providers charge more than others for the same services. For this reason, using an in-network provider may mean you receive a lower rate. The negotiated rates could save you money when you or your covered dependents needs medical care and chooses a participating provider.

When do I need to check to see if the doctor I am going to is in-network?

In-network providers may change at any time, so you should confirm that your provider or facility is part of the network when you make an appointment and before you receive services.

What if I have a procedure or lab work in a hospital that is in-network, but the doctor (such as a radiologist who reads my x-ray) is not an in-network provider?

You will receive the in-network negotiated rate for hospital charges, but the physician's fee is not eligible for the in-network negotiated rate (subject to usual and prevailing fee limits).

What if my doctor is in-network and the hospital is in-network too, will all my charges be eligible for the in-network negotiated rate?

The charges for your lab or x-ray services may not be if your provider or hospital uses a lab that is not part of the network. Some lab and x-ray services performed in a hospital are contracted to an out-of-network provider (subject to usual and prevailing fee limits).

Prescription Drug Benefits

Express Scripts/Medco is the prescription drug vendor for the RSM option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Mail Order pharmacy. Only eligible expenses for covered prescription drugs purchased at a retail pharmacy apply to your deductible or out-of-pocket maximum.

Express Scripts/Medco has a broad network of retail pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the Express Scripts website.

Generic Drugs

Your prescription may be substituted with a generic when available and if your physician considers it appropriate. Generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using generic drugs, you save money. If a brand name drug is not specified, your prescription may be filled with the generic equivalent.

Retail Pharmacy Coverage

- For most covered medications, the plan pays 80% of the Express Scripts/Medco discounted price after you have satisfied your medical option deductible when using a network pharmacy.
- You must present your Express Scripts/Medco prescription drug card every time you purchase prescription medications in order to receive the discounted medication rates.
- If you do not present your Express Scripts/Medco prescription drug card at the time of purchase…
    - You will pay the non-discounted price at that time, AND
    - Reimbursement from the plan will be based on the discounted price.

How do I fill a prescription at an In-Network pharmacy?

Follow these steps to fill a prescription:

- ❑ Present your Express Scripts/Medco prescription drug card to the pharmacy every time you order your prescription.
- ❑ Pay the Express Scripts/Medco price for the prescription and obtain a receipt when you pick up your prescription.
- ❑ File a claim for reimbursement of your covered expenses through Express Scripts/Medco. See Filing Claims for Prescriptions for more information on how to file a claim.

What if I need to fill my prescription at a pharmacy that is Out-of-Network?

- ❑ Pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- ❑ File a claim for reimbursement with Express Scripts/Medco. See Filing Claims for Prescriptions for more information on how to file a claim.

- Prescription medications filled at an out-of-network pharmacy will be reimbursed based on the Express Scripts/Medco discount price, not the actual retail cost of the medication.

Example of Retail Pharmacy Prescription Coverage

- Assumes individual annual deductible is met
- Non-discounted medication price = $250
- Discounted medication price = $100

If you Use a…	In-Network Pharmacy		Out-of-Network Pharmacy
And	You show your Express Scripts/Medco card	You do NOT show your Express Scripts/Medco card	N/A
Prescription Cost:	$100	$250	
Amount Express Scripts/Medco considers as an eligible expense when paying the claim:	$100	$100	
RSM plan pays:	$80* (80% co-insurance)	$80* (80% co-insurance)	
You Pay:	$20 (20% co-insurance)	$170 (20% coinsurance, plus $150 difference between the non-discounted price of the medication and the discounted price)	

* You will have to pay for the full prescription cost at the pharmacy and submit a claim for reimbursement from the plan.

Prescription Claim Filing

After filling a prescription at a retail pharmacy, how do I file claim for reimbursement?

Follow this checklist:

- ❑ Complete Express Scripts/Medco claim form, which can be obtained by contacting Express Scripts/Medco via telephone or through their website
- ❑ Submit the completed Express Scripts/Medco claim form along with your receipts to Express Scripts/Medco.
- ❑ Express Scripts/Medco reports the claim to your Network/Claims Administrator.
- ❑ Your Network/Claims Administrator will process your claim, based on the information received from Express Scripts/Medco.

- ❑ Your Network/Claims Administrator will send you any applicable reimbursement and an Explanation of Benefits (EOB), advising you of all of the following…
  - The total charges you submitted
  - Any amounts not covered and the reason
  - The amounts eligible and paid under the medical option

What is the deadline for me to file a pharmacy claim?
You must submit all health (including pharmacy) claims within one year of the date the expenses were incurred, for them to be considered for payment.

Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Mail Order Pharmacy Coverage

You and your covered dependents are eligible for Mail Order prescription coverage through the Express Scripts/Medco Mail Order pharmacy. You may use this option to order prescription drugs…

- Your annual deductible does not need to be met when filling prescriptions through Mail Order.
- You take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease, and ulcers.
- Including inject able drugs that are approved by the Food and Drug Administration (FDA) for self-administration.
- For up to a 90-day supply (but no more than the number of days prescribed by your physician)

When you fill your prescriptions through Mail Order, a registered pharmacist fills your prescription and, you pay:

- **Generic drugs**: $25 co-pay per prescription or refill (or the actual cost, if the prescription cost is less than $25).
- **Brand name drugs**: 25% co-insurance of the cost of the drug, up to a $150 maximum per prescription or refill.
- **Brand name drug** when a generic is available: $25 co-pay per prescription or refill, plus the cost difference between the brand name and the generic, with no maximum cost per prescription or refill.

How do I use the Express Scripts/Medco Mail Order pharmacy to fill prescriptions?
To place your first order for a prescription through Mail order, follow these steps:

- ❑ Complete the Mail Order Form(found on the Express Scripts website)
- ❑ Complete the Health Allergy, and Medical Questionnaire (found on the Express Scripts website)

- The questionnaire will not be necessary on refills or future orders unless your health changes significantly.

- ❑ Include the original written prescription signed by your physician.
- ❑ Indicate your method of payment on the form, you may use any of the following…
  - Major credit or debit card
  - Personal check
  - Money order
  - Invoice billed by Express Scripts/Medco when medications are delivered (up to $100)
- ❑ Mail your order to the address on the Mail Order Form.

Do I need to send money with my order?
If paying by check or money order, enclose your payment with the order. Do not send cash. Express Scripts/Medco will bill you when your medications are delivered (up to $100).

How long will it take for my filled prescription to arrive after I order it from Express Scripts/Medco Mail Order?
You should allow 7-10 days for your first order. Generally, orders are shipped within three working days of receipt. Your order will be sent via UPS or first class mail.

How can I order refills of my medication, after the first fill with Express Scripts/Medco Mail Order?
Choose from any of the following methods to order your refills, always allow for up to 14 days for delivery of your prescription:

- ❑ **Internet refill option**
  - Log on to the Express Scripts website
  - View available prescriptions for refill
- ❑ **Call to request a refill**, provide all of the following:
  - Your Express Scripts/Medco ID number
  - Current mailing address
  - Express Scripts/Medco prescription number
- ❑ **Complete and mail in your Mail Order Form,**
  - Attach your Express Scripts/Medco refill prescription label to the form, OR
  - Write the prescription refill number on the form
  - Include your payment with your order

Specialty Pharmacy Services

Specialty pharmacy services are dedicated to providing a broad spectrum of outpatient prescription medicines and integrated clinical services to patients on long-term therapies, which support the treatment of complex and chronic diseases.

Accredo Health Group, a subsidiary of Express Scripts/Medco, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications. Accredo is a mail order specialty pharmacy staffed with pharmacists that are educated and trained to help patients with their specialty medication needs. When you call Express Scripts/Medco, it will automatically connect you with Accredo.

Medications prescribed to manage medical conditions such as the following **must** be filled at a retail pharmacy or through Accredo(Express Scripts/Medco):

- Anemia
- Growth Hormone
- Hemophilia
- Hepatitis C
- Immune Deficiency Therapy
- Metabolic Disorders
- Multiple Sclerosis
- Oral Cancer Drugs
- Osteoporosis
- Pulmonary/Pulmonary Arterial Hypertension
- Rheumatoid Arthritis or Other Autoimmune Conditions

Please note that other conditions may be added as appropriate and required.

Applicable co-insurance associated with the prescription medications will apply to the Specialty Pharmacy prescriptions.

What if my physician will be administering my specialty drug prescription in his/her office?

Prescriptions used to treat the above mentioned conditions are covered under your prescription drug benefits and will not be paid by the medical plan if billed by your physician as part of the office visit. You will need to fill the prescription at a retail pharmacy using your Express Scripts/Medco prescription drug card or through Accredo (Express Scripts/Medco's Specialty Mail Order Pharmacy). Accredo can ship the prescription to your home for self-administration or to your physician's office for medications that will be administered by a physician.

Prior Authorization

What does it mean if my medication needs Prior Authorization?
To be eligible for coverage under RSM, certain covered prescriptions require a review by Express Scripts/Medco to determine medical necessity before you can obtain them at a participating pharmacy or through the Express Scripts/Medco Mail Order Pharmacy.

What do I do if Prior Authorization is needed?
Follow these steps to request prior authorization:

- ❑ Ask your physician to contact Express Scripts/Medco or to complete Express Scripts/Medco prior authorization form with the following information:
  - Name of the drug, strength and supply being prescribed
  - Medical condition for which the drug is being prescribed
  - Proposed treatment plan
  - Any other information your physician believes is pertinent
- ❑ When you fill your prescription, your pharmacist will…
  - Contact Express Scripts/Medco
  - Both your pharmacist and an Express Scripts/Medco pharmacist will review the request for approval
- ❑ Express Scripts/Medco will send you and your physician a letter about the authorization review.
  - This letter will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

Do I have to get Prior Authorization each time a refill is needed?
No, if authorization is approved, the system automatically allows refills for up to one year. Prior authorizations must be renewed periodically. When the renewal date approaches, you should contact Express Scripts/Medco for renewal instructions.

What if my pharmacy does not fill a prescription, because there is no prior authorization on file?
The pharmacy's denial will not be treated as a claim for benefits. You must submit the request for prior authorization to Express Scripts/Medco. If the prior authorization is denied, you must file a first level appeal through Express Scripts/Medco to be considered for coverage for that medication.

Prescription Clinical Programs

- Express Scripts/Medco uses a number of clinical programs that help ensure clinically appropriate coverage and drug cost controls.
- Some medications may require prior authorization, and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).
- When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions.
- Because new clinical programs are continuously being developed and existing programs enhanced, they are subject to change.
- Additional information about these clinical programs and the specific drugs subject to these programs can be obtained from Express Scripts/Medco(see Information in the Reference Information section).

What if I have questions about my prescription drug coverage or cost of a medication?
You should call the Express Scripts/Medco Member Services number on your Prescription Drug ID card or access the Express Scripts website (see Information in the Reference Information section).If the questions are about the benefit amount reflected on your EOB, call your Network/Claims Administrator. For specialty medications see Specialty Pharmacy Services in this section).

Retiree Value Plus (RVP) Option – Detailed Summary

The Retiree Value Plus (RVP) Option, is available for eligible retirees and their dependents, who meet all of the requirements as detailed in the Additional Eligibility Requirements. The RVP offers access to a network of physicians and hospitals that have agreed to provide medical services to plan participants at preferred rates. Throughout this section, you will find questions and answers specific to the RVP Option that may help you further understand how this option works.

If I am a retiree who elects RVP and uses In-Network Services…

- RVP pays 85% of in-network eligible expenses, after you and your covered dependents have met the annual deductible.
- You pay 15% co-insurance for in-network services.
- After you and your covered dependents meet the annual out-of-pocket max for services that require you to pay 15% co-insurance, further eligible expenses are covered at 100% for the remainder of the year.
- In most cases in-network providers will file your claims for you.

If I am a retiree who elects RVP and uses Out-of-Network Services…

- RVP pays 65% of in-network eligible expenses (that fall within 140% of Maximum Out-of-Network Reimbursement Program (MNRP) fee limits), after you and your covered dependents have met the annual deductible.
- You pay 35% co-insurance for in-network services, in addition to any amount of the provider's billed fee that exceeds the MNRP fee limits.
- There is no out-of-pocket maximum for out-of-network services, on the RVP option.

How can I find out if my doctor is in-network?

You can contact your Network/Claims Administrator or access the Network/Claims Administrator's website for more information and to obtain a list of the current in-network providers.

If my doctor is not in-network, can I still use him/her?

You may use any qualified licensed physician you wish. If you go to a provider who is not part of the network, you are covered for eligible medically necessary services; however, the RVP Option coverage reimbursement is at a lower level (out-of-network benefit level). Additionally, you must pay any amount of the provider's billed fee that exceeds the MNRP fee limits. This amount could be significant, therefore, you may want to consider having a predetermination of benefits, using CheckFirst, prior to services being rendered. The following detailed RVP Features Chart details what you will pay for various services, both in- and out-of-network.

Retiree Value Plus (RVP) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
Individual Maximum Medical Benefit	$1,000,000	
Annual Deductible • Deductible must be met, for most covered services with co-insurance, before benefits are payable • Co-pays are not subject to the deductible • Family deductible not applicable on RVP	$250 per person	$750 per person
Annual Out-of-Pocket Max • Only each individual's portion of covered expenses can be used to meet the individual annual out-of-pocket maximum • Co-pays, deductibles, and pharmacy expenses cannot be used to meet the individual annual out-of-pocket maximum	$1,750 per person for services that require you pay 15%	No Limit
PREVENTIVE CARE		
Annual routine physical exams	$0	Not Covered
Well-child care For any of the following: • children up to age 2 • Initial hospitalization following birth • All immunizations • Up to 7 well-child care visits	$0	35%
MEDICAL SERVICES		
Physician's office visit • Primary Care Physician (PCP) • Including X-ray and lab work	$30 per visit	35%
Specialist office (including X-ray and lab work)	$40 per visit	35%
Urgent/Immediate Care Clinic	$40 per visit	35%
Retail Clinic Visits Establishments such as CVS, Walgreens, Wal-Mart, etc.	$40 per visit	35%
Second surgical opinions • No cost if ordered by the plan or claims processor	$40 per visit	35%

Retiree Value Plus (RVP) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
Chiropractic care • Max 20 chiropractic visits per person per year combined in- and out-of-network	$40 per visit	35%
Speech, physical, occupational, restorative, and rehabilitative therapy	$40 per visit	35%
GYNECOLOGICAL CARE		
OB/GYN • Same as a visit to a PCP, whether the OB/GYN is treating you in the capacity of a specialist or a PCP • OB/GYN visits related to care during pregnancy are subject to the $150 co-pay (see below)	$30 per visit	35% If medically necessary. Preventive care not covered (except for mammograms, as listed below)
Pap tests • Routine pap tests are not covered	$0 if part of office visit	35% if medically necessary
Mammograms – routine preventive • Regardless of facility • Routine mammograms are covered beginning at age 35	$0 Based on age guidelines	35% if medically necessary
Mammograms –diagnostic • If medically necessary, test performed because of symptoms/problem	15% if hospital outpatient	35%
Pregnancy • Includes pre- and post-natal visits and delivery • Includes physician's charges only • Hospital charges are the same as for any hospitalization	$150 per pregnancy	35%
ALLERGY CARE		
Physician's office visit	PCP – $30 per visit Specialist – $40 per visit	35%
Allergy testing, shots, or serum	$0 If administered in physician's office If office visit is charged, co-pay above applies	35%

Retiree Value Plus (RVP) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
OUTPATIENT SERVICES	**In-Network** Provider	**Out-of-Network** Provider
Diagnostic X-ray and/or lab	Varies by facility see below	
At a Hospital	15%	35%
At an independent in-network lab or at a physician's office	$0	35%
Outpatient surgery • Pre-authorization recommended to ensure medical necessity • See (CheckFirst)	Varies by facility see below	
In physician's office	PCP – $30 per visit Specialist – $40 per visit	35%
In a hospital or independent surgical facility	15%	35%
Pre-admission testing		
At a hospital	15%	35%
At an independent in-network lab or at a physician's office	$0	35%
HOSPITAL SERVICES		
Inpatient room and board • Including intensive care unit or special care unit • Pre-authorization required	15%	35%
Ancillary services • Including radiology, pathology, operating room and supplies • Pre-authorization required	15%	35%
Newborn nursery care • Considered under the baby's coverage, not the mother's. • Within 60 days of the birth, a Life Event must be processed for the baby to have coverage. • Payment of maternity claims does not automatically enroll the baby.	15%	35%
Surgery and related expenses • Such as anesthesia and medically necessary assistant surgeon	15%	35%

Retiree Value Plus (RVP) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
Blood transfusions	$0 If administered in physician's office 15% if performed in hospital or freestanding facility	35%
Organ transplants	15%	35%
Emergency ambulance • When determined to meet the criteria that define an emergency	$0	$0
Emergency room (ER) • When determined to meet the criteria that define an emergency	15%	15%
OUT OF HOSPITAL CARE		
Convalescent and skilled nursing facilities following hospitalization • Max of 60 days per illness for in-network and out-of-network combined	15%	35%
Home Health Care	$0 When approved by your network administrator	35%
Hospice care	15%	35%
OTHER SERVICES		
Tubal ligation or vasectomy • Reversals are not covered	Specialist – $40 per visit 15% if performed in hospital	35%
Infertility treatment • Including in-vitro fertilization	Not Covered	Not Covered
Radiation therapy and chemotherapy	$0 If administered in physician's office 15% if performed in hospital or	35%

Retiree Value Plus (RVP) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
	freestanding facility	
Kidney dialysis • If the dialysis continues more than 12 months, participant must apply for Medicare	$0 If administered in physician's office 15% if performed in hospital or freestanding facility	35%
Supplies, equipment, and durable medical equipment (DME) • Regardless of where the device is purchased	15%	35%
MENTAL HEALTH BENEFITS No Treatment Limit		
Inpatient mental health care	15%	35%
Alternative mental health care center – residential treatment	15%	35%
Alternative mental health care center – intensive outpatient and partial Hospitalization	15%	35%
Outpatient mental health care	Hospital - 15% PCP – $30 Specialist – $40	35%
CHEMICAL DEPENDENCY BENEFITS No Treatment Limit		
Detoxification	15%	35%
Inpatient chemical dependency rehabilitation	15%	35%
Outpatient chemical dependency rehabilitation	Hospital - 15% PCP – $30 Specialist – $40	35%

Retiree Value Plus (RVP) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
GENDER REASSIGNMENT BENEFIT (GRB) Cumulative benefit (Active & Retiree Coverage combined) for Surgery is $75,000 and for Travel is $10,000		
Surgery • One bilateral mastectomy or bilateral augmentation mammoplasty • One genital revision surgery	15%	Not Covered
Travel Expenses	Up to $10,000	Not Covered
GENDER REASSIGNMENT BENEFIT (GRB), CONTINUED		
Non-Surgical Treatments • Physician's visits • Specialist visits • Outpatient mental health care • X-rays and lab work • Retail prescription drugs • Mail Order prescription drugs	Covered as any other illness or injury under the Plan	Not Covered
PHARMACY		
Retail Pharmacy • Up to a 30-day supply • Express Scripts/Medco in-network pharmacies offer discounts on prescriptions • If you select a brand name drug when a generic is available, you will pay the appropriate generic co-pay, plus the cost difference between generic and brand prices, with no maximum	Generic Drugs: $10 co-pay Formulary Drugs: 30% ($20 min/$75 max) Non-Formulary Drugs: 50% ($35 min/$90 max)	Drug reimbursement is based on in-network pricing.
Mail Order Pharmacy • Up to a 90-day supply • If you select a brand name drug when a generic is available, you will pay the appropriate generic co-pay, plus the cost difference between generic and brand prices, with no maximum.	Generic Drugs: 20% (no min/$80 max) Formulary Drugs: 30% ($40min/ $150 max) Non-Formulary Drugs: 50% ($70min/ $180 max)	Not Covered

Retiree Value Plus (RVP) Option Features Chart All services must be medically necessary to be considered covered expenses.		
	Amount you will pay if you utilize a…	
	In-Network Provider	**Out-of-Network** Provider
Oral contraceptives • Oral contraceptives used for family planning or birth control are not covered • See Mail Order Prescription Drug Benefit	Not covered Unless prescribed as medically necessary treatment of a diagnosed illness or injury	
Fertility (infertility) medications • Medications used to treat infertility or promote fertility are never covered	Not Covered	
Over-the-counter medication (OTC)	Not Covered	

Special Provisions
The RVP option includes additional special provisions not outlined in the chart above.

Maximum Out-of-Network Reimbursement Program (MNRP) fee limits
The plan determines the eligible charge amount for out-of-network expenses by using the MNRP. The eligible amount is the actual billed fee, up to 140% of the Medicare-allowable expense (whichever is less). You must pay any amount of the provider's billed fee that exceeds the MNRP fee limits. This amount could be significant, therefore, you may want to consider having a predetermination of benefits, using CheckFirst, prior to services being rendered. These fee limits apply to all medical services and supplies. For example: hospital charges, physician's fees, lab fees, radiology fees and all other covered, medically necessary out-of-network expenses. For the following rare occurrences, the allowable expense is determined as explained:

- **If the claim is for care in a life/limb endangering emergency** (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the RVP option will allow the out-of-network provider's full billed charge as an eligible expense.
- **If the claim is for care in a "network gap"**, the RVP option will allow the out-of-network provider's full billed charge as an eligible expense, as long as all of the following apply:
  - ❑ The nearest source of appropriate medical treatment is greater than the Network/Claims Administrator's network gap mile limit
  - ❑ The covered person has received prior approval from the Network/Claims Administrator
- **If the claim is for care in a "clinical gap"**, the RVP option will allow the out-of-network provider's full billed charge as an eligible expense, as long as all of the following apply:
  - ❑ In-network providers in the area with the same credentials cannot provide the specific treatment that a patient needs

- ❑ The covered person has received prior approval from the Network/Claims Administrator

- If the claim is for services, for which there is not a MNRP comparator, the RVP option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.

Preventive care with the RVP Option
You and each covered family member are eligible to receive benefits at 100% for in-network annual routine physical exams, including:

- Well-woman exams,
- Well-child exams
- Certain screening exams, such as mammograms, PSA tests and colonoscopies.

Prescription Drug Benefits
Express Scripts/Medco is the prescription drug vendor for the RVP option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Mail Order pharmacy. Co-pays paid for prescription drugs purchased at a retail pharmacy do not apply to your deductible or out-of-pocket maximum. Co-insurance paid for prescription drugs purchased at a retail or Mail Order pharmacy do not apply to your out-of-pocket maximum.

Express Scripts/Medco has a broad network of retail pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the Express Scripts website.

Generic Drugs

Your prescription may be substituted with a generic when available and if your physician considers it appropriate. Generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using generic drugs, you save money for yourself and the Company. If a brand name drug is not specified, your prescription may be filled with the generic equivalent.

Prescription drug coverage for the RVP option is based upon an incentive formulary. The amount paid by the RVP option is based upon whether the medication is a generic, formulary or non-formulary drug.

- **Generic drugs** are chemically and therapeutically equivalent to the corresponding brand name drug, but cost less.
- **Formulary drugs** are preferred brand name drugs. Formulary drugs are just as safe and effective as the alternatives, but cost less. The formulary list is based on safety and cost considerations.
- **Non-formulary drugs** are brand name drugs that are not in the formulary, but they have preferred alternatives (either generic or brand) that are in the formulary.

Retail Pharmacy Coverage

- You receive greater benefits when you use a participating in-network pharmacy.
- You pay, for up to a 30-day supply:
  - **Generic Drugs**: $10 co-pay
  - **Formulary Drugs:** 30% ($20 min/$75 max)
  - **Non-Formulary Drugs:** 50% ($35 min/$90 max)
  - **If you select a brand name drug when a generic is available**, you will pay 10$ generic co-pay, plus the cost difference between generic and brand prices. Maximums do not apply.

How do I fill a prescription at an In-Network pharmacy with RVP?
Follow these steps to fill a prescription:

- ❑ Present your Prescription Drug ID card at the pharmacy.
- ❑ Pay your portion of the cost for the prescription, at the pharmacy.
- ❑ You do not have to file a claim form because the pharmacy calculates your portion of the cost when you pay and pick up your prescription.
  - If the pharmacy advises that you are responsible for the entire purchase price of the medication, make sure you have presented your Prescription Drug ID card to the pharmacy and that the pharmacy is in the Express Scripts/Medco network.

Prescription Claim Filing

What if I need to fill my prescription at a pharmacy that is Out-of-Network?
At the time you purchase your prescription

- ❑ Pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- ❑ File a claim for reimbursement with Express Scripts/Medco.
  - For prescription medications filled at an out-of-network pharmacy, you will be reimbursed based on the Express Scripts/Medco discount price, not the actual retail cost of the medication.

What is the deadline to file a pharmacy claim, if needed?
You must submit all health (including pharmacy) claims within one year of the date the expenses were incurred, for them to be considered for payment.

Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Can I get my medication that I have to take on a regular basis from a Retail Pharmacy?
You may obtain your long-term medication from a retail pharmacy. It is important to note that the RVP option does have a Retail Refill Allowance provision for long-term medications. You may fill this type of medication at a retail pharmacy three times. After the third fill, you and your covered dependents will pay 50% of the drug cost if both of the following apply:

- ❑ It is a long-term medication
- ❑ Filled at a retail pharmacy three (3) times previously

When using the retail pharmacy for long-term medication and paying 50% of the drug cost, your payment maximums do not apply.
Long-term medication should be ordered from the Mail Order Pharmacy. You can contact Express Scripts/Medco for assistance in moving your long-term medications to mail order. Short-term medications (for example, antibiotics) should continue to be purchased at a retail pharmacy and you will pay your retail pharmacy co-payment/coinsurance.

How do I know if my medications are considered long-term?
Long-term prescriptions include medications taken on an on-going basis for conditions such as, but not limited to high cholesterol, high blood pressure, depression, diabetes, and arthritis. To determine if your prescription medications fall within the long-term medications listing, contact Express Scripts/Medco.

How can I purchase my long-term medications without having to pay 50% of the cost at a retail pharmacy?
Beginning with your fourth refill (or prior) of a long-term Medication, you should utilize the Mail Order pharmacy for the refill. You can purchase up to a 90-day supply of your long-term medications, which can ultimately save you money on your prescription costs. See Mail Order Pharmacy Coverage in this section for more information.

Mail Order Pharmacy Coverage

You and your covered dependents are eligible for Mail Order prescription coverage through the Express Scripts/Medco Mail Order pharmacy. You may use this option to order prescription drugs…

- You take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers.
- Including injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration.
- For up to a 90-day supply (but no more than the number of days prescribed by your physician)

When you fill your prescriptions through Mail Order, a registered pharmacist fills your prescription and, you pay:

- **Generic Drugs:** 20% (no min/$80 max)
- **Formulary Drugs:** 30% ($40min/ $150 max)
- **Non-Formulary Drugs:** 50% ($70min/ $180 max)
- **If you select a brand name drug when a generic is available**, you will pay the 20% generic co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.

How do I use the Express Scripts/Medco Mail Order pharmacy to fill prescriptions?

To place your first order for a prescription through Mail order, follow these steps:

- ❑ Complete the Mail Order Form(found on the Express Scripts website)
- ❑ Complete the Health Allergy, and Medical Questionnaire (found on the Express Scripts website)
  - The questionnaire will not be necessary on refills or future orders unless your health changes significantly.
- ❑ Include the original written prescription signed by your physician.
- ❑ Indicate your method of payment on the form, you may use any of the following…
  - Major credit or debit card
  - Personal check
  - Money order
  - Invoice billed by Express Scripts/Medco when medications are delivered (up to $100)
- ❑ Mail your order to the address on the Mail Order Form.

Do I need to send money with my order?

If paying by check or money order, enclose your payment with the order. Do not send cash. Express Scripts/Medco will bill you when your medications are delivered (up to $100).

How long will it take for my filled prescription to arrive after I order it from Express Scripts/Medco Mail Order?

You should allow 7-10 days for your first order. Generally, orders are shipped within three working days of receipt. Your order will be sent via UPS or first class mail.

How can I order refills of my medication, after the first fill with Express Scripts/Medco Mail Order?

Chose from any of the following methods to order your refills, always allow for up to 14 days for delivery of your prescription:

- ❑ **Internet refill option**
  - Log on to the Express Scripts website
  - View available prescriptions for refill

- ❑ **Call to request a refill**, provide all of the following:
  - Your Express Scripts/Medco ID number
  - Current mailing address
  - Express Scripts/Medco prescription number
- ❑ **Complete and mail in your Mail Order Form,**
  - Attach your Express Scripts/Medco refill prescription label to the form, OR
  - Write the prescription refill number on the form
  - Include your payment with your order

Specialty Pharmacy Services

Specialty pharmacy services are dedicated to providing a broad spectrum of outpatient prescription medicines and integrated clinical services to patients on long-term therapies, which support the treatment of complex and chronic diseases.

Accredo Health Group, a subsidiary of Express Scripts/Medco, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications. Accredo is a mail order specialty pharmacy staffed with pharmacists that are educated and trained to help patients with their specialty medication needs. When you call Express Scripts/Medco, it will automatically connect you with Accredo.

Medications prescribed to manage medical conditions such as the following **must** be filled at a retail pharmacy or through Accredo (Express Scripts/Medco):

- Anemia
- Growth Hormone
- Hemophilia
- Hepatitis C
- Immune Deficiency Therapy
- Metabolic Disorders
- Multiple Sclerosis
- Oral Cancer Drugs
- Osteoporosis
- Pulmonary/Pulmonary Arterial Hypertension
- Rheumatoid Arthritis or Other Autoimmune Conditions

Please note that other conditions may be added as appropriate and required.

Applicable co-insurance associated with the prescription medications will apply to the Specialty Pharmacy prescriptions.

What if my physician will be administering my specialty drug prescription in his/her office?

Prescriptions used to treat the above mentioned conditions are covered under your prescription drug benefits and will not be paid by the medical plan if billed by your physician as part of the office visit. You will need to fill the prescription at a retail pharmacy using your Express Scripts/Medco prescription drug card or

through Accredo (Express Scripts/Medco's Specialty Mail Order Pharmacy). Accredo can ship the prescription to your home for self-administration or to your physician's office for medications that will be administered by a physician.

Prior Authorization

What does it mean if my medication needs Prior Authorization?
To be eligible for coverage under RSM, certain covered prescriptions require a review by Express Scripts/Medco to determine medical necessity before you can obtain them at a participating pharmacy or through the Express Scripts/Medco Mail Order Pharmacy.

What do I do if Prior Authorization is needed?
Follow these steps to request prior authorization:

- ❑ Ask your physician to contact Express Scripts/Medco or to complete Express Scripts/Medco prior authorization form with the following information:
  - Name of the drug, strength and supply being prescribed
  - Medical condition for which the drug is being prescribed
  - Proposed treatment plan
  - Any other information your physician believes is pertinent
- ❑ When you fill your prescription, your pharmacist will…
  - Contact Express Scripts/Medco
  - Both your pharmacist and an Express Scripts/Medco pharmacist will review the request for approval
- ❑ Express Scripts/Medco will send you and your physician a letter about the authorization review.
  - This letter will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

Do I have to get Prior Authorization each time a refill is needed?
No, if authorization is approved, the system automatically allows refills for up to one year. Prior authorizations must be renewed periodically. When the renewal date approaches, you should contact Express Scripts/Medco for renewal instructions.

What if my pharmacy does not fill a prescription, because there is no prior authorization on file?
The pharmacy's denial will not be treated as a claim for benefits. You must submit the request for prior authorization to Express Scripts/Medco. If the prior authorization is denied, you must file a first level appeal through Express Scripts/Medco to be considered for coverage for that medication.

Prescription Clinical Programs

- Express Scripts/Medco uses a number of clinical programs that help ensure clinically appropriate coverage and drug cost controls.
- Some medications may require prior authorization, and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).
- When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions.
- Because new clinical programs are continuously being developed and existing programs enhanced, they are subject to change.
- Additional information about these clinical programs and the specific drugs subject to these programs can be obtained from Express Scripts/Medco(see Information in the Reference Information section).

What if I have questions about my prescription drug coverage or cost of a medication?
You should call the Express Scripts/Medco Member Services number on your Prescription Drug ID card or access the Express Scripts website (see Information in the Reference Information section).If the questions are about the benefit amount reflected on your EOB, call your Network/Claims Administrator. For specialty medications see Specialty Pharmacy Services in this section).

Retiree Health Maintenance Organization (RHMO)

The Retiree Health Maintenance Organization (RHMO)is a fully insured program that provides medical care through a network of physicians, hospitals and other medical service providers. You must live in Puerto Rico to be eligible for the RHMO, please see the Eligibility section of this guide for more complete eligibility guidelines. Throughout this section you will find questions and answers specific to the RHMO that may help you further understand how the RHMO works.

How RHMO Works

The RHMO is a fully insured program whose covered services are paid by the Humana HMO in Puerto Rico.

Key features of the RHMO include:

- Medical care is provided through a network of physicians, hospitals and other medical service providers.
- You must use network providers to receive benefits under the RHMO.
- You are required to:
  - Choose a primary care physician (PCP) who coordinates all your medical care; and
  - Obtain a referral from your PCP before receiving care from a specialist.
- This medical option is completely independent of the Company.

The Retiree Health Maintenance Organization is an independent organization; the benefits, restrictions and conditions are determined by the RHMO and the Company cannot influence or dictate the coverage provided.

If you choose RHMO coverage, your coverage replaces medical coverage offered by the Retiree Standard Medical Option and the Retiree Value Plus Option.

What is covered by the Retiree Health Maintenance Organization?

Your medical benefits, including prescription drugs and mental health care, are covered according to the rules of the RHMO. If you enroll in the RHMO, you will receive information describing the services and exclusions of the plan.

What if I have a problem or complaint with the Retiree Health Maintenance Organization?

The RHMO has a grievance procedure or policy to appeal claim denials or other issues involving the Retiree HMO. Call Humana for information on filing complaints or grievances. (See Information section)

Filing Medical Claims

In most cases, if you received services from an in-network provider, you do not need to file a claim as the provider will file claims on your behalf. If you used an out-of-network provider or need medical care while you are traveling, you may need to file a claim form. Throughout this section you will find specific questions and answers that may help you further understand the claim form filing procedures for the plan option in which you are enrolled.

Claim Form Filing Procedures

What do I need to do to file a medical claim myself?
Follow the procedures below:

- ❑ Complete a Medical Benefit Claim Form (found on your Network/Claims Administrator's website, see Contact Information)
- ❑ Submit the completed form and ALL original itemized billing statements from your physician or other health care provider to your Network/Claims Administrator
  - Each bill or receipt submitted must include ALL the following:
    - ❑ Name of patient
    - ❑ Date the treatment or service was provided
    - ❑ Diagnosis of the injury or illness for which treatment or service was given
    - ❑ Itemized description and charges for the treatment or service
    - ❑ Provider's name, address and tax ID number
  - A cancelled check or credit card receipt is not acceptable.

- ❑ Make copies of the original itemized bill or receipt for your own records

Will I receive a check for the claim?
All medical claim payments are sent to you with an Explanation of Benefits (EOB) explaining the amount paid. If your physician or other health care provider has agreed to accept Assignment of Benefits the payments will go to the provider. In most cases, the EOB will be mailed to you and the payment mailed to your provider, unless you have already paid the provider in full. EOBs are also available on your Network/Claims Administrator's website.

What is the *Other Coverage* section of the claim form?
Use the *Other Coverage* section of the claim form to indicate if you have other coverage that may pay for all or part of the claim you are submitting. Examples of other coverage you may have include a spouse's group health plan, Workers' Compensation, Medicare, TRICARE and no-fault motor vehicle insurance. It is very important that you fully complete the *Other Coverage* section of the form.

Claim Filing Deadline
You must submit all health claims within one year (12 months) of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

What if I have claim or filing questions?
For all questions about your coverage or your claim under the Retiree Standard Medical or Retiree Value Plus Options, contact your Network/Claims Administrator.

Eligible Retiree Medical Expenses

This section is separated into two distinct lists, covered expenses and excluded expenses. Each list contains descriptions of medical expenses (listed alphabetically) that are either covered or excluded under the Retiree Standard Medical Option and the Retiree Value Plus Options.

Covered Expenses

All services must be medically necessary to be considered covered expenses. Benefits for some of the following eligible expenses vary depending on the retiree medical option you have selected and whether or not you use in-network providers. See the Features Chart under the Retiree Standard Medical and Retiree Value Plus sections for information on how most services are covered. For covered expenses under the Retiree Health Maintenance Organization (RHMO), check with the RHMO directly.

- **Acupuncture**: Treatment for illness or injury when performed by a Certified Acupuncturist for diagnosed illnesses or injury and only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury. Coverage does not include acupuncture treatment for conditions in which the treatment has not been proven safe and effective, such as glaucoma, hypertension, acute low back pain, infectious disease, allergy and the like.
- **Allergy care**: Charges for physician's office visits, allergy testing, shots and serum are covered. (See Excluded Expenses for allergy care not covered under the Retiree Medical Benefit)
- **Ambulance**: Professional ambulance services and air ambulance once per illness or injury to and from:
  - The nearest hospital qualified to provide necessary treatment in the event of an emergency,
  - The nearest hospital or convalescent or skilled nursing facility for inpatient care, or an in-network hospital, if you are covered under any Medical Option and your Network/Claims Administrator authorizes the transfer

  Ambulance services are only covered when determined to meet the criteria that define an emergency and only when care is required en route to or from the hospital. Air ambulance services are covered when medically necessary services cannot be safely and adequately performed in a local facility and the patient's medical condition requires immediate medical attention for which ground ambulance services might compromise the patient's life.
- **Ancillary charges**: Ancillary charges including charges for hospital services, supplies and operating room use. See Inpatient Hospital Expenses in this section.
- **Anesthesia expenses**: Anesthetics and administration of anesthetics. Expenses are not covered for an anesthesiologist to remain available when not directly attending to the care of a patient.

- **Assistant surgeon**: Assistant surgeon's fees are covered when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use CheckFirst to complete a predetermination of benefits.
- **Blood**: Coverage includes blood, blood plasma and expanders. Benefits are paid only to the extent there is an actual expense to the participant.
- **Chiropractic care**: Coverage includes services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license.
- **Convalescent or skilled nursing facilities**: To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital for a covered inpatient hospital confinement and be recommended by your physician for the condition that caused the hospitalization. Eligible expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement and your Network/Claims Administrator must approve your stay. Maximum benefit is 60 days per illness or injury for network and out-of-network facilities. Custodial care is not covered.
- **Cosmetic surgery and treatment**: Expenses for cosmetic surgery only if they are incurred under either of the following conditions:
    - As a result of a non-work related injury, or
    - For replacement of diseased tissue surgically removed.

  Other cosmetic surgery is not covered because it is not medically necessary.
- **Dental care**: Dental expenses for medically necessary dental examination, diagnosis, care and treatment of one or more teeth, the tissue around them, the alveolar process or the gums, only when care is rendered for one of the following:
    - Accidental injury(ies) to sound natural teeth, in which both the cause and the result are accidental, due to an outside and unforeseen traumatic force
    - Fractures and/or dislocations of the jaw
    - Cutting procedures in the mouth (this does not include extractions, dental implants, repair or care of the teeth and gums, etc., unless required as the result of accidental injury, as set forth in the first bullet above)
    - Loss of teeth due to radiation-induced xerostomia/ chemotherapy treatment rendered for the diagnosis(es) of cancer
- **Detoxification**: This is a medical benefit, not a mental health care benefit. Detoxification is covered as any other medical condition. Contact your Network/Claims Administrator for authorization.

- **Durable medical equipment (DME)**: Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME resulting from normal wear and tear is not covered.
    - Examples of DME are items such as CPAP or BiPAP machines, wheelchairs, hospital beds, nebulizers, oxygen concentrators, TENS units, passive range of motion devices, joint cooling devices, bone stimulators, etc.
- **Emergency:** An injury or illness that happens suddenly and unexpectedly and could risk serious damage to your health or is life threatening if you do not get immediate care. Examples include poisoning, drug overdose, multiple trauma, uncontrolled bleeding, fracture of large bones, head injury, severe burns, loss of consciousness and heart attacks.
- **Emergency room**: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies (when determined to meet the criteria that define an emergency). You must call your Network/Claims Administrator for QuickReview approval within 48 hours of an emergency resulting in admission to the hospital.
- **Eyeglasses and contact lenses**: Coverage includes the initial purchase of eyeglasses or contact lenses required because of cataract surgery.
- **Facility charges**: Charges for the use of an outpatient surgical facility, when the facility is either an outpatient surgical center affiliated with a hospital or a freestanding surgical facility.
- **Gender reassignment/sex changes**: Covered under the Gender Reassignment Benefit (GRB) under the Retiree Value Plus (RVP) Option. It is not offered under the Retiree Standard Medical (RSM) Option.
- **Hearing care**: Covered expenses include hearing exams and up to one hearing aid for each ear per year. Coverage for hearing aids is limited to basic hearing aids.
  Cochlear implants and osseointegrated hearing implant systems (such as BAHAs) are covered if medically necessary.
- **Hemodialysis**: Removal of certain elements from the blood through selective diffusion for treatment of kidney failure.
- **Home health care**: When your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. Custodial care is not covered. Contact your Network/Claims Administrator to initiate the QuickReview process to be sure home health care is considered medically necessary.

- **Hospice care**: Eligible expenses for the care and treatment of a terminally ill covered person. Expenses in connection with hospice care include both facility and outpatient care. Hospice care is covered when approved by your Network/Claims Administrator. Contact your Network/Claims Administrator to initiate the QuickReview process to be sure hospice care is considered medically necessary.
- **Inpatient hospital expenses**: The inpatient hospital expense benefit applies to all inpatient hospital admissions, including hospitalization for mental health and chemical dependency care facility confinements. Physicians' charges are separate from inpatient hospital facility expenses.
    - The Retiree Standard Medical and Retiree Value Plus Options cover and pay inpatient hospital expenses based upon the negotiated rates with that particular in-network hospital.
    - Out-of-network eligible hospital expenses are determined based on the most common semiprivate room rate in that geographic area. They are subject to the out-of-network annual deductible and out-of-network co-insurance percentages.
- **Intensive care, coronary care or special care units (including isolation units)**: Coverage includes room and board and medically necessary services and supplies.
- **Laboratory or pathology expenses**: Coverage is provided for medically necessary diagnostic laboratory tests.
    - Under the Retiree Value Plus Option in-network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility.
- **Mammograms**: Medically necessary diagnostic mammograms, regardless of age.
    - Under the RVP Option in-network coverage, there are no limits on the number of mammograms covered in-network.
    - Coverage under the RSM Option and out-of-network under the RVP Option for routine mammograms for female retirees and female dependents is based on the following guidelines:
        - Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared
        - Once every year beginning at age 40
- **Mastectomy**: Certain reconstructive and related services are covered following a medically necessary mastectomy, including ALL of the following:
    - Reconstruction of the breast on which surgery was performed
    - Reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses
    - Services in connection with complications resulting from a mastectomy, including lymphedemas

- **Medical supplies**: Covered medical supplies include, but are not limited to:
  - Oxygen, blood and plasma
  - Sterile items including sterile surgical trays, gloves and dressings
  - Needles and syringes
  - Colostomy bags
  - The initial purchase of eyeglasses or contact lenses required because of cataract surgery

  Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered.
- **Multiple surgical procedures**: Reimbursement for multiple surgical procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery.
  - In-network surgeons are reimbursed based on negotiated rates
  - If using an out-of-network surgeon, use the CheckFirst predetermination of benefits program to determine the amount of coverage under the medical option you are enrolled in and to be sure the charges are within the applicable fee limits.

  Newborn nursery care: The hospital expenses for a newborn baby are considered under the baby's coverage, not the mother's. To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. The filing or payment of a maternity claim does not automatically enroll the baby. If you miss the 60-day deadline, you will not be able to add your baby to your coverage until the next Annual Benefits Enrollment period, even if you have other children enrolled in coverage.
  - Under RVP Option, hospital and medical expenses for a newborn baby's illness or injury are considered under the baby's coverage, not the mother's. The RVP Option covers hospital and medical expenses for a healthy newborn.
  - Under the RSM Option, newborn nursery care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits.
- **Nursing care**: Coverage includes medically necessary private duty care by a licensed nurse, if it is of a type or nature not normally furnished by hospital floor nurses.
- **Oral surgery**: Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process, only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the RSM Option and the RVP Option will pay room and board, anesthesia and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the Retiree Medical Benefit.
- **Outpatient surgery**: Charges for services and supplies for a surgical procedure performed on an outpatient basis at a hospital, freestanding surgical facility or physician's office. You should pre-authorize the surgery through QuickReview to ensure the procedure is medically necessary.
- **Physical or occupational therapy**: Restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a physician.

- **Physician's services**: Office visits and other medical care, treatment, surgical procedures and post-operative care for diagnosis or treatment of an illness or injury. The RVP Option covers office visits for certain preventive care, as explained under Preventive Care. The RSM Option does not cover preventive care, except as explained under Mammograms in this section.
- **Pregnancy**: Charges in connection with pregnancy, only for female retirees, female spouses of male retirees and female Company-recognized Domestic Partners, who are not eligible for Medicare. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed or certified by the state in which he/she practices. Within the first 16 weeks of pregnancy, you should call QuickReview to pre-authorize your hospitalization.
    - Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority.
    - Prescription prenatal vitamin supplements are covered.
    - Federal law prohibits the plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery or from requiring your provider to obtain pre-authorization for a longer stay. However, federal law does not require you to stay any certain length of time. If, after consulting with your physician, you decide on a shorter stay, benefits will be based on your actual length of stay.

  Charges in connection with pregnancy for covered dependent children are covered only if due to certain complications of pregnancy, for example: ectopic pregnancy, hemorrhage, toxemia, placental detachment and sepsis.
- **Prescription drugs**: Prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition. See Prescription Drug Benefit in the Retiree Value Plus Option section or the Retiree Standard Medical Option section. Prescriptions related to infertility treatment, weight control and oral contraceptives (used for family planning or birth control) are not covered. See Excluded Expenses for additional information regarding drugs that are excluded from coverage.

  Medically necessary medications are also covered for the following situations:
    - Medications administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit unless the medication is considered a specialty medication. In that case, it may only be covered under the Prescription Drug program. Check with your Network/Claims Administrator or Express Scripts/Medco to make sure that a specialty medication is covered if dispensed in a doctor's office. See the Specialty Medications section of the Retiree Standard Medical Option or Retiree Value Plus Option.

  - Medications that are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy are covered as part of the facility's ancillary charges.
  - Medications that are administered as part of home health care.
  - Diabetic supplies, including insulin, needles, chem-strips, lancets and test tape.
- **Preventive care**: The Retiree Value Plus Option covers preventive care, including well-child care, immunizations, mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages at 100% when administered by an in-network PCP. Non-routine tests for certification, sports or insurance are not covered.
  Preventive care is not covered under the RSM Option. Under the RSM Option, well-child care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits.
- **Prostheses**: Prostheses (such as a leg, foot, arm, hand or breast) necessary because of illness, injury or surgery. Replacement of prosthesis is only covered when medically necessary because of a change in the patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of a prosthesis resulting from normal wear and tear is not covered.
- **Radiology (X-ray) and laboratory expenses**: Examination and treatment by X-ray, radium or other radioactive substances, imaging/scanning (MRI, PET, CAT and ultrasound), diagnostic laboratory tests and annual mammography screenings for women (see Mammograms for guidelines).
  - Under the RVP Option, your in-network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility. If you use an in-network, non-hospital facility (doctor's office, imaging center, etc.), then these services are covered at 100%.
- **Reconstructive surgery**: Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears.
  Under the Women's Health and Cancer Rights Act, covered reconstructive services include:
  - Reconstruction of the breast on which a mastectomy was performed,
  - Surgery or reconstruction of the other breast to produce a symmetrical appearance,
  - Services in connection with other complications resulting from a mastectomy, such as lymphedemas, and
  - Prostheses
- **Retail Clinic Visits**: If you go to an in-network retail clinic (such as Minute Clinic in CVS stores, Healthcare Clinics in Walgreens stores, the Clinic at Wal-Mart, etc.) for health care services, under the RSM Option the eligible expense is subject to the deductible and co-insurance,(not paid as a co-payment). Under the RVP Option the eligible expense is paid as a copay.

- **Speech therapy**: Restorative and rehabilitative care and treatment for loss or impairment of speech when the treatment is medically necessary because of an illness, injury or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy.
- **Surgery**: When medically necessary and performed in a hospital, freestanding surgical facility or physician's office. (See CheckFirst for details about hospital pre-authorization and predetermination of benefits.)
- **Temporomandibular joint dysfunction (TMJD):** Eligible expenses under the medical benefits include only the following, if medically necessary:
    - Injection of the joints
    - Bone resection
    - Application of splints, arch bars or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion (crowns, bridges, or orthodontic procedures for treatment of TMJD are not covered)
    - Manipulation or heat therapy
    - Total TMJ replacement with prosthetic implant system (see requirements for coverage in the following paragraph)

  In order for total TMJ replacement to be covered, you need to meet ALL of the following requirements:
    - Your physicians/dentists must document, through their clinical records, that your TMJ replacement is the procedure "of last resort" (also termed, "salvage" procedure)
    - Your physicians/dentists must document, through their clinical records, all surgical and non-surgical care they've provided to you for this condition; that all other lesser procedures have been tried and have failed to improve your condition
    - The prosthetic implant system used in your surgery is one manufactured by either TMJ Concepts, Inc. (TMJ Solutions) or Walter Lorenz Surgical, Inc.
    - Your case meets all the generally accepted medical criteria for TMJ replacement
    - You are not undergoing TMJ replacement on any experimental or investigational basis
- **Transplants**: Expenses for transplants or replacement of tissue or organs if they are medically necessary and not experimental, investigational or unproven services. Benefits are payable for natural or artificial replacement materials or devices.

  Donor and recipient coverage is as follows:
    - If the donor and recipient are both covered under the Plan, expenses for both individuals are covered by the Plan.
    - If the donor is not covered under the Plan and the recipient is covered, the donor's expenses are covered to the extent they are not covered under any other medical plan, and only if they are submitted as part of the recipient's claim.
    - If the donor is covered under the Plan but the recipient is not covered under the Plan, no expenses are covered for the donor or the recipient.

The total benefit paid under this Plan for the donor's and recipient's expenses will not be more than any Plan Benefit applicable to the recipient.

You may arrange to have the transplant at an in-network transplant facility. Your Network/Claims Administrator can help you locate a transplant facility. These facilities specialize in transplant surgery and may have the most experience, the leading techniques and a highly qualified staff. Using an in-network transplant facility is not required. However, use of an out-of-network facility will be covered at the out-of-network rate.

It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria — not all transplant situations will be eligible for benefits. Therefore, you must contact your Network/Claims Administrator to initiate the QuickReview process as soon as possible for pre-authorization before contemplating or undergoing a proposed transplant.

The following transplants are covered if they are medically necessary for the diagnosed condition and are not experimental, investigational, unproven or otherwise excluded from coverage under the Medical Options, as determined in the sole discretion of the Plan Administrator and its delegate, the Network/Claims Administrator:

- Artery or vein
- Bone
- Bone marrow or hematopoietic stem cell
- Cornea
- Heart
- Heart and lung
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataract surgery
- Intestine
- Kidney
- Kidney and pancreas
- Liver
- Liver and kidney
- Liver and intestine
- Lung
- Pancreas
- Pancreatic islet cell (allogenic or autologous)
- Prosthetic bypass or replacement vessels
- Skin

This is not an all-inclusive list. It is subject to change. Contact your Network/Claims Administrator for more information.

- **Transportation expenses**: Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip ticket is covered for any illness or injury and will be covered only if medical attention is required en route. See Ambulance for information on ambulance services.
- **Tubal ligation and vasectomy**: These procedures are covered. Reversal of these procedures is not covered.
- **Urgent/immediate care**: Charges for services and supplies provided at an Urgent Treatment Clinic are covered. In order to receive the in-network benefit level, you should contact your Network/Claims Administrator if you go to an out-of-network provider within 48 hours to ensure that you receive the in-network level of benefits.
- **Well-child care**: Under the Retiree Value Plus (RVP) Option, in-network well-child care services are covered, with no age limit for such care.
    - The RVP Option covers out-of-network well-child care services for children up to age two for the initial hospitalization following birth, all immunizations and up to seven well-child care visits.
    - Under the Retiree Standard Medical Option, well-child care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits.
- **Wigs and hairpieces**: Eligible expense for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to:
    - Chemotherapy
    - Radiation therapy
    - Alopecia areata
    - Endocrine disorders
    - Metabolic disorders
    - Cranial surgery
    - Severe burns

  Only one wig or hairpiece benefit is covered under the Retiree Plan for the entire time the individual is covered. This benefit is subject to the usual and prevailing fee limits, deductibles, co-pays, co-insurance and out-of-pocket limits of the selected Retiree Medical Option. The maximum benefit available for wigs and hairpieces is $350. Replacement wigs or hairpieces are not covered, regardless of any change in the patient's physical condition. Hair transplants, styling, shampoo and accessories are also excluded.

Excluded Expenses

This section contains a list of alphabetical items that are excluded from coverage under the Retiree Standard Medical (RSM) Option and the Retiree Value Plus (RVP) Option, unless otherwise stated. For exclusions under the Retiree HMO, check with Humana directly.

- **Allergy testing**: Specific testing (called provocative neutralization testing or therapy), which involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.
- **Alternative and/or Complementary medicine**: Evaluation, testing, treatment, therapy, care and medicines that constitute alternative or complementary medicine, including but not limited to herbal, holistic and homeopathic medicine. (see the Glossary in the Reference Information section).
- **Claim forms**: The Plan will not pay the cost for anyone to complete your claim form.
- **Care not medically necessary**: All services and supplies considered not medically necessary.
- **Cosmetic treatment:** Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction and sclerotherapy for varicose veins or spider veins).
- **Cosmetic surgery:** Unless medically necessary and required as a result of accidental injury or surgical removal of diseased tissue.
- **Counseling**: All forms of marriage and family counseling.
- **Custodial care and custodial care items**: Custodial care and items such as incontinence briefs, liners, diapers and other items when used for custodial purposes, unless provided during an inpatient confinement in a hospital. or convalescent or skilled nursing facility.
- **Dental care**: No benefits are payable under the Retiree Medical Benefit for routine dental care or treatment of dental disease or defect, except as specifically described.
- **Developmental therapy for children**: Charges for all types of developmental therapy.
- **Dietician services**: Under the RSM Option no dietician services are covered. For the Retiree Value Plus Option, contact your Network/Claims Administrator to determine the services that are covered.
- **Drugs**:
    - Drugs, medicines and supplies that do not require a physician's prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem-strips, lancets and test tape.)
    - Drugs that are not required to bear the legend "Caution – Federal Law Prohibits Dispensing Without Prescription"
    - Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
    - Contraceptive drugs, patches or implants when used for family planning or birth control.

  - Drugs requiring a prescription under state law, but not federal law
  - Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy)
  - Drugs prescribed for cosmetic purposes (such as Minoxidil)
  - Medications used primarily for the purpose of weight control
  - Drugs used to treat infertility or to promote fertility
  - Drugs or devices used for smoking cessation
  - Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs not approved by the Food and Drug Administration (FDA) or experimental drugs, even though the individual is charged for such drugs
  - Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis
- **Ecological and environmental medicine**: See Alternative and/or Complementary Medicine
- **Educational testing or training**: Testing or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded).
- **Experimental, Investigational or Unproven treatment**: Medical treatment, procedures, drugs, devices or supplies that are generally regarded as experimental, investigational or unproven, including, but not limited to:
  - Treatment for Epstein-Barr Syndrome
  - Hormone pellet insertion
  - Plasmapheresis

  See the Experimental, Investigational or Unproven Treatment definitions in the Glossary of the Reference Information section.
- **Eye care**: Eye exams, refractions, eyeglasses or the fitting of eyeglasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training and vision therapy.
- **Foot care**: Diagnosis and treatment of weak, strained or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses or toenails. (This exclusion does not apply to the removal of nail roots.)
- **Free care or treatment**: Care, treatment, services or supplies for which payment is not legally required.
- **Gender reassignment/sex changes**: The Gender Reassignment Benefit (GRB) is not offered under the Retiree Standard Medical Option, only under the Retiree Value Plus Option. Any expenses received from an out-of-network provider will not be payable under the Retiree Value Plus Option. There is no coverage under the GRB for spouses, Company-recognized Domestic Partners or other eligible dependents.
- **Government-paid care**: Care, treatment, services or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian retirees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

- **Infertility treatment**: Expenses or charges for infertility treatment or testing and charges for treatment or testing for hormonal imbalances that causes male or female infertility, regardless of the primary reason for hormonal therapy.
    - Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction and infertility drugs such as Clomid or Pergonal are also excluded.
    - Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.
- **Lenses**: No lenses are covered except the first pair of medically necessary contact lenses or eyeglasses following cataract surgery.
- **Massage therapy**: All forms of massage and soft-tissue therapy, regardless of who performs the service.
- **Medical Error Events**: Services or supplies charged by the health care provider that are directly associated with, resulting from, or caused by medical mistakes, medical or surgical error, medical negligence or malpractice, preventable illness, preventable injury, or certain preventable complications arising from medical or surgical treatment, as defined by the Center for Medicare and Medicaid Services and identified as “never events.” Go the Center for Medicare and Medicaid Services website for fact sheets and news releases about these “never events”.
- **Medical records**: Charges for requests or production of medical records.
- **Missed appointments**: If you incur a charge for missing an appointment, the Plan will not pay any portion of the charge.
- **MNRP (Maximum Non-Network Reimbursement Program)**: For out-of-network providers under the Retiree Value Plus Option, any portion of the fees for physicians, hospitals and other providers that exceeds 140% of MNRP value.
- **Newborn nursery care**: Under the Retiree Standard Medical Option, hospital and/or medical expenses for a healthy newborn baby.
- **Nursing care**:
    - Care, treatment, services or supplies received from a nurse that do not require the skill and training of a nurse
    - Private duty nursing care that is not medically necessary or if medical records establish that such care is within the scope of care normally furnished by hospital floor nurses
    - Certified nurse’s aides
- **Organ donation**: Expenses incurred as an organ donor, when the recipient is not covered under the Plan. For additional information, see Transplant under Covered Expenses.

- **Prescription drugs**: Most specialty prescription drugs are excluded under the Retiree Medical Plans, but are included under the pharmacy benefit. These prescriptions must be filled at a retail pharmacy using your Express Scripts/Medco pharmacy drug card or through Accredo (Express Scripts/Medco's Specialty Mail Order Pharmacy) for you to receive prescription drug benefits. See Specialty Prescription Drugs in the RVP or RSM Option section.
- **Pregnancy for dependents**: Prenatal care and delivery charges are excluded for covered dependent children unless the charges are due to certain complications. Examples of covered complications include ectopic pregnancy, hemorrhage, toxemia, placental detachment and sepsis.
- **Preventive care**: Coverage for preventive care varies, depending on the Retiree Medical Option you have elected for coverage. To determine if preventive care is covered by your selected Retiree Medical Option, see Retiree Medical Benefit Options Overview Comparison Chart.
- **Relatives**: Coverage is not provided for treatment by a medical practitioner (including, but not limited to: a nurse, physician, physiotherapist or speech therapist) who is a close relative (spouse/Company-recognized Domestic Partner, child, brother, sister, parent or grandparent of you or your spouse/ Company-recognized Domestic Partners, including adopted and step relatives).
- **Sleep disorders**: Treatment of sleep disorders, unless it is considered medically necessary.
- **Sex changes**: Sex change, gender reassignment/revision, treatments or transsexual and related operations, except as provided under the Gender Reassignment Benefit (GRB).
- **Sexual performance treatment**: Prescription medications (including, but not limited to, Viagra, Levitra or Cialis), procedures, devices or other treatments prescribed, administered or recommended to treat erectile or other sexual dysfunction, or for the purpose of producing, restoring or enhancing sexual performance/experience.
- **Speech therapy**: Except as described in Covered Expenses, expenses are not covered for losses or impairments caused by conditions such as learning disabilities, developmental disorders or progressive loss due to old age. Speech therapy of an educational nature is not covered.
- **Temporomandibular joint dysfunction (TMJD):** Except as described in Covered Expenses, diagnosis or treatment of any kind for temporomandibular joint disease or disorder (TMJD) or syndrome by a similar name, including orthodontia to treat TMJD. Crowns, bridges or orthodontic procedures to treat TMJD.
- **Transportation**: Transportation by regularly scheduled airline, air ambulance or train for more than one round trip per illness or injury.
- **Usual and prevailing**: Any portion of fees for physicians, hospitals and other providers that exceeds the usual and prevailing fee limits. Applies to services rendered by out-of-network providers under the Retiree Standard Medical Option.
- **War-related**: Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.

- **Weight reduction**: Hospitalization, surgery, treatment and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact your Network/Claims Administrator to determine if treatment is covered.
- **Well-child care**: Under the RSM Option, well-child care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits. (See Covered Expenses for a description of coverage for well-child care under the RVP Option.)
- **Wellness items**: Items that promote well-being and are not medical in nature and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas and health club memberships). Also excluded are:
    - Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning, and
    - Services related to vocation, including but not limited to: physical or FAA exams, performance testing and work hardening programs.

  If you are covered under the RVP Option, contact your Network/Claims Administrator to determine if your option covers a specific preventive service for a particular medical condition.
- **Work-related**: Medical services and supplies for treatment of any work-related injury or illness sustained by you or your covered dependent, whether or not it is covered by Workers' Compensation, occupational disease law or other similar law.

Mental Health and Chemical Dependency Benefits

In addition to covered medical expenses, the Retiree Standard Medical (RSM) and Retiree Value Plus (RVP) Options cover medically necessary mental health and chemical dependency care as described below.

Mental Health Care

Covered expenses include medically necessary inpatient care (in a psychiatric hospital, acute care hospital or an alternative mental health care center) and outpatient care for a mental health disorder.

Inpatient mental health care

Under the RSM or RVP Option when you use in-network providers for hospitalization in a psychiatric hospital for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses for any other illness (see Inpatient room and board expenses under Covered Expenses), up to Retiree Medical Option maximums. To receive in-network mental health care benefits, you or your covered dependent should call your Network/Claims Administrator for an authorization or referral.

Alternative mental health care center

Each of the following are also covered under the Retiree Standard Medical Option and Retiree Value Plus Option. See the detailed Option Features Chart (RSM or RVP) for the option you are enrolled in for additional information on coverage.

- Residential treatment
- Intensive outpatient
- Partial hospitalization
- Outpatient mental health care

Chemical Dependency Care

Chemical dependency rehabilitation

Medically necessary chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient, or a combination. There are no limits on the number of chemical dependency rehabilitation programs a participant may attend (regardless of whether the program is inpatient or outpatient). The Plan does not cover expenses for a family member to accompany the patient being treated, although many chemical dependency treatment centers include family care at no additional cost.

Detoxification

This is a medical benefit, not a mental health care benefit. The coverage for this is detailed in the Retiree Medical Option Features Chart of the option you are enrolled in (RSM or RVP).

Gender Reassignment Benefit (GRB)

The Gender Reassignment Benefit (GRB) provides coverage for gender reassignment. The GRB is a limited, one-time benefit for the entire time you are covered under an AMR health plan (either as an active employee or retiree). Throughout this section you will find specific questions and answers that help to describe key features of the GRB.

Key features of the GRB Benefit include:

- The GRB is offered under Retiree Value Plus Option only; it is not offered under the Retiree Standard Medical Option or the Retiree HMO (if you reside in Puerto Rico).
- The GRB only offers benefits on an in-network basis, there are no GRB benefits offered out-of-network.
- The GRB offers a $75,000 surgical benefit and $10,000 for travel reimbursement.
- Any co-insurance or co-payment amounts for in-network medical visits and prescription drugs do not accumulate towards the surgical benefit limit.
- This benefit applies only to retirees. This benefit is not available to spouses, Company-recognized Domestic Partners and other eligible dependents.
- You must have approval from the Network/Claims Administrator both at the time you begin your treatment and at the time you are admitted for surgery.

What happens if I use part of my $75,000 GRB surgical benefit with one Network/Claims Administrator and then change to a different Network/Claims Administrator for the following plan year?

Coverage for surgical benefits under the GRB is limited to $75,000, regardless of your Network/Claims Administrator, even if you change administrators. Therefore, the amount you used under the first administrator will be carried over to the new administrator and you will have the same remaining benefit available as with the previous carrier.

Do I have any additional benefit if I received the full benefit amount under the GRB for active employees?

No, an employee who receives the full benefit amount under AMR's health plan for active employees cannot receive any additional benefits under the retiree plan. However, if you did not receive the maximum GRB as an active employee, you may receive a balance GRB under the Retiree Medical Plan, not to exceed a combined benefit of $75,000 for surgical benefits and $10,000 for travel reimbursement.

What if I chose to use a doctor or facility that is out-of-network?

The GRB is not offered out-of-network. All medical visits and prescription drugs incurred from out-of-network providers are excluded from coverage. This includes any doctor's or specialist visits, therapy, and retail or mail order prescription drugs.

GRB Coverage
The Retiree Value Plus Option pays the following benefits:

- Continuous hormone replacement (hormones of the desired gender), including laboratory testing to monitor the safety of continuous hormone therapy.
- Evaluation and diagnosis by a psychological professional and psychotherapy, as set forth in standard treatment protocols.
- Genital revision surgery and bilateral mastectomy or bilateral augmentation mammoplasty, as applicable to the desired gender.

Surgical Benefit
Surgical benefits are limited to one bilateral mastectomy or bilateral augmentation mammoplasty, and one genital revision surgery for the entire time you are covered under an AMR health plan, (either as an employee or a retiree). Subsequent surgical revisions, modifications or reversals are excluded from coverage. Coverage is limited to treatment performed by in-network providers.

Consideration for benefits is guided by the most current standards of care as published by the World Professional Association for Transgender Health (WPATH) and by the provisions, limitations and exclusions as set forth by the Plan.

Prescription drugs and mental health treatment associated with the GRB are considered under the Plan's behavioral and mental health and prescription drug provisions; subject to applicable provisions, limitations and exclusions.

Travel Reimbursement
Gender reassignment surgery is performed at limited locations in the United States, and most patients will need to travel outside their immediate home area. If travel is required for surgery because it is not offered in your immediate home area, travel to an in-network surgery provider and lodging expenses will be reimbursed up to a maximum of $10,000. To be eligible for reimbursement, travel must be over 100 miles away from your home and must be by air, rail, bus or car. The $10,000 covers you and one caretaker to travel with you for in-network surgery only. You are only allowed to travel in-network within the 48 contiguous United States. Lodging expenses include hotel or motel room, car rental, tips and cost of meals while you are not hospitalized and for your caretaker.

> **How do I obtain reimbursement for my travel expenses related to my GRB?**
> Contact your Network/Claims Administrator for instructions on receiving reimbursement for your expenses. Keep in mind, itemized receipts will be required by your Network/Claims Administrator.

Preauthorization for the GRB
You must have approval from the Network/Claims Administrator **both at the time you begin your treatment and at the time you are admitted for surgery**. Your failure to obtain preauthorization both at the time you begin treatment and at the time you are admitted for surgery will result in denial of your claims.

See CheckFirst (Pre-Determination of Benefits) and QuickReview (Pre- Authorization) — Network/Claims Administrator later in this section.

Maximum Medical Benefit

The Maximum Medical Benefit is the most a benefit or plan will pay for eligible expenses during the entire time a person is covered by the benefit or plan. Maximum Medical Benefit amounts for retirees and eligible dependents are based on the Retiree Medical Benefit Option you select.

Maximum Medical Benefit Overview Chart

If you are a…	**Enrolled in…**	**You and your eligible covered dependents each have a Maximum Medical Benefit of:**
Retiree from any workgroup *	Retiree Standard Medical (RSM) Option	$300,000 Automatic $3,500 annual restoration applies
Retiree from any workgroup	Retiree Value Plus (RVP) Option	$1,000,000. No annual restoration
Split Coverage Spouse *(effective 1/1/13)*	RSM Option	$300,000 Automatic $3,500 annual restoration applies
Split Coverage Spouse *(effective 1/1/13)*	RVP Option	$1,000,000. No annual restoration
Surviving Spouse *(effective 1/1/13)*	Either Retiree Medical Benefit Option (RSM or RVP)	$300,000 No annual restoration

**Flight Attendants who leave the Company under Article 30 on or after 11/1/2012 are not eligible for Retiree Medical Benefits.*

****SPECIAL TRANSITION PROVISION ****
Applies to Split Coverage & Surviving Spouses between 11/1/12 and 12/31/12 ONLY

If you are a…	At the time of the Life Event change, you may enroll in…	On January 1, 2013 you may enroll yourself and your eligible dependents in the…
Spouse of a Retiree who turns age 65 between 11/1/12 and 12/31/12	Retiree COBRA plan for coverage until being eligible to enroll in a Retiree Medical Benefit option as a Split Coverage Spouse on 1/1/13	Retiree Medical Benefit option as a Split Coverage Spouse
Spouse of an Active Employee who dies between 11/1/12 and 12/31/12 and was eligible for retirement at the time of his/her death	Active COBRA plan for coverage until being eligible to enroll in a Retiree Medical Benefit option as a Surviving Spouse on 1/1/13	Retiree Medical Benefit option as a Surviving Spouse
Spouse of an Retiree who dies between 11/1/12 and 12/31/12	Retiree COBRA plan for coverage until being eligible to enroll in a Retiree Medical Benefit option as a Surviving Spouse on 1/1/13	Retiree Medical Benefit option as a Surviving Spouse

Maximum Medical Benefit – When Moving Between Plan Options

Your retiree Maximum Medical Benefit is determined at the time you enter a new medical benefit option (i.e. your annual election). However, if you elect to move between the RSM and the RVP Option, the amount you have used as a retiree will accumulate from both the RSM and RVP Options (or other company-sponsored retiree medical benefit, should other such benefits be created) toward a common retiree Maximum Medical Benefit. See the following examples for more information.

Examples of Maximum Medical Benefits When Moving Between Plan Options

A participant in the…	**The plan has previously paid …**	**Transitions to the…**	**Will now have…**
RSM Option	$100,000 *(Of $300,000 Medical Max for RSM)*	RVP Option	$900,000 *($1,000,000 minus the amount previously paid under the Retiree Medical Benefit)*
RSM Option	$300,000 *(Of $300,000 Medical Max for RSM)*	RVP Option	Because the Maximum Medical Benefit has been exhausted before the desired transition, he/she is not permitted to become a RVP Option participant and no longer has medical coverage under the Retiree Medical Benefit
RVP Option	$100,000 *(Of $1,000,000 Medical Max for RVP)*	RSM Option	$200,000 (*$300,000 minus the amount previously paid under Retiree Medical Benefit)*

Retiree-to-Rehire

American Airlines may, from time-to-time, offer active employment to retirees. If you retire from American Airlines and are later rehired by American you are referred to as a retiree-to-rehire employee.

Upon Rehire

Retiree-to-rehire employees move from retiree to active benefit status. This only applies to retirees who are rehired as active regular employees, and does not apply to retirees who work at American Airlines as temporary workers.

What am I eligible for, if I am hired as a retiree-to-rehire employee?
You will be eligible for the same active health and welfare benefits available to other eligible active employees in your workgroup. And you will pay the same active rates (See the Employee Benefit Guide for active employees).

If I am rehired in a workgroup eligible for limited benefit plans, such as a Home-Based Representatives or Level 84 Premium Services Representatives, what will I be eligible for?
You will be eligible for the same active limited health and welfare benefits available to other eligible active employees in your workgroup. Your coverage limits will be in accordance with the provisions of these limited active benefit plans.

When You Return to Retirement

When your retiree-to-rehire employment with the Company ends, and you return to retirement, you will return to retiree benefit status based on your original retirement date. You will be eligible to return to the same retiree coverage you participated in immediately prior to your most recent rehire, subject to any changes made to the coverage since you left the plan. That is, if you originally retired on or prior to October 31, 2012, you will return to the same benefits that were in force at the time you originally retired, therefore you should reference the applicable Retiree Benefit Guide.

Your claims paid under the Retiree Medical Benefit (not your Active Medical Benefit) will accumulate towards your Maximum Medical Benefit under the Retiree Medical Benefit. You may re-enter the Retiree Medical Benefit when you return to retirement by resuming payment of your coverage contributions (if applicable).Your rates will be those in effect at the time of your return to retirement. Your rates will not be retroactive.

Upon your return to retirement, should you need to make any changes to your benefits, contact HR Services.

Your Network/Claims Administrator

A network administrator is the health plan administrator that processes health care claims and manages a network of health care providers and care facilities.

Retiree Medical Benefits – BOTH Retiree Standard Medical (RSM) and Retiree Value Plus (RVP) Options – are administered by three Network/Claims Administrator:

- Aetna
- Blue Cross and Blue Shield of Texas (BCBS)
- UnitedHealthcare (UHC)

Each state has ONE preferred Network/Claims Administrator. The preferred Network/Claims Administrator for each state is the sole network provider of health care services for Retiree Medical Benefits. Therefore, you cannot select a different Network/Claims Administrator. The map of the Network/Claims Administrator by state can be found on the Benefits Page of my.aa.com.

Your state is determined by the ZIP code listed as part of your Jetnet alternate address. If you do not have an alternate address on file in the Update MY Information Page of Jetnet, your state will be determined by your permanent address.

Remember, because many retirees maintain more than one residence, you may list both addresses in Jetnet and your alternate address determines your geographical Retiree Medical Benefit eligibility.

Administrator's Discretion

The Plan Administrator may, at its sole discretion, pay benefits for services and supplies not specifically stated under the Plans. If this service or supply you've received is more expensive when a less expensive alternative is available, the Plan(s) pays benefits based on the less expensive service or supply that is consistent with generally accepted standards of appropriate medical, dental or other professional health care.

CheckFirst

This pre-determination of benefits service is included as part of your coverage under the Retiree Standard Medical (RSM) or the Retiree Value Plus (RVP) Option.

CheckFirst allows you to find out if:

- The recommended service or treatment is covered by your selected Retiree Medical Option
- Your physician's proposed charges fall within the Plan's usual and prevailing fees (applies to RSM Option only for out-of-network services), or
- Your physician's proposed charges fall under the MNRP fee limits (applies to RVP Option only for out-of-network services). See "MNRP" in the RVP Option section.

If you are covered by the RSM Option, or the RVP Option and you are using an in-network provider, the provider's fees are not subject to usual and prevailing fee limits or MNRP. However, you may want to contact your Network/Claims Administrator to determine if the proposed services are covered under your selected Medical Option.

To use CheckFirst, you may either submit a CheckFirst Pre-determination of Medical Benefits form before your proposed treatment or you may call your Network/Claims Administrator to obtain a predetermination of benefits by phone. If you are having surgery your Network/Claims Administrator(as part of your Network/Claims Administrator's hospital preauthorization process) will determine the medical necessity of your proposed surgery before making a pre-determination of benefits. Your Network/Claims Administrator will mail you a written response. Even if you use CheckFirst, your Network/Claims Administrator reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different than the information submitted for pre-determination of benefits. Claims are processed in order of receipt. Payment of a claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

For hospital stays, CheckFirst can pre-determine the amount payable by the Plan. A CheckFirst pre-determination does not pre-authorize the length of a hospital stay or determine medical necessity. You must call your Network/Claims Administrator for your Medical Plan Option for preauthorization

(see QuickReview (Pre-Authorization)).

Although you may find CheckFirst beneficial whenever you need medical treatment, there are two circumstances when you may especially benefit by using CheckFirst. Use this predetermination procedure if your physician recommends either of the following:

- Assistant surgeon: A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if there is a medical necessity, you must use the CheckFirst procedure.
- Multiple surgical procedures: If you are having multiple surgical procedures performed at the same time, any procedure that is not the primary reason for surgery is covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgeon. You must use CheckFirst to find out how the Plan reimburses the cost for any additional procedures.

In addition, for the Gender Reassignment Benefit (GRB), you must have approval from the Network/Claims Administrator both at the time you begin your treatment and at the time you are admitted for surgery. See the Gender Reassignment Benefit (GRB) section for more information.

QuickReview (Pre-Authorization)

This pre-determination of benefits service is included as part of your coverage under the Retiree Standard Medical (RSM) or the Retiree Value Plus (RVP) Option.

You or your provider acting on your behalf are required to request pre-authorization from your Network/Claims Administrator before any hospital admission, or within 48 hours (or the next business day if admitted on a weekend) following emergency care. If you do not contact your Network/Claims Administrator, your expenses are still subject to review and will not be covered under the Plan if they are considered not medically necessary. To Request Pre-authorization, call your Network/Claims Administrator or Retiree HMO (as applicable).

When should I request approval from my Network Administrator?
Any portion of a stay that has not been approved through your network administrator is considered not medically necessary and will not be covered by the option. For example, if your Network/Claims Administrator determines that five hospital days are medically necessary for your condition and you stay in the hospital seven days, charges for the extra two days will not be covered. Your physician should contact your Network/Claims Administrator to request pre-authorization for approval of any additional hospital days.

Call your Network/Claims Administrator for the following situations:

- ❑ Before you are admitted to the hospital for an illness, injury, surgical procedure or pregnancy
- ❑ Within 48 hours after an emergency hospital admission (or the next business day if you are admitted on a weekend)
- ❑ Before outpatient surgery to ensure that the surgery is considered medically necessary
- ❑ Before you undergo testing or treatment for sleep disorders
- ❑ Before you contemplate or undergo any organ transplant
- ❑ Before you undergo a procedure that will incur a substantial expense

The list above is not comprehensive. Contact your Network/Claims Administrator for more information.

Contacting the Network/Claims Administrator for pre-authorization
If you are using an in-network provider, the provider will on your behalf. If you are in seeing an out-of-network provider, you must call yourself.

If your physician recommends surgery or hospitalization, ask your physician for the following information before calling your Network/Claims Administrator for pre-authorization:

- Diagnosis and diagnosis code
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician's name and telephone number
- Name and telephone number of the hospital or clinic where surgery is scheduled.

What if my illness or injury prevents me from personally contacting my Network/Claims Administrator, can someone else call on your behalf?
Yes, any of the following may call on your behalf:

- A family member or friend
- Your physician
- The hospital

What happens when I call my Network/Claims Administrator?
Your Network/Claims Administrator will tell you:

- Whether the proposed treatment is considered medical necessity and appropriate for your condition
- The number of approved days of hospitalization

In some cases, your Network/Claims Administrator may refer you for a consultation before surgery or hospitalization will be authorized. To avoid any delays in surgery or hospitalization, notify your Network/Claims Administrator as far in advance as possible.

What happens after I am admitted to the hospital?
After you are admitted, your Network/Claims Administrator program provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, your Network/Claims Administrator consults with your physician and hospital to verify the need for any extension of your stay.

What if I am discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness?
You must contact your Network/Claims Administrator again to authorize any additional hospitalization.

Do I need to call my Network/Claims Administrator if I am only having outpatient surgery?
Yes, you should still call your network administrator for scheduled for outpatient surgery, If you do not call, you may be subject to a retrospective review of the surgery to determine whether it was medically necessary. This means you or your physician may be asked to provide medical documentation to support the medical necessity.

Gender Reassignment Benefit – Pre-Authorization
You must have approval from the Network/Claims Administrator both at the time you begin your treatment and at the time you are admitted for surgery. See the Gender Reassignment Benefit (GRB) section for more information.

Claims are processed in order of date received. Payment of any claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

What other medical benefits may I be eligible for?

In this section, you will find general information about Medicare, in addition to details of the Supplemental Medical Plan and Additional Rules pertaining to Retiree Medical Benefits.

Contents of the "What other medical benefits may I be eligible for?" Section:

About Medicare Coverage

If you are covered by Medicare or will soon be eligible for Medicare coverage, knowing how Medicare coverage works will help you understand how benefits apply under the Retiree Medical Benefit. This summary provides general information about Medicare, but does not explain all of its benefits and features. If you have specific questions contact the Social Security Administration or refer to your written materials received from Medicare. Medicare information is also available on the Medicare website.

Medicare Eligibility

When you become eligible for Medicare, it will become your primary coverage. If you are still eligible for the Company Retiree Medical Benefit, (See the Am I Eligible? Section) this benefit coverage will become secondary.

Medicare at Age 65

You or your spouse are eligible for Medicare on the first day of the month in which you turn age 65 if both of the following apply:

- ❑ You or your spouse worked at least 10 years in Medicare-covered employment
- ❑ You or your spouse are either a U.S. citizen or a permanent resident.

If you attain age 65 on the first day of the month, Medicare coverage is effective on the first day of the month prior to your 65th birthday.

Pre-65 Medicare

You may qualify for Medicare coverage if you are Pre-65 and are disabled or have chronic kidney disease. Visit the Medicare website for the most current information on Medicare.

What are the Types of Medicare?
There are four (4) types of Medicare to consider. You may choose coverage under Original Medicare or under a Medicare Advantage Plan (Part C). Original Medicare includes Part A (hospital coverage) and Part B (medical coverage). In addition, you may also choose a Medicare prescription drug program under Medicare Part D. See the Chart below for a quick overview of the types of Medicare.

Note that this guide and overview are not designed to give all the details about Medicare coverage. Please visit the website as it provides more information about all types of Medicare. Carefully review the website and any written materials you receive from Medicare when choosing the option(s) that will best fit your needs.

Overview of Medicare Types		
	Type of Medicare	**Coverage includes**
Original Medicare	**Medicare Part A (Hospital Care)**	• Inpatient hospital care • Skilled nursing facilities following a hospital stay • Home health care • Hospice care
	Medicare Part B (Medical Coverage)	Medical expenses such as: • Doctor's charges, • Inpatient medical and surgical services and supplies • Outpatient medical and surgical services and supplies • Physical, occupational and speech therapy • Diagnostic tests • Durable medical equipment • Clinical laboratory and X-ray services • Home health care • Outpatient hospital services for diagnosis and treatment of an illness or injury • Certain preventive services • Blood

Overview of Medicare Types		
	Type of Medicare	**Coverage includes**
Medicare Advantage	**Medicare Part C** Health care coordinated through a Health Maintenance Organization (HMO), an HMO with a Point of Service (POS) option, a Preferred Provider Organization (PPO) or a Provider Sponsored Organization (PSO). Medicare Advantage also includes private Fee-for-Service plans and Medical Savings Accounts.	All of the same benefits as Parts A and B. Some plans may include additional benefits such as coverage for: • Prescription drugs • Routine physical exams • Hearing aids and exams • Eye exams and glasses • Dental services • Health education and wellness programs
	Medicare Part D	Primary prescription drug coverage at participating pharmacies for: • Brand name drugs • Generic drugs

If you have specific questions contact the Social Security Administration or refer to the written materials you receive from Medicare. In addition, Medicare information is also available on the Medicare website.

Supplemental Medical Plan

The Supplemental Medical Plan is a medical benefit plan covering eligible retirees of the Company and their eligible spouses. In this section, the Supplemental Medical Plan may also be referred to as the "SMP." The SMP offers participants an additional $500,000 coverage should the retiree Benefit be exhausted. The SMP will pay a percentage of eligible expenses for medically necessary care, treatment and supplies up to the usual and prevailing fee limits. Throughout this section, you will find questions and answers specific to the Supplemental Medical Plan that may help you further understand how it works.

Supplemental Medical Plan Eligibility

You are eligible for the Supplemental Medical Plan if you meet all of the following eligibility requirements:

- ❑ Are a retired American Airlines, Inc. employee or the spouse (or Company-recognized Domestic Partner) of a retired employee
- ❑ Have not yet reached your 65th birthday
- ❑ Are eligible for and maintain enrollment in one of the following Company-sponsored Medical Benefit Options (under age 65 only):
  - Retiree Standard Medical (RSM) Option
  - Retiree Value Plus (RVP) Option
  - Retiree HMO (RHMO) (Puerto Rico retirees only)
- ❑ Enroll for Supplemental Medical Plan coverage when you first initiate your retiree medical coverage

The following retirees are NOT eligible for the Supplemental Medical Plan:

- Pilots
  (access is available to a union-sponsored supplemental health plan)
- Flight Attendants who selected the Article 30 option of the APFA contract
- Any Retiree age 65 and over

Maintaining Eligibility

The Supplemental Medical Plan is a term (year-to-year) plan. To remain eligible for the SMP, you must maintain your coverage every year by paying your contributions when due annually. If you do not pay your contributions, you will no longer have coverage or be eligible to re-enroll under the Supplemental Medical Plan.

I did not enroll in the Supplemental Medical Plan when I first enrolled in my Retiree Medical Benefit Option, can I enroll later?

No, if you do not enroll for coverage when you first initiate your retiree medical coverage or do not maintain the coverage through your retirement, you are not eligible for this coverage.

Eligibility for Spouses of Retired Employees
You may elect coverage for your spouse (or Company-recognized Domestic Partner (DP)) at the time you enroll yourself in the Supplemental Medical Plan (when you first initiate your retiree medical coverage). You (the retiree) must be enrolled in the Supplemental Medical Plan in order for your spouse/DP to be eligible for the Supplemental Medical Plan. If currently covered under the SMP, the spouse/DP is eligible to retain the SMP in the event of the retiree's death (see eligibility for Surviving Spouses below).

If your spouse/DP is not enrolled in a Company-sponsored Retiree Medical Benefit Option, your spouse will not be eligible to participate in the SMP.

Eligibility for Surviving Spouses and Company-recognized Domestic Partners
Your surviving spouse must notify HR Services and Health First TPA of your (the retiree's) death (see Information in the Reference Information section). If he/she was enrolled in the SMP at the time of your death, Health First TPA will send the enrolled surviving spouse information within 30 days of receipt of notification of the retiree's death. The enrolled surviving spouse will receive an ID card, the Retiree Benefit Guide and a claim form. The enrolled surviving spouse will receive a bill for the annual contribution each year thereafter.

If your surviving spouse does not receive the enrollment information from HealthFirst TPA within 30 days of notifying HR Services of the retiree's death, he/she should contact HealthFirst TPA.

If you die as a retired employee while you and your spouse (or Company-recognized Domestic Partner) are covered under the Supplemental
Medical Plan and are both under age 65, he/she may remain in coverage under the SMP. Use the chart below to understand how long your Surviving Spouse/DP will be eligible to maintain coverage in the SMP.

If you are a retiree from any workgroup (other than Pilot or Flight Attendant who retired under the Article 30 option)	
Your under 65 Surviving Spouse may:	Continue coverage on the SMP and use it as his/her primary medical coverage if enrolled in the Company-sponsored Retiree Medical Benefit and only after exhausting the Maximum Medical Benefit. If your Surviving Spouse has other medical coverage, he/she must first file claims with that plan. The SMP will pay as the secondary plan according to Coordination of Benefits provisions. Eligibility for coverage on the SMP ends on the date when one of the following first occurs: • Your Surviving Spouse reaches age 65 • Your Surviving Spouse remarries
Your under 65, Surviving Company-recognized Domestic Partner, may:	Continue coverage for 90 days from the date of your death, provided he/she pays the SMP contribution rate to continue coverage. At the end of the 90-day period, SMP coverage ends and is not available through COBRA.

Making Changes to Your Coverage
Contact HealthFirst TPA to make changes to your coverage if you have a qualifying Life Event and you wish to make a change in your Supplemental Medical Plan coverage. You must make the change within 60 days of the event.

What do I need to do if I am already retired and I get married or declare a Company-recognized Domestic Partner (DP)?
As long as you are enrolled in and have maintained your Supplemental Medical Plan coverage, you may add your spouse/DP to your SMP within 60 days of the event. If you miss the 60-day deadline, you will not be able to add your spouse/DP to your coverage.

Paying for Supplemental Medical Plan Coverage
To remain eligible for the Supplemental Medical Plan, you must maintain your coverage every year by paying your contributions when due annually. There are two ways you pay for SMP coverage as a retiree. You make payments directly to one of the following:

- HealthFirst TPA (call HealthFirst TPA at 1-800-711-7083 between 8:00 a.m. and 5:00 p.m. Central time for instructions).
- HealthFirst's COBRA Administrator, if your coverage is being continued under COBRA.

How the Supplemental Medical Plan Works

The Supplemental Medical Plan pays a percentage of eligible expenses for medically necessary care, treatment and supplies up to the usual and prevailing fee limits. Refer to the Supplemental Medical Plan Benefits chart later in this section for a detailed summary.

When will the Supplemental Medical Plan pay a benefit?

If you elect coverage under the Supplemental Medical Plan, it will pay a benefit under any of these three circumstances:

- ❑ When you or your covered spouse/ Domestic Partner (DP)exhausts your Benefit under your Company-sponsored Retiree Medical Benefit Option
- ❑ If you are the surviving spouse of a retired employee who dies while you are both covered under the SMP and you have exhausted your maximum medical benefits under your selected Company-sponsored Retiree Medical Benefit Option
- ❑ If you die while you and your Company-recognized Domestic Partner are covered under the SMP, coverage for your DP continues for 90 days from the date of your death, provided he/she pays the SMP contribution rate to continue coverage. At the end of the 90-day period, SMP coverage ends and is not available through COBRA.

Supplemental Medical Plan Key Features

- **Eligible expenses**: The Supplemental Medical Plan covers regular, medically necessary services, supplies, care and treatment of non-work related injuries or illnesses when ordered by a licensed physician acting within the scope of his or her license (see the Covered Expenses under Supplemental Medical Plan later in this section).
- **Usual and prevailing fee limits**: The amount of benefits paid for eligible medical expenses is based on the usual and prevailing fee limits for that service or supply in that geographic location.
- **Maximum Medical benefit**: When the individual's Maximum Medical Benefit is exhausted, coverage terminates as of the date the expenses resulting in exhaustion of the benefit are incurred.
    - If the retiree exhausts his/her Maximum Medical Benefit but his/her covered eligible spouse has not yet exhausted his/her respective Maximum Medical Benefit, that covered eligible spouse may remain in his or her medical coverage under the Supplemental Medical Plan (as long as he/she continues to meet eligibility requirements).
- **CheckFirst (Predetermination of Benefits)**: To determine if a proposed medical service is covered under the SMP, use CheckFirst to obtain a predetermination. Call HealthFirst TPA (see Contact Information) to request a predetermination by phone or to request a predetermination form. You must receive the predetermination from HealthFirst TPA before you receive the proposed medical service.

Supplemental Medical Plan Benefits Features Chart	
SMP Feature	**Amount of Coverage**
Individual Maximum Medical Benefit	$500,000 per SMP participant
Annual Individual Deductible • Deductible must be met before benefits are payable • Does not count towards the out-of-pocket maximum	$250 per person
Annual Out-of-Pocket Max (OOP Max) • After meeting OOP Max, the SMP pays 100% of eligible expenses within usual and prevailing fee limits for the rest of the calendar year • This does not include expenses paid by the SMP at 50% • The deductible cannot be used to meet the out-of-pocket max	$1,000 per person each calendar year
Illness and diagnostic services	80%
Emergency room	
Surgery (inpatient or outpatient)	
Physician's office visit	
X-ray and laboratory charges	
Prescription drugs	
Hospital care	80%
Daily hospital room allowance (based on average semiprivate room rate)	
Intensive care room allowance	
Ancillary charges	
Convalescent and skilled nursing facilities • Limited to 30 days confinement per illness or injury for skilled nursing facility	50%
Home health care	80%
Hospice care • Including bereavement counseling within 90 days of the death of the participant for family members (siblings, spouse and children of the patient)	80%
Mental health care inpatient services	80%
Alternative mental health care centers	Actual facility charge or 80% of the area's semiprivate room rate, whichever is less

Supplemental Medical Plan Benefits Features Chart	
SMP Feature	**Amount of Coverage**
Mental health care outpatient services, including prescription drugs	80%
Chemical dependency care • **No Max confinement limits**	80%
Inpatient services	
Outpatient services	
Other covered expenses	80%

Covered Expenses
All services must be medically necessary to be considered covered expenses. To be covered, an expense must be medically necessary, within usual and prevailing fee limits and an eligible/covered expense under the SMP. Only eligible expenses can be used to satisfy the annual deductible and annual out-of-pocket maximum.

Hospital Care

- **Inpatient hospital expenses**: Hospital room and board charges, based upon the average semiprivate room rate in that geographical area. If the hospital does not have semiprivate rooms, the SMP considers the eligible expense to be 90% of the hospital's lowest private room rate.
- **Intensive care unit**: The usual and prevailing fee limits for services and supplies (excluding personal items) provided while the covered person is hospitalized in the hospital's intensive care unit.
- **Emergency room**: Services and supplies provided by a hospital emergency room.
- **Ancillary charges**: Ancillary charges for inpatient hospital services and supplies and operating room use.
- **Illness and Diagnostic Services**: In addition to hospital care, the following medically necessary services are covered:
  - **Physician's office visits**: For a diagnosis or treatment of an illness or injury.
  - **X-ray (Radiology) and laboratory charges**
  - **Prescription drugs**
  - **Surgery**: When performed in a hospital, a freestanding surgical facility or a physician's office.

Out-of-Hospital Care

- **Convalescent or skilled nursing facilities:** Eligible expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility and are under the continuous care of a physician. Your physician must certify that this admission is an alternative to a hospital admission. Benefits are limited to a maximum of 30 days' confinement per illness or injury. Room and board charges are covered at one-half the most common semiprivate room

rate for inpatient hospital expenses in a geographical area. Custodial care is not covered.

- **Home health care:** Covered only when the visits are medically necessary and when certified by your physician for the care and treatment of a covered illness or injury. The claims processor may require the physician to provide an approved treatment plan before paying benefits and may periodically review that treatment plan. Custodial care is not covered. The SMP does not limit the number of covered home health care visits.
- **Hospice care**: Eligible expenses in connection with hospice care include hospice facility, outpatient care and bereavement counseling.
  - If the physician determines that the patient is terminally ill, the patient may receive hospice care for an unlimited period of time. Bereavement counseling is covered for the participant's family (the patient's spouse, children [natural, step and adopted] and siblings) (including Company-recognized Domestic Partners) for 90 days, beginning on the date of the participant's death. Bereavement counseling benefits continue even if coverage ends under the SMP.
  - HealthFirst TPA, the claims processor, may require the physician to provide an approved treatment plan before paying hospice benefits and may periodically review the treatment plan.
- **Pregnancy**: Charges in connection with pregnancy are covered only for female retirees, female spouses of male retirees and female Company-recognized Domestic Partners. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed or certified by the state in which he/she practices.
  - Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority. Federal law prohibits the SMP from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a Cesarean delivery or from requiring your provider to obtain pre-authorization for a longer stay. However, federal law does not require you to stay any certain length of time. If, after consulting with your physician, you decide on a shorter stay, benefits will be based on your actual length of stay.

Mental health and chemical dependency care: Mental health and dependency care is benefited the same as any other illness or injury covered by the Supplemental Medical Plan.

- **Mental health care**: Covered expenses include inpatient care (in a psychiatric hospital or a residential treatment center) and outpatient care for a mental health disorder.
- **Inpatient mental health care**: When you are hospitalized in a psychiatric hospital or a residential treatment center for a mental health disorder, expenses during the period of hospitalization are covered (the same as inpatient hospital expenses) up to Supplemental Medical Plan maximums.

- **Alternative mental health care center**: Expenses for alternative mental health care are covered at 80%.
- **Outpatient mental health care**: Expenses for outpatient mental health care (including prescription drugs) are covered at 80%.
- **Chemical dependency care**: Covered chemical dependency care expenses can be inpatient, outpatient, or a combination. You are covered at 80% for inpatient chemical dependency rehabilitation programs or at 80% for outpatient chemical dependency. The SMP does not cover expenses for a spouse or family member to accompany the patient being treated.

Other Covered Expenses

- **Ambulance**: Medically necessary professional ambulance services to and from:
  - The nearest hospital able to provide necessary treatment in the event of an emergency, or
  - The nearest hospital or convalescent or skilled nursing facility for inpatient care.
- **Anesthesia**: Medically necessary anesthesia and its administration. The SMP does not cover expenses for an anesthesiologist to remain available when not directly tending to the care of the patient.
- **Assistant surgeon**: Assistant surgeon's fees only when the surgical procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst predetermination procedure.
- **Chiropractic care**: Medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license.
- **Cosmetic surgery or treatment**: Expenses for cosmetic surgery or treatment are only covered if they are medically necessary and incurred for either of the following:
  - As the result of a non-work related injury, or
  - For replacement of diseased tissue surgically removed.
- **Durable medical equipment**: Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The SMP may, at its option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME and/or components (such as batteries or software) resulting from normal wear and tear is not covered.
  - Examples of DME are items such as CPAP or BiPAP machines, wheelchairs, hospital beds, nebulizers, oxygen concentrators, TENS units, passive range of motion devices, joint cooling devices, bone stimulators, etc.
- **Laboratory or pathology expenses**: Coverage is provided for medically necessary diagnostic laboratory tests.
- **Medical supplies**: Including, but not limited to:

- Oxygen, blood and plasma
- Sterile items, including surgical trays, gloves and dressings
- Needles and syringes
- Colostomy bags
- The initial purchase of eyeglasses or contact lenses required because of cataract surgery performed while covered.
- Diabetic supplies, including needles, chem-strips, lancets and test tape covered under the prescription drug benefit
- Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered.

- **Nursing care**: Medically necessary private duty care by a licensed nurse, if the care is a type or nature not normally furnished by hospital floor nurses.
- **Oral surgery**: Expenses in connection with treatment of the teeth, gums or alveolar process are covered only for:
  - Hospital expenses for necessary inpatient care
  - Treatment of tumors in the mouth
  - Surgery to remove an impacted tooth
  - Repair to sound natural teeth or their supporting structures because of an accidental injury and only if the expense is incurred within 12 months of the injury.
- **Physical or occupational therapy**: Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist, when ordered by a physician.
- **Physicians**: Office visits, medical care and treatment by a physician, including surgical procedures and post-operative care.
- **Prescription drugs**: Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition.
  Medications are also covered for the following special situations:
  - As part of an office visit when administered and entirely consumed in connection with care rendered in a physician's office.
  - As part of the facility's ancillary charges when taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy. .

  Prescriptions related to infertility treatment, weight control and oral contraceptives are not covered. See Excluded Expenses for additional information.
- **Radiology (X-ray)**: Examination and treatment by X-ray or other radioactive substances, imaging/scanning (MRI, PET, CAT, ultrasound), diagnostic laboratory tests and routine mammography screenings for women.
- **Reconstructive surgery**: Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears.
  Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:

- Reconstruction of the breast on which a mastectomy was performed,
- Surgery or reconstruction of the other breast to produce a symmetrical appearance,
- Services in connection with other complications resulting from a mastectomy, such as lymphedemas, and
- Prostheses.

- **Secondary or multiple surgical procedures**: Secondary or multiple surgical procedures will be covered at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage, use the CheckFirst predetermination procedure.
- **Speech and hearing care**: The care and treatment for loss or impairment of speech or hearing are covered when the treatment is necessary because of a physical condition such as a stroke, accident or surgery. Expenses are not covered for conditions such as learning disabilities or progressive hearing loss due to the natural aging process because they are not medically necessary for the treatment of an illness.
- **Transplants**: Expenses for transplants or replacements of tissue or organs, if they are medically necessary for the diagnosed illness or injury and are not experimental, investigational, unproven or otherwise excluded from coverage under the Supplemental Medical Plan, as determined at the sole discretion of the Plan Administrator and/or claims processor. Benefits are payable for natural or artificial replacement materials or devices.
  Transplants include, but are not limited to, the following (listed alphabetically):
  - Artery or vein
  - Bone
  - Bone marrow or hematopoietic stem cell
  - Cornea
  - Heart
  - Heart and lung
  - Heart valve replacements
  - Implantable prosthetic lenses in connection with cataract surgery
  - Intestine
  - Kidney
  - Kidney and pancreas
  - Liver
  - Liver and kidney
  - Liver and intestine
  - Lung
  - Pancreas
  - Pancreatic islet cell (allogenic or autologous)
  - Prosthetic bypass or replacement vessels
  - Skin

This is not an all inclusive list. It is subject to change.

Donor and recipient coverage is as follows:

- If the donor and the recipient are both covered under the SMP , expenses for both individuals are covered.
- If the donor is not covered under the SMP and the recipient is covered, the donor's expenses will be covered to the extent they are not covered under any other medical plan and only if they are submitted as part of the recipient's claim.
- If the donor is covered under the SMP but the recipient is not covered under the SMP, no expenses are covered for the donor or the recipient.

The total benefit paid under the SMP for the donor's and recipient's combined expenses will not be more than any Supplemental Medical Plan maximums applicable to the recipient.

It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria — not all transplant situations will be eligible for benefits. To determine if your proposed transplant is covered use the CheckFirst predetermination procedure.

- **Transportation**: Regularly scheduled commercial transportation by train or plane is covered within the continental United States and Canada when necessary for your travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip for any illness or injury is covered and only if medical attention is required en route.
- **Tubal ligations and vasectomies**: These procedures are covered; however, reversal of these procedures is not covered.

Excluded Expenses

No benefits will be paid for expenses in connection with the following items:

- **Allergy testing:** Specific testing (called provocative neutralization testing or therapy) that involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.
- **Alternative and/or Complementary Medicine:** Evaluation, testing, treatment, therapy, care and medicines that constitute Alternative and/or Complementary Medicine, including but not limited to herbal, holistic and homeopathic medicine.
- **Care not medically necessary:** All services and supplies considered not medically necessary.
- **Claim forms:** The Supplemental Medical Plan will not pay for the cost of anyone to complete your claim form.
- **Cosmetic treatment:**
  - Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars and sclerotherapy for varicose veins or spider veins)
  - Cosmetic surgery unless required and medically necessary as a result of accidental injury or illness (as explained in Other Covered Expenses).

- **Counseling**: All forms of marriage and family counseling.
- **Custodial care and custodial care items**: Care provided in a convalescent or skilled nursing facility or hospital and items such as incontinence briefs, liners, diapers and other items when used for custodial purposes.
- **Dental treatment**: Except as described in Covered Expenses, charges for diagnosis and/or treatment of the teeth, their supporting structures, the alveolar process or the gums are not covered.
- **Dietician services**: Costs of dietician services.
- **Drugs:**
  - Drugs, medicines and supplies that do not require a physician's prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem-strips, lancets and test tape.)
  - Drugs that are not required to bear the legend "Caution-Federal Law Prohibits Dispensing Without Prescription"
  - Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
  - Contraceptive drugs, patches or implants when used exclusively for family planning or birth control. Even though oral contraceptives are not covered, you may order these drugs through the mail service prescription program and receive a discount.
  - Drugs requiring a prescription under state law, but not federal law
  - Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy)
  - Drugs prescribed for cosmetic purposes (such as Minoxidil)
  - Medications used for weight control
  - Drugs used to treat infertility or to promote fertility
  - Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs not approved by the Food and Drug Administration (FDA) or experimental drugs, even though the individual is charged for such drugs
  - Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis
  - Medications or products used for smoking or tobacco use cessation
- **Ecological and environmental medicine**: See "Alternative and/or Complementary Medicine," above.
- **Educational testing or training**: Testing and/or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded).

- **Experimental, Investigational or Unproven Treatment**: Medical treatment, drugs or supplies that are generally regarded as experimental, investigational or unproven (as such terms are defined in the Glossary), including but not limited to treatment of Epstein-Barr syndrome, hormone pellet insertion or plasmapheresis.
- **Eye care**: Eye exams, refractions, eyeglasses or the fitting of eyeglasses, contact lenses, radial keratotomy or treatment/surgery to correct refractive errors, visual training and vision therapy.
- **Foot care**: Services for diagnosis or treatment of weak, strained or flat feet, including corrective shoes or devices or the cutting or removal of corns, calluses or toenails. (This exclusion does not apply to the removal of nail roots.)
- **Free care or treatment**: Any care, treatment, services or supplies for which payment is not legally required.
- **Government-paid care**: Any care, treatment, services or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)
- **Infertility treatment**: Expenses or charges for infertility treatment or testing and charges for treatment or testing for hormonal imbalances that cause male or female infertility, regardless of the primary reason for hormonal therapy.
  - Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction and infertility drugs such as Clomid or Pergonal, are also excluded.
  - Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.
- **Lenses**: No lenses are covered except the first pair of medically necessary contact lenses or eyeglasses following cataract surgery.
- **Massage therapy**: All forms of massage therapy and soft tissue therapy, regardless of who performs the service.
- **Medical records**: Charges for requests or production of medical records.
- **Missed appointments**: If you incur a charge for missing an appointment, the Supplemental Medical Plan will not pay any portion of the charge.
- **Nursing care**:
  - Care, treatment, services or supplies received from a nurse that does not require the skill and training of a nurse
  - Private duty nursing care that is not medically necessary or if medical records establish that such care is in the scope of care normally furnished by hospital floor nurses
  - Certified nurse's aides

- **Organ donation**: Expenses incurred as an organ donor when the recipient is not covered under the SMP.
- **Preventive care**: Unless specifically stated elsewhere in the SMP, preventive care is excluded from coverage.
- **Relatives**: Coverage is not provided for treatment by a medical practitioner (including but not limited to: a nurse, physician, physical therapist or speech therapist) who is a close relative (spouse or Company-recognized Domestic Partner, child, brother, sister, parent or grandparent of you or your spouse or Company-recognized Domestic Partner, including adopted or step relatives).
- **Sex changes**: Sex change, gender reassignment/revision, treatment or transsexual and related operations.
- **Sleep disorders**: Treatment of sleep disorders, unless medically necessary. If you are under age 65, you should call HealthFirst TPA to request pre-authorization for any sleep disorder treatment. See "Contact Information" in the Reference Information section.
- **Speech therapy**: Expenses are not covered for conditions such as learning disabilities or progressive hearing loss due to the natural aging process because they are not medically necessary for the treatment of an illness.
- **TMJD**: Expenses for diagnosis and treatment of any kind for temporomandibular joint disease or disorder (TMJD) or syndrome by similar name.
- **Transportation**: Transportation by regularly scheduled airline, air ambulance or train for more than one round trip per illness or injury.
- **Usual and prevailing**: Expenses that exceed the usual and prevailing fee limits.
- **War-related**: Services or supplies received as a result of a declared or undeclared act of war or armed aggression.
- **Weight reduction**: Hospitalization, surgery, treatment and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact HealthFirst TPA to determine if treatment is covered. See "Contact Information" in the Reference Information section.
- **Wellness items**: Items that promote well-being and are not specific for the illness or injury involved (including but not limited to massage therapy, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas and health club memberships).
  Also excluded are:
  - Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning
  - Services related to vocation, including but not limited to: physical or FAA exams, performance testing and work hardening programs.
- **Work-related**: Medical services and supplies for treatment of any work-related illness or injury sustained by you or your spouse, whether or not covered by Workers' Compensation, occupational disease law or other similar law.

Administrator's Discretion
The Supplemental Medical Plan Administrator may, at its sole discretion, pay benefits for services and supplies not specifically stated under the SMP. If this service or supply you've received is more expensive when a less expensive alternative is available, the SMP pays benefits based on the less expensive service or supply that is consistent with generally accepted standards of appropriate medical, dental, or other professional health care.

CheckFirst for Predetermination of Benefits
CheckFirst, administered by HealthFirst TPA, allows you to find out if the recommended service or treatment is covered by the SMP. HealthFirst TPA will determine if the recommended service or treatment is covered by the SMP

How to Use CheckFirst
To use CheckFirst, you call HealthFirst TPA for pre-authorization. See "Contact Information" in the Reference Information section. Before calling to confirm benefit coverage, you will need the following information from your physician:

- Diagnosis
- Clinical name of the procedure and the CPT code
- Description of the service
- Physician's name and office ZIP code
- Name and ZIP code of the hospital or clinic where surgery is scheduled

If you receive predetermination of benefits over the phone, ask for written confirmation. If you have questions about your eligibility or Supplemental Medical Plan coverage for a particular procedure, call HealthFirst TPA (see "Contact Information" in the Reference Information section).

Although you may find CheckFirst beneficial whenever you need medical treatment, there are two circumstances when you especially benefit by using CheckFirst. Use this predetermination procedure if your physician recommends either of the following:

- Assistant surgeon: A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if it is medically necessary to have an assistant surgeon present at the time of surgery, you must use the CheckFirst procedure.
- Secondary or multiple surgical procedures: If you are having a secondary or multiple surgical procedures at the time of scheduled surgery, the secondary or multiple procedures will be covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgery. There are further reimbursement reductions if a third procedure is involved. You must use CheckFirst to find out how the SMP reimburses the cost for the secondary surgery.

Filing a Claim on the Supplemental Medical Plan

You are eligible to file claims under the Supplemental Medical Plan once you have reached the Benefit under your Company-sponsored Retiree Medical Benefits — if you have elected coverage under this Supplemental Medical Plan.

For my first claim on the Supplemental Medical Plan, what do I need to do?
You or your spouse/ Domestic Partner, other than a Surviving Spouse, must first file a claim under your Company-sponsored Retiree Medical Benefits Option and receive an Explanation of Benefits (EOB) showing your claim was denied due to exceeding the Maximum Medical Benefit before you may file your first claim under the SMP.

After my initial claim on Supplemental Medical Plan am I required to again show an EOB from my Company-sponsored Retiree Medical Benefits Option?
No, after you have filed your initial claim under the SMP, HealthFirst TPA records will show that you are eligible to file further claims.

I am a Surviving Spouse, and I am not covered by a Company-sponsored Retiree Medical Benefits Option, what do I need to do to file my first claim? As the covered under age 65 spouse of a deceased retiree, the SMP is primary if you do not have any other group medical coverage. You will send your claim directly to HealthFirst TPA.

I have other medical coverage (such as Medicare), do I file my claim with the Supplemental Medical Plan or my other coverage first?
You must file a claim with the other coverage first. Then, attach a copy of your Explanation of Benefits (EOB) from that coverage when you file your claim under the Supplemental Medical Plan. Coordination of benefits will be calculated.

How to File a Claim
To file a claim on the Supplemental Medical Plan, be sure to complete all of the following steps:

- ❑ Completely fill out a Supplemental Medical Benefits claim form according to the instructions on the form (See HealthFirst TPA in the Contact Information section)
  - Provide all required information about your other coverage
- ❑ Obtain your Explanation of Benefits (EOB) from your Company-sponsored Retiree Medical Benefit Option or other group medical coverage showing the denied claim that makes you eligible to file under the SMP.
  - This is not required if you are covered as a surviving spouse with no other coverage
- ❑ Submit an original, itemized statement of expenses from your service provider, showing the following information:
  - Name and identifying information of patient
  - Date of treatment
  - Description of treatment and charge per treatment code
  - Charge per treatment
  - Diagnosis of the injury or illness for which treatment was rendered

- ❑ Send your claims and all documentation for the claim to:
  HealthFirst TPA
  P.O. Box 130217
  Tyler, TX 75713-0217
- ❑ Keep a copy of your completed claim form and any other information you are including with the claim

What are some examples of "Other Coverage", as asked about on the claim form?
Examples of other coverage include your Company-sponsored Retiree Medical Benefit Option, your spouse's other group medical coverage, Workers' Compensation, Medicare, TRICARE and no-fault motor vehicle insurance.

What happens to my claim if I accidentally forget to attach my documentation or skip part of the claim form?
If your claim form is incomplete or you do not attach an itemized statement from your service provider, processing of your claim will be delayed until the information has been received.

Will I receive the payment for my claim or will it go to my provider?
If you assign payment of your benefits directly to the service provider (as described under Assignment of Benefits), the claims processor will send the payment directly to your service provider. Otherwise, the payment will be sent to you.

What Happens to My Claim after Submission
Your claim information goes to a HealthFirst TPA claims processing unit. HealthFirst TPA is not an insurance company. It is responsible for processing claims for the Supplemental Medical Plan according to the terms of this coverage. You will receive an Explanation of Benefits (EOB) which summarizes the benefit calculation and provides documentation of any payment made or benefit denied.

How long will it take my claim to be processed?
Claims are processed in order of receipt. Normally, you will receive an EOB within three weeks after filing a properly documented claim, unless further information is required. Your claims will be processed in accordance with the Claim Processing Requirements. Payment of claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations and exclusions of the SMP (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.). The claims processor will contact you or the provider to request any additional information. Your prompt response will expedite processing of your claim. In addition, the claims processor, at the SMP expense, has the right to have a physician of its choice examine any Supplemental Medical Plan participant as often as reasonably necessary while a claim is pending.

Claim Filing Deadline

You must submit all health claims within one year (12 months) of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

What if I have questions about the Supplemental Medical Plan?

For claim forms, questions about the Supplemental Medical Plan or the status of your claim, contact HealthFirst TPA at 1-800-711-7083 between 8:00 a.m. and 5:00 p.m. Central time.

Coordination of Benefits under the Supplemental Medical Plan

If you or your spouse is covered under any other medical coverage, the SMP will coordinate benefits to avoid duplication of payment. The total amount payable under both plans will not be more than 100% of the expenses eligible for reimbursement under the SMP. The benefits that are payable under this Plan will be coordinated with any other medical coverage that provides benefits for the same expenses.

What are Other Plans?

With respect to the Supplemental Medical Plan, the term "other medical coverage" includes any of the following:

- ❑ Government or tax-supported programs, including Medicare (Parts A and B, Medicare Advantage and Medicare Part D) or Medicaid
- ❑ Other employer-sponsored medical coverage under which the employer pays all or part of the costs or takes payroll deductions, regardless of whether the medical coverage is insured or self-funded
  - Note: This does not include Company-sponsored Retiree Medical Benefits under your Retiree Medical Benefit Option.
- ❑ Property or homeowner's insurance
- ❑ No-fault motor vehicle insurance
- ❑ Union-sponsored medical coverage

Which Plan Is Primary

When a person is covered by more than one plan, one is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid.

The following determines which plan is primary:

- ❑ Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- ❑ A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an active employee. The Supplemental Medical Plan is not primary if a retiree has coverage under any other group health coverage and/or union-sponsored medical coverage.
- ❑ Any benefits payable under the SMP and Medicare will be paid according to federal regulations. In case of a conflict between SMP provisions and federal law, federal law controls.
- ❑ If none of the above conditions apply, the plan that has been covering the retiree the longest will be primary.

When Coordination Applies

The Supplemental Medical Plan pays after all other medical coverages have paid. Coordination of benefits is required in all of the following situations:

- ❑ If a retired employee or spouse has exceeded the Benefit under a Company-sponsored Retiree Medical Benefit Option, but the covered person has coverage under the spouse's other group medical coverage
- ❑ If a retired employee, spouse or surviving spouse has Medicare coverage (after the covered person has exhausted his or her Maximum Medical Benefit under one of the Company-sponsored Retiree Medical Benefit Option)
- ❑ If a surviving spouse has coverage through his or her employer (employer-sponsored coverage)
- ❑ If the retiree has been covered longer under another supplemental medical coverage.

Additional Rules for Retiree Medical Benefits

The following sections explain rules applicable to the Retiree Medical Benefit Options and the Supplemental Medical Plan.

Contents of the Additional Rules Section:

Qualified Medical Child Support Order (QMCSO)

Federal law authorizes state courts and administrative agencies to issue Qualified Medical Child Support Orders (QMCSOs). A QMCSO may require you to add your child as a dependent for health and dental benefits in some situations, typically a divorce.

The following procedures have been adopted and amended with respect to medical child support orders received by group health benefits and plans maintained for retirees of participating AMR Corporation subsidiaries. These procedures shall be effective for medical child support orders issued on or after the Consolidated Omnibus Budget Reconciliation Act of 1993 (COBRA) relating to employer-provided group health plan benefits.

These procedures are for health coverage under the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries ("the Plan"), consisting of the following options:

- Retiree Standard Medical Option
- Retiree Value Plus Option
- Retiree HMO (for retirees in Puerto Rico only)

Use of Terms

The term "Plan" as used in these procedures refers to the options and benefits described above, except to the extent that a plan is separately identified.

The term "Participant," as used in these procedures, refers to a Participant who is covered under the Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.

The term "Alternate Recipient," as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The term "Order," as used in these procedures, refers to a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under such plan or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

The term "QMCSO" or "NMSN," as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient's right to or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these procedures or a notice from a state agency ordering the coverage of an Alternate Recipient under health benefits with respect to a Participant under a plan and which meets the requirements to be an NMSN decreed to be a QMCSO.

The term "Plan Administrator," as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures Upon Receipt of Medical Child Support Order or State Agency Notice
Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at:

American Airlines - HR Services
P.O. Box 9741
Providence, RI 02940-9741

In addition, QMCSOs or NMSNs should be delivered to the same address.

Upon receipt (or within 15 days of receipt) by the Plan Administrator of a request for information on health coverage or a state agency notice to enroll a child, the Plan Administrator will send out a letter notifying the requesting party that it has received the order or notice and describing the Plan's procedures for determining whether the order is qualified or a notice is received, whether the coverage is available under the Plan to the child and the steps to be taken by the custodial parent or agency to effectuate coverage.

Upon receipt of an Order or upon request, the Plan Administrator will advise each person or party specified in the medical child support order that, in order to be a QMCSO or NMSN, the Order must satisfy the requirements of ERISA and OBRA '93 before the Plan Administrator is obligated to comply with its terms. These requirements state that the Order:

- Must be a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under such plan or (ii) enforces a law relating to medical child support described in section 1908 of

the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

- Must relate to the provision of medical child support and create or recognize the existence of an Alternate Recipient's right to or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a Plan and that meets the requirements set out in these procedures.
- Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.
- Does not require the Plan to provide any type or form of benefit or option that is not otherwise available under the Plan.
- Must clearly specify:
    - The name and last known mailing address of the participant and the name and address of each alternate recipient covered by the Order
    - A reasonable description of the coverage that is to be provided by the Plan to each Alternate Recipient or the manner that the coverage shall be determined
    - The period to which the Order applies (if no date of commencement of coverage is provided or if the date of commencement of coverage has passed when the Order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the Order)
    - The name of each Plan to which the Order applies (or a description of the coverage to be provided)
    - A statement that the Order does not require a plan to provide any type or form of benefit or any option, not otherwise provided under the Plan (except as a condition of receiving federal assistance for Medicaid)
    - The fact that all Plan contributions with regard to the Alternate Recipient shall be deducted from the Participant's pay.

American Airlines, Inc. does not provide interim coverage to any retiree's dependent during the pendency of a QMCSO or NMSN review. A dependent's entitlement to benefits under the Plan prior to the approval of a QMCSO or an NMSN is determined by the dependent's eligibility and enrollment in the Plan in accordance with the terms of the Plan. Without a QMCSO or NMSN American cannot be held liable if a retiree's dependent is either (i) not enrolled in coverage in the Plan or (ii) is eliminated from coverage in the Plan. In addition, neither American Airlines, Inc. nor the Plan has any obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) a retiree's dependent except upon application by the retiree in accordance with the terms of the Plan or in accordance with a QMCSO or NMSN. If the requesting party needs assistance in preparing or submitting a QMCSO or NMSN, he/she may contact the Plan Administrator or go to the Department of Labor website for more information on QMCSOs and NMSNs and for sample NMSN forms or to obtain a sample National Medical Support Notice.

Review of a Medical Child Support Order or Notice
Not later than 20 business days after receipt by the Plan Administrator of a medical child support order, the Plan Administrator shall review the Order to determine if it meets the criteria to make it a QMCSO or NMSN. Under OBRA '93, a state-ordered medical child support order is not necessarily a Qualified Medical Child Support Order. Thus, before the Plan honors the Order, the Order must meet the requirements for a QMCSO or NMSN specified above.

Procedures Upon Final Determination
The Participant, Alternate Recipient and any party specified in the medical child support order shall be notified of the acceptance of the medical child support order or national medical support notice as being qualified. Once the Order is determined to be a QMCSO or NMSN, the Plan Administrator will follow the terms of the Order and shall authorize enrollment of the Alternate Recipient as well as have any payments for such coverage deducted from the payroll of the
Participant. In addition, a copy of the appropriate health benefit guide and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipient, at the issuing agency's address. If the Participant is not enrolled, the Plan Administrator shall enroll the Participant as well as the child in the coverage. Notification will occur within 40 business days of receipt of the Order or notice.

If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Participant, the Alternate Recipient, the state agency issuing the notice or any designated representative in writing of such fact within 40 business days of receipt of the Order or notice. The notification will state the reasons the Order or notice is not a QMCSO or NMSN and that the Plan Administrator shall treat the Participant's benefits as not being subject to the Order. Any subsequent determination that an Order is a QMCSO will be administered prospectively only.

Appeal Process
If the Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he/she must file an Application for Appeal within 60 days of receiving notification of denial of the medical child support order's or medical support notice's qualification. Appeals will be reviewed by the Pension Benefits Administration Committee (PBAC) in accordance with ERISA and the terms and provisions of the Plan and notify the Participant or Alternate Recipient within 60 days of receipt of the appeal of their decision. A copy of the Plan's appeal procedures, as set forth in the Employee Benefits Guide (the formal Plan Document and Summary Plan Description) shall be provided upon request.

When Coverage Ends

This section explains when your and your spouse's Company-sponsored Retiree Medical Benefits end. Expenses incurred after the date your coverage (or your spouse's coverage) terminates are not eligible for reimbursement under the Plan or benefit option. Also see "When Coverage Ends" in the Retiree Enrollment/Payment section.

Retiree benefits for you and your spouse will automatically terminate on the earliest of:

- The date this Plan or benefit option terminates
- The last day for which your contribution has been paid The date you are no longer eligible for this coverage
- The date you reach age 65
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan or benefit option

Your spouse's coverage will automatically terminate on the earliest of:

- The date this Plan or benefit option terminates
- The last day for which your spouse's contribution has been paid The date he/she is no longer your spouse
- The date your spouse is no longer eligible for this Plan or benefit option
- The date your spouse reaches age 65
- The date the Plan Administrator determines in its sole discretion that your spouse has made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan or benefit option
- The date your surviving spouse remarries
- For a Company-recognized Domestic Partner, 90 days after your death

Coordination of Benefits for the Retiree Medical Benefit

This section explains how to coordinate coverage between the Company-sponsored Retiree Medical Benefit and any other benefits/plans that provide coverage for you or your eligible dependents. Throughout this section, you will find questions and answers specific designed to help you further understand how Coordination of Benefits works for the Retiree Medical Benefit Options.

If you or any other covered dependents have primary coverage under any other group medical benefits/plans, your Company-sponsored Retiree Medical Benefit will coordinate to avoid duplication of payment for the same expenses. The Retiree Medical Benefit will take into account all payments you have received under any other benefits/plans and will only supplement those payments up to the amount you would have received if your Company-sponsored Retiree Medical Benefit was your only coverage.

If your dependent is covered by another benefit/plan and the Retiree Medical Benefit is his/her secondary coverage, the selected Retiree Medical Benefit Option pays only up to the maximum benefit amount payable under the Option and only after the primary benefit/plan has paid. The maximum benefit payable depends on whether the in-network or out-of-network providers are used.

If you or your dependent is hospitalized when coverage begins, your prior coverage is responsible for payment of medical services until you are released from the hospital. If you have no prior coverage, Retiree Medical Benefit will pay benefits only for the portion of the hospital stay occurring after you became eligible for coverage under the benefit program for Retirees.

If you or your dependent is hospitalized when your Retiree Medical Benefit coverage changes from one Retiree Medical Benefit Option to another, your prior coverage is responsible for payment of eligible expenses until you or your dependent is released from the hospital.

Other Plans

The term “other group medical benefit/plan” in this section includes any of the following:

- Employer-sponsored benefits/plans under which the employer pays all or part of the cost or takes payroll deductions, regardless of whether the plans are insured or self-funded
- Government or tax-supported programs, including Medicare (Parts A and B, Medicare Advantage and Medicare Part D) or Medicaid
- Property or homeowner’s insurance or no-fault motor vehicle coverage, except if the plan participant has purchased this coverage
- Other individual insurance policies.

Which Plan Is Primary?
When a person is covered by more than one plan, one plan is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid. Proof of other coverage will be required from time to time.

The following determines which plan is primary:

- If you are covered by Medicare (Parts A and B, Medicare Advantage and Medicare Part D) or another government-sponsored or tax-supported program, Medicare is your primary plan unless your spouse is still working and you are covered as a dependent under a plan sponsored by your spouse's employer
    - Once you are Medicare-eligible, your primary prescription drug coverage will be Medicare Part D.
    - Your coverage under the Retiree Standard Medical (RSM) Option or Retiree Value Plus (RVP) Option will become your secondary coverage and will coordinate benefits with Medicare Part D in the same way it coordinates with Medicare Parts A and B and Medicare Advantage.
    - If you or your covered dependents are Medicare-eligible and you do not enroll in all or part of the Medicare program, your benefits under the Retiree Medical Benefit will be calculated as though you are enrolled in and are receiving Medicare benefits.
- Any plan that does not have a coordination of benefits provision is automatically the primary plan
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee
- If a participant has coverage under two retiree plans and both plans have a coordination of benefits provision, the plan that has covered the retiree the longest is primary
- Any benefits payable under the Retiree Medical Benefit and Medicare are paid according to federal regulations. In case of a conflict between the Retiree Medical Benefit provisions and federal law, federal law prevails.
- If the coordination of benefits is on behalf of a covered child:
    - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan.
        - If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise (see Qualified Medical Child Support Order (QMCSO))
    - For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents'

ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan.

- A stepchild not living in the retiree's home is not an eligible dependent under the benefit program for Retirees, regardless of any child support order.

- If the other plan has a gender rule, that plan determines which plan is primary.

Use the following two tables to help you in understanding which plan is primary for you (the Retiree) and your spouse.

Determining Primary Medical Coverage as a **Retiree**		
If you are…	**Your PRIMARY Plan is…**	**Your SECONDARY Plan is…**
1. Not eligible for Medicare AND 2. Not covered as a dependent under your spouse's employer-sponsored health plan	Retiree Medical Benefit	1. None OR 2. any other medical coverage you have (if applicable)
1. Eligible for Medicare AND 2. Not covered as a dependent under your spouse's employer-sponsored health plan	Medicare	Retiree Medical Benefit
1. Married to an active employee of an AMR subsidiary AND 2. Covered as a dependent under your spouse's Company-sponsored Active plan	Active employee Medical plan (You defer Retiree Medical Benefit coverage)	1. Medicare (if eligible) OR 2. Any other medical coverage you have
1. Eligible for Medicare AND 2. Covered as the dependent of your spouse who is actively working for a company that is not an AMR Corporation subsidiary	Your spouse's employer-sponsored health plan	3. Medicare OR 1. Any other medical coverage you have (including the Retiree Medical Benefit)
1. Eligible for Medicare AND 2. Reemployed by an AMR Corporation subsidiary	Active employee Medical plan (You defer Retiree Medical Benefit coverage)	1. Medicare OR 2. Any other medical coverage you have

Determining Primary Medical Coverage as a **Spouse** of a Retiree		
If you are a Spouse who is…	**Your PRIMARY Plan is…**	**Your SECONDARY Plan is…**
1. Not employed AND 2. Have no other group medical plan (including Medicare)	Retiree Medical Benefit	None
1. An active employee of an AMR Corporation subsidiary AND 2. Not eligible for Medicare	Active employee Medical plan	None
1. Employed by another company AND 2. Not eligible for Medicare	Your (the spouse's) employer-sponsored health plan	Retiree Medical Benefit
1. Eligible for Medicare AND 2. Has no other coverage	Medicare	Retiree Medical Benefit
1. Eligible for Medicare AND 2. Has coverage on another retiree plan	Medicare	Your (the spouse's) retiree plan Then, the Company-Sponsored Retiree Medical Benefit would be third to pay benefits (as applicable)

Retiree Medical Benefit Plan – As a Secondary Plan
The maximum benefit payable depends on whether the in-network or out-of-network providers are used. When this Plan is secondary, the eligible expense is the primary plan's allowable expense (for primary plans with provider networks, this will be the network allowable expense; for primary plans that base their reimbursement on reasonable and customary or usual and prevailing charges, the allowable expense is the primary plan's reasonable and customary or usual and prevailing charge). If both the primary plan and this Plan do not have a network allowable expense, the eligible expense will be the greater of the two plans' reasonable and customary or usual and prevailing charges. The maximum combined payment you can receive from all plans may be less than 100% of the total eligible expense.

How can I calculate my benefits under the Retiree Medical Benefit when it is the secondary plan and the primary plan is not Medicare?
Use this process to determine your secondary benefits under the Retiree Medical Benefit:

- ❑ First, the normal benefits are calculated as though the Retiree Medical Benefit is the primary plan
- ❑ Next, the amount paid by the primary plan is subtracted from normal benefits under the Retiree Medical Benefit
- ❑ Finally, the Retiree Medical Benefit pays the difference (if any)

Coordination when Medicare Is Primary

If you are eligible for Medicare, it is your primary plan unless your spouse is actively working and covers you as a dependent under the plan sponsored by his or her employer. The Retiree Medical Benefit coordinates benefits with Original Medicare (Parts A and B) if you are eligible for that coverage. Coordination applies regardless of whether you are actually enrolled in Medicare coverage and regardless of whether you select Original Medicare or a Medicare Advantage Health Plan.

Medicare Coordination of Benefits Examples

The examples on the following pages show how the Retiree Medical Benefit coordinates with Medicare and how your benefit is calculated based on the Retiree Medical Benefit Option you are enrolled in.

Retiree Standard Medical (RSM) Option

For this example, the following assumptions have been made:

1. $10,000 in billed charges for services covered under Part B
2. Medicare-approved charge = $7,500
3. Medicare Cap = 115%* (Federal and state laws limit the amount a provider can "balance bill" a patient after the Medicare payment) = $8,625
4. Medicare Part B Deductible = $140
5. You have not had any other charges applied to your RSM Deductible or Out-of-Pocket (OOP) Max for the year

		Remaining Balance	**(P)rimary (S)econdary Benefits Pay**	
Billed Charges		$ 10,000		
Calculate Medicare Cap (115% of Medicare Approved Charges)	$ 8,625	$ 1,375		
Medicare Write Off				**$1,375**
Calculate the Primary Benefit (Medicare)				
Medicare Approved Charges	$ 7,500	$7,500		
Subtract the Medicare Part B Deductible	$ -140	$ 7,360		
Medicare Part B Covers 80%	$ -5,888	$ 1,472	$5,888 (P)	
Begin with the Medicare Cap Charges	$ 8,625	$ 8,625		
Subtract RSM deductible	$ -150	$ 8,475		
Calculate the RSM Benefit as if it were Primary				
80% of the first $5,000	$ -7,475	$ 1,000		
100% of the remaining				
Use above calculation to calculate how much RSM will pay as secondary benefits.				
RSM Benefit if Primary	$ 7,475	$ 7,475		
Subtract Primary Benefit	$ -5,888	$ 1,587	$1,587 (S)	
Benefits Paid = SUBTOTAL1				**$7,475**

Calculate Member/Patient Responsibility				
Billed Charges	$ 10,000	$ 10,000		
Write Off (per Medicare)	$ -1,375	$ 8,625		
Primary Benefit (Medicare)	$ -5,888	$ 2,737		
Secondary Benefit (RSM Plan)	$ -1,587	$ 1,150		
Patient / Member Responsibility = SUBTOTAL2				**$1,150**
			TOTAL	**$10,000**

Retiree Value Plus (RVP) Option
The following tables show examples of how the Retiree Value Plus (RVP) Option coordinates benefits when other coverage is primary and how your benefit under the RVP Option is calculated.

For this example, the following assumptions have been made:

1. You have used an in-network provider
2. The RVP Option benefit is based on the in-network provider's contract negotiated rate with your Network/Claims Administrator

RVP Example 1

PCP Office Visit Charge	$100
Medicare Paid	$60
RVP Option Benefit Minus the $20 Co-payment (the amount payable if you had no other coverage)	$45
RVP Option Pays	$0*

* No benefits are paid from the Retiree Value Plus (RVP) Option because Medicare paid a benefit amount greater than what would have been paid under the RVP Option if it were your only coverage.

RVP Example 2

PCP Office Visit Charge	$100
Medicare Paid	$30
RVP Option Benefit Minus the $20 Co-payment (the amount payable if you had no other coverage)	$45
RVP Option Pays	$15*

* Because the Retiree Value Plus (RVP) Option benefit amount is greater than the amount paid by Medicare, RVP Option pays the difference, up to the amount RVP Option would have paid in the absence of other coverage

RVP Example 3

Outpatient Surgery Charge	$1,000
Medicare Paid	$600
RVP Option Benefit, paid at 90% co-insurance (the amount payable if you had no other coverage)	$710
RVP Option Pays	$110*

* Because the Retiree Value Plus (RVP) Option benefit amount is greater than the amount paid by Medicare, RVP Option pays the difference, up to the amount RVP Option would have paid in the absence of other coverage.

Coordination With Medicare Advantage Health Plans

If you participate in a Medicare HMO or another Medicare+Choice Health Plan and you incur an expense not covered by that plan, the Retiree Medical Benefit calculation follows the formula it would use to calculate the amount that would have been paid by Medicare Parts A and B. If a medical service is not covered by any part of Medicare, but it is covered by the Retiree Medical Benefit, the Retiree Medical Benefit pays its normal benefit amount.

Medicare Crossover

The claims processor for the Retiree Medical Benefit (your network/claims administrator), offers you a way to make coordination of benefits and claim filing easier with respect to your Medicare Part B and Durable Medical Equipment ("DME") expenses. If you wish to do so, you may authorize Your network/claims administrator to receive—directly from the Medicare processor — an electronic copy of the Explanation of Medicare Benefits ("EOMB"). Upon receipt of this EOMB, Your Network/Claims Administrator will process the balance of your claim under the provisions of the Retiree Medical Benefit (including processing under the Coordination of Benefits provisions). This eliminates the need for you and your provider of service to make copies of the EOMB and submit a second claim to your Network/Claims Administrator for Medicare Part B and DME expenses. To learn more or to take advantage of this Medicare Crossover Process, access the Medicare Crossover Information and Enrollment Form or contact HR Services (see "Contact Information" in the Reference Information section)

COBRA Continuation of Coverage

The Retiree Medical Benefit and the Supplemental Medical Plan ("Plan") provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain Qualifying Events. If your dependents have coverage at the time of the Qualifying Event, they may be eligible to elect continuation of coverage under the Plan. The continuation coverage is identical to coverage provided under the Plan for similarly situated retirees or their dependents, including future changes.

COBRA Continuation for Dependents

Your covered dependents may continue coverage for a maximum period of 36 months if coverage would otherwise end because of any of the following:

- Your divorce or legal separation
- Your Company-recognized Domestic Partner relationship ends
- You become entitled to (enrolled in) Medicare benefits
- Loss of eligibility because the dependent, including a child of a covered Company-recognized Domestic Partner, no longer meets the Plan's definition of a dependent (for example, if a child reaches the Plan's limiting age)
- Your death
- Your Company-recognized Domestic Partner's death

Your Company-recognized Domestic Partner and his or her covered dependents will be eligible to purchase continuation of coverage if they lose benefits as a result of the termination of your Company-recognized Domestic Partner relationship, your partner's child's loss of eligibility under the Plan, or the death of your Company-recognized Domestic Partner or yourself.

Although a Company-recognized Domestic Partner and his or her children do not have rights to COBRA coverage under existing federal law, "the Company" currently offers them the opportunity to continue health coverage that would be lost when certain events occur, with the exception that Supplemental Medical Plan is not available under COBRA to surviving Company-recognized Domestic Partners.

If you experience more than one of these Qualifying Events, your maximum continuation of coverage is the number of months allowed by the event that provides the longest period of continuation.

If the Plan requires you or your eligible dependents to timely pay ongoing contributions/premiums in order to maintain coverage under the Plan, (i.e., you must pay the full amount of the required ongoing contribution by the due date or before the end of the grace period allowed for payment), your failure to pay or timely pay such required contributions/premiums, with resulting termination of coverage, is not a Qualifying Event and you/your eligible dependents are not eligible to continue coverage under COBRA.

Additional Qualifying Event for Retirees
Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Company and you are a retired employee who loses coverage under the Plan as a result of that bankruptcy, you, your surviving spouse and dependent children may be entitled to elect Continuation Coverage under the Plan. Continuation of coverage extends until:

- The date of your (the retiree's) death or the death of your surviving spouse (if you died before the bankruptcy filing and your spouse still had coverage under the Retiree Medical Benefit), or
- 36 months after the date of your (the retiree's) death, in the case of your surviving spouse or dependent child.

If the Plan requires you (and/or your eligible dependents) to timely pay ongoing contributions or premiums in order to maintain coverage under the Plan (i.e., you must pay the full amount of the required ongoing contribution or premium by the payment due date reflected on the monthly invoice or before the end of the 30-day grace period allowed for payment), your failure to pay or timely pay such required ongoing contributions or premiums, with resulting termination of coverage, is not a Qualifying Event and you (and/or your eligible dependents) are not eligible to continue coverage under COBRA.

How to Elect Continuation of Coverage
Solicitation following a Qualifying Event: In the event of a Qualifying Event (as shown above as for your dependents only) (divorce, legal separation, the end of a Company-recognized Domestic Partner relationship, your entitlement to or enrollment in Medicare, a dependent's reaching the limiting age for coverage, or your Company-recognized Domestic Partner's death), you must notify the Company by processing a Life Event change within 60 days of the event. Your Company-recognized Domestic Partner and his or her covered dependents will be eligible to purchase continuation of coverage if they lose benefits as a result of the termination of your Company-recognized Domestic Partner relationship, your partner's child's loss of eligibility under the Plan, or the death of your Company-recognized Domestic Partner or yourself.

You can process most Qualifying Events that are also Life Events online through the Retiree Benefits page on Jetnet; however, in some instances, you must contact HR Services to process the change. For example, in the event of your death, your supervisor or a dependent must call HR Services to make the appropriate notification. If the Qualifying Event is also a Life Event that involves your Company-recognized Domestic Partner, you must call HR Services to process the change. If you fail to notify the Company of a dependent's loss of eligibility within 60 days after the Life Event, the dependent will not be eligible for continuation of coverage through COBRA, and you will be responsible for reimbursing the Company for any benefits paid for the ineligible person. You are also required to repay the Company for premium amounts that were overpaid for fully insured coverage.

Enrolling for Coverage
Following notification of any Qualifying Event (see the Life Events section) HR Services will advise Benefit Concepts, Inc., who in turn will notify you or your dependents of the right to continuation of coverage. When you process your Life Event, you should provide your dependent's address (if different from your own) where Benefit Concepts, Inc. can send solicitation information.

You (or your dependents) must elect to continue coverage and provide written notification of your desire to purchase continuation coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage, or you will lose your right to elect to continue coverage. (See Benefit Concepts, Inc.'s Information in the Reference section). You and your dependents may each independently elect continuation coverage. Once you elect continuation coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election If you waive continuation of coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify Benefit Concepts, Inc. before your 60-day election period expires.

Federal laws require the Company to provide a Certificate of Group Health Plan Coverage outlining your coverage under the Plan and showing the dates you were covered by this Plan. This certificate is sent to you by Benefit Concepts, Inc.

Processing Life Events After Continuation of Coverage Is in Effect
If you elect continuation of coverage for yourself and later marry or declare a Company-recognized Domestic Partner, give birth or adopt a child while covered by continuation of coverage, you may elect coverage for your newly acquired dependents after the Qualifying Event. To add your dependents, contact Benefit Concepts, Inc., the COBRA administrator, at 877-902-9207, within 60 days of the marriage, Company-recognized Domestic Partner relationship, birth or adoption.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29 or 36 months, depending on the Qualifying Event). This new dependent will not have the right to continue coverage on his or her own if there is a divorce, end of Company-recognized Domestic Partner relationship or another event that causes loss of coverage. You may add a newborn child or a child newly placed for adoption to your COBRA continuation coverage. You should notify Benefit Concepts, Inc. and the Plan Administrator of the newborn or child newly placed for adoption within 60 days of the child's birth or placement for adoption.

All rules and procedures for filing and determining benefit claims under the Retiree Medical Benefit also apply to continuation of coverage.

If you have questions regarding continuation of coverage, contact Benefit Concepts, Inc. (see the Information section).

Paying for or Discontinuing COBRA Coverage
To maintain COBRA continuation of coverage, you must pay the full cost of continuation of coverage on time, including any additional expenses permitted by law. Your first payment is due within 45 days after you elect continuation of coverage. Premiums for subsequent months of coverage are due on the first day of each month for that month's coverage. If you elect continuation of coverage, you will receive payment coupons or invoices from Benefit Concepts, Inc. indicating when each payment is due. Contributions are due even if you have not received your payment coupons. Failure to pay the required contribution on or before the due date or by the end of the grace period will result in termination of COBRA coverage, without the possibility of reinstatement. All checks shall be made payable to Benefit Concepts, Inc. (see the Information section).

Refund of Premium Payments
If you elect continuation of coverage and later discover that you do not meet the eligibility requirements for coverage, for example, if you become entitled to (enrolled in) Medicare benefits, you must contact Benefit Concepts, Inc.(see the Information section) immediately, but no later than three months after you make your first COBRA premium payment in order for you to be eligible for a refund. No payments will be refunded after this three-month period, regardless of the reason.

If claims have been paid during this three-month time period, the Plan will request reimbursement from you. If the amount of your premium payments for continuation of coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the Plan receives reimbursement for your claim, the Plan will refund your premiums.

This time limit for refunds also applies if the Company discovers that continuation of coverage has been provided to you or your dependent in error.

When does Continuation of Coverage Begin and End?

Continuation of coverage begins
If you or your dependents elect continuation of coverage within 60 days of receiving your election forms, the coverage becomes effective on the date your other coverage would otherwise end. Thus, the first premium for continuation of coverage includes payment for this retroactive coverage period.

Continuation of coverage ends
Continuation of coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29 or 36 months) expires.
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on

the invoice, your coverage will be terminated, without the possibility of reinstatement.
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a preexisting condition limitation that affects the plan participant. In that event, the participant is entitled to continuation of coverage up to the maximum time period.
- The Plan participant continuing coverage becomes entitled to Medicare
- The Company no longer provides the coverage for any of its retirees or their dependents.

Impact of Failing to Elect Continuation Coverage on Future Coverage
In considering whether to elect continuation coverage, you should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63 day gap in health coverage and election of continuation coverage may help you not have such a gap.

Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Plan coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Who do I contact if I have Additional Questions?
If you have any additional questions on continuation of coverage under COBRA, you should contact Benefit Concepts, Inc.(see the Information section).

HIPAA Certificate of Creditable Coverage
If you lose your coverage (or when you notify Employee Services of your dependent's loss of coverage), you will automatically be sent a certificate of creditable coverage showing how long you had been covered under the Plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's pre-existing medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will receive another certificate of coverage within the 24 months after your coverage has ended. You may also request a certificate of creditable coverage within the 24 months after your coverage has ended.

To request a certificate of creditable coverage, contact HR Employee Services (see the Information section), and request a HIPAA certificate of creditable coverage.

Enrollment, Payment & Effective Date

The following sections explain how to enroll and when Retiree Medical Benefits begin, in addition to how payment is made for your benefits and when the coverage ends.

Contents of this Section:

How Do I Enroll?

You may enter the Retiree Medical Benefit when you first become eligible (as outlined in the Am I Eligible? section) or you may defer entry to a later date. You must take action by contacting HR Services to initiate entry into your Retiree Medical Benefit. If you are eligible for the benefit you may defer enrollment, and no action is required until you are ready to commence the benefit. The questions and answers throughout this section may help you better understand how to enroll.

Initial Enrollment – Upon Retirement

When you retire, HR Services will mail you a notification advising you of your enrollment options as a retiree and providing you with detailed information about how to enroll on the Retiree Benefits page of Jetnet. Be sure to review this information carefully and access the Benefits Service Center to review the benefits for which you are eligible.

When you retire and move from Active medical coverage to Retiree medical coverage, you will select a different Medical Benefit Option. Your deductibles and out-of-pocket maximums will not carry over from the Active coverage to the new Retiree Medical Benefit.

Who should I contact if I have enrollment questions?

If you have questions after reviewing the notification information, you may contact HR Services (see the Contact Information section).

When can I enroll for Retiree Medical Benefits?

Once the Company processes your retirement, you can log on to Jetnet through the retiree website and enroll in the Retiree Medical Benefit.

Is my enrollment in Retiree Medical Benefits automatic when I retire?

No, you will not automatically be enrolled in a Retiree Medical Benefit option. Since you will be required to pay timely ongoing monthly contributions to begin and maintain any Retiree Medical Benefit option coverage, you must take action and enroll in the Option of your choice via Jetnet to begin your retiree medical coverage. If you do not enroll when you retire, you will have no Retiree Medical Benefits until you initiate enrollment. You are in a deferment status until you call HR Services to commence the benefit, if eligible to receive Retiree Medical Benefits.

How do I initiate my Retiree Medical Benefits?

To enter the Retiree Medical Benefit, you must do both of the following:

- ❑ Actively elect a Retiree Medical Option online through the Center located on the Benefits page of Jetnet. This page will reflect the current benefit coverage options available to you, along with the rates for each option.
- ❑ Make your first payment for the Retiree Medical Benefit option you selected. Your timely payment must be received before your Retiree

Medical Benefit coverage will begin ("on time" or "timely" means your payment must be postmarked on or before the contribution due date, or before the end of the 30-day grace period for payment).

How do my Pre-65 Spouse and Dependents enroll if I am age 65 or older?
Effective January 1, 2013, if you are an age 65 or over Retiree and your spouse is under the age of 65, the spouse/Company-recognized Domestic Partner (DP) may enroll in Retiree Medical Benefits separately. Eligible Dependent Children will enroll under the spouse's coverage, as long as all eligibility requirements are met (as outlined in the Am I Eligible? section)

Annual Benefits Enrollment
Eligible retirees will have the opportunity to participate in annual benefit enrollment, which occurs during the fall each year. This Annual Benefits Enrollment enables you to select your Retiree Medical option for the upcoming year.
During this time, you may elect to…

- Change your Retiree Medical Option election (if other Options are available in your area)
- Make changes to eligible dependents' enrollment

Once Annual Benefits Enrollment ends, the benefit elections you chose for the upcoming plan year are recorded and "locked in". Once the new plan year begins on January 1st, you will not be allowed to make changes to these elections unless you experience a Life Event that would enable you to make such changes. This is a rule set down by the federal government, and American Airlines cannot override this rule; to do so would jeopardize the benefit plan for all retirees.

If future benefits or coverage become available to retirees, the Company will advise you as soon as you are eligible to enroll in those benefits.

How do I make my selection during Annual Benefits Enrollment?
Just like your initial enrollment, you elect a Retiree Medical Option online through the Center located on the Benefits page of Jetnet. The Benefits Service Center is updated by the beginning of annual enrollment period with your benefits options and the new rates for the upcoming Plan year.

What will happen if I do not make an election for the upcoming year during Annual Benefits Enrollment?
If you do not select a Retiree Medical Benefit Option at this time, you will default into the same Retiree Medical Benefit as you are enrolled inform the current year. Your network administrator may change.

Note: If the Retiree Medical Benefit selection you are currently enrolled in is not available for election, you will be automatically moved into the Company default option offered for the plan year. It is recommended that you review options annually and not rely on the default because options can change.

What if I make a mistake on my Annual Benefits Enrollment and need to have it corrected?

Between the close of Annual Benefits Enrollment and the start of the new plan year (January 1 following Annual Benefits Enrollment), you may be permitted to CORRECT any erroneous elections you made during Annual Benefits Enrollment, as long as you request correction of your mistake before the beginning of the upcoming plan year. However, if you fail to discover your mistake or fail to request correction until after the new plan year begins (such as on January 12), you will not be permitted to make any correction of your enrollment mistake unless you experience a Life Event. Remember, these post-Annual Benefits Enrollment changes to your benefit elections are permitted to allow you to correct elections errors ONLY. Any other changes (such as, you have changed your mind about enrolling in a particular Option) are not permitted.

How do I Defer Enrollment?

You may defer entry in the Retiree Medical Benefit to a later date (prior to your 65th birthday), if you have other coverage(e.g., if you are covered as a dependent under your spouse's active medical coverage or you obtain active medical coverage from another employer). Since you are required to actively enroll in the Retiree Medical Benefit, you will automatically default to deferment if no active election is made. You are allowed to defer entry only once. Once coverage is stopped or canceled (e.g. because of non or late payment), you may not re-enroll in coverage at a later date.

When do Retiree Medical Benefits Begin?

The following chart summarizes when your Active Medical coverage ends, how to activate your Retiree Medical Benefit, and when your Retiree Medical Benefit become effective.

If you are…	Your Active Medical Coverage Ends…	Your Retiree Medical Benefit is Activated…	Your Retiree Medical Coverage is Effective…
Retiree who is ❑ Under age 65 ❑ Retired from ANY workgroup	On your last day on active payroll, unless you elect to purchase COBRA coverage	Upon receipt of your enrollment and first timely payment to activate the Retiree Medical Benefit	On the first day immediately following your last day on active payroll, if you activate the benefit If you defer enrollment, coverage is effective after you activate and make payment for the benefit.

If you are…	Your Active Medical Coverage Ends…	Your Retiree Medical Benefit is Activated…	Your Retiree Medical Coverage is Effective…
Retiree ❑ From a leave of absence from any workgroup ❑ Under Age 65	On the day prior to your retirement date, unless you elect to purchase COBRA coverage	Upon receipt of your enrollment and first timely payment to activate the Retiree Medical Benefit Note: An enrollment window will be available for you on Benefit Service Center and will remain open for 30 days from the date of your retirement.	If you enroll during the 30-day period, eligibility will be effective the date of your retirement. If you defer enrollment, coverage is effective the date of your election and upon first timely payment to activate the Retiree Medical Benefit
Disabled ❑ From ANY workgroup (except Pilot) ❑ Under age 65 ❑ AND you have received a Social Security Disability Award	At the end of one-year of unpaid sick leave or injury-on-duty leave. Be advised if you elect to purchase COBRA coverage Medicare becomes your primary coverage and COBRA is secondary	Upon retiring and election of retiree medical. Once PayFlex is in receipt of your first payment after one of the following takes place, whichever occurs earlier: • Notify your supervisor and HR Services that you wish to retiree • Following your termination from COBRA coverage and contact HR Services to request to retire • At the end of one-year of unpaid sick leave or injury-on-duty leave and election to retire Once you retire an enrollment window is available for you on	If you enroll during the 30-day period, eligibility will be effective the date of your retirement. If you defer enrollment, coverage is effective the date of your election and upon first timely payment to activate the Retiree Medical Benefit

If you are…	Your Active Medical Coverage Ends…	Your Retiree Medical Benefit is Activated…	Your Retiree Medical Coverage is Effective…
		Benefit Service Center and will remain open for 30 days from the date of your retirement.	
Pilot or Flight Engineer ❑ Receiving a disability pension benefit from the Pilot Retirement Benefit Program ❑ Under Age 65	Upon commencement of your disability pension benefit	Upon receipt of your enrollment and first timely payment to activate the Retiree Medical Benefit	On the first of the month in which your disability pension benefit begins.
Pilot ❑ Receiving a disability benefit from the American Airlines, Inc. Pilot Long-Term Disability Plan (2004) or from the 2012 American Airlines, Inc. Pilot Long Term Disability Plan ❑ Under Age 65	At the end of the month in which you retire from your disability, at age 50 to 65	Upon receipt of your enrollment and first timely payment to activate the Retiree Medical Benefit	On the first of the month on or after your retirement from disability at age 50 to 65

How Do I Pay For Coverage?

The Retiree Medical Benefit is billed directly to you and you will be required to make timely monthly payments of the ongoing contributions for your elected Retiree Medical Benefit Option. You must pay 100% of the ongoing monthly contribution costs for coverage (the Company does not subsidize any portion of your retiree medical contributions).This section details how to make payments.

Direct Bill

You must make the initial contribution payment before your retiree medical coverage will begin. You must make timely payments of the required contributions to maintain your Retiree Medical Benefit. Once you are in the Retiree Medical Benefit, you will be billed monthly for coverage. PayFlex is the direct billing administrator (see the Contact Information section) for the Retiree Medical Benefit.

You will receive your monthly invoices prior to the month in which payment is due. The invoice provides you all of the following information about your coverage and contribution:

- ❑ The type(s) of coverage for which you are being billed
- ❑ The time period of coverage being billed
- ❑ The amount of contribution due
- ❑ The due date of payment
- ❑ The ending date of the 30-day grace period allowed for payment

In addition, the monthly invoice provides:

- ❑ Instructions for sending your payment
- ❑ How to contact PayFlex
- ❑ Information about paying contributions via automatic bank draft

When are the monthly payments due?

Payments are due on the first (1st) of each month or before the end of the 30-day grace period allowed for payment. Payments must be postmarked by the due date or before the end of the 30-daygraceperiod allowed for payment. If payment is not postmarked by the end of the grace period, your Retiree Medical Benefit will be terminated, without the possibility of reinstatement.

Once you have entered the Retiree Medical Benefit, if you stop making monthly contribution payments at any time or if you fail to make your required monthly contribution payment by the due date (or within the 30-day grace period allowed for payment) your Retiree Medical Benefit will terminate and you will not be permitted to re-enter the Retiree Medical Benefit.

Health Retirement Account Benefit for Retired Pilots Only

In keeping with the terms of the Collective Bargaining Agreement (CBA) between American Airlines, Inc. and the Allied Pilots Association (APA), the Retiree Medical Benefit, effective January 1, 2013, includes Health Reimbursement Accounts (HRAs) for Pilots who retire with a bank of unused sick time hours.

These unused sick leave hours will be converted into HRA funds that the retired Pilot can use to pay contributions (or premiums) for his/her retiree medical coverage—whether it is retiree medical coverage sponsored by the Company or retiree medical coverage purchased outside the Company. The formula for converting unused sick bank hours to funds used for HRA contributions is shown below:

$25,000	X	Pilot's total-short-term & long-term sick leave hours as of his/her retirement date ÷ Pilot's maximum possible accrued sick bank hours—1000 hours*	=	Total amount of funds in the retired Pilot's HRA

*These 1000 hours are made up of 940 hours from long-term sick bank and 60 hours from short-term sick bank

Pilot eligibility requirements for the HRA are as follows—a Pilot retiree must meet all of the following requirements:

- ❑ Be age 60 or older at the time of his/her retirement; and
- ❑ His/her retirement occurs between January 1, 2013 and the amendable date of the collective bargaining agreement that was signed in December, 2012; **and**
- ❑ Gives the Company at least four (4) months' advance notice of his/her intent to retire

Pilots who retire prior to age 60, or who retire after the amendable date of the 2012 collective bargaining agreement are not eligible to receive this HRA.

The conditions and requirements under which these Pilot HRA funds may be used are as follows:

- To purchase retiree medical coverage from the Company-sponsored Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries (the Plan) OR from a third party insurer or medical coverage provider outside the Company
- To purchase such retiree medical coverage for the Pilot retiree and his/her spouse on record as of the date of his/her retirement
- This Pilot HRA is a notional account; that is, a Pilot retiree's HRA is funded only when the reimbursements for contributions or premium payments are made
- This Pilot HRA is not portable and cannot be "cashed out"

When Coverage Ends

Your coverage in the Retiree Medical Benefit will end in any of the following situations.

Coverage Ends…

- For you when you reach age 65.
- For your spouse or Company-recognized Domestic Partner when he/she reaches age 65
- For you and your covered dependents, when you elect to discontinue payments, fail to make payments or when a payment is returned unpaid for insufficient funds (this is the same as discontinuing payment)
- For you and your covered dependents, when your payment is not made timely (this means that the payment is not postmarked by the due date or before the end of the 30-day grace period allowed for payment)
- For you or a covered dependent, when the individual exhausts his/her individual medical maximum benefit
- For your dependent children when whichever of the following first occurs:
    - You die
    - You reach age 65 (unless your under age 65 spouse/DP elects to enroll in Retiree Medical Benefits separately and cover the eligible dependent)
    - The dependent no longer meets the eligibility requirements

  When your dependents' coverage ends, he or she may be eligible for Continuation of Coverage under COBRA for up to 36 months. (See COBRA Continuation of Coverage in the Additional Rules section for more information).

What if I have a Life Event during the year?

The following sections detail what type of events are considered Recognized Life Events and how to make changes to your benefits enrollment if you experience such a Life Event during the Plan year.

Contents of this Section:

Life Events

- General Guidelines
- Reporting a Life Event

Recognized Life Events

- Life Events Chart

Special Life Event Considerations

- Previously Deferred Retiree Medical Benefits Coverage
- Special Dependent
- Stepchild
- Stepchild of your Company-recognized Domestic Partner (DP)
- Change of Address

Life Events

Each year after annual enrollment is completed, and when the new benefit year begins on January 1, you may only change your benefit elections if you experience a Life Event and your change is consistent with that event. Allowable changes vary by the type of Life Event you experience.

General Guidelines

Remember these guidelines when you experience a Life Event and you want to make benefit changes.

- Life Events do not affect your selected Retiree Medical Benefit Option. Once you elect your Retiree Medical Benefit Option for the year (either at initial enrollment or at annual enrollment), you must remain in your elected Option for the entire plan year.
    - Relocation is the only Recognized Life Event that enables you to change your Retiree Medical Benefit Option outside the annual enrollment period as detailed later in this section (see Special Life Event Considerations).
- The Company reserves the right to request documented proof of Eligibility Dependent Criteria for benefits at any time.
    - Coverage may be terminated if you do not provide proof of eligibility when requested, or if any of the information you provide is not true and correct
- Any change in your cost for coverage applies on the date the change is effective.
- Dependents must be enrolled in the same benefits coverage as you (the retiree)

Reporting a Life Event

When making a Life Event Change, you will be required to…

- ❑ Report the Life Event and make changes within 60 days from the event.
    - If you miss the 60 day deadline, your Life Event change will not be processed and you must wait until the next annual enrollment period to make changes to your benefits.
    - Your Life Event changes are retroactive to the date the Life Event occurred (if made within the 60-day timeframe).
- ❑ Process your Life Event online through the Benefits Service Center.
    - Most Life Events are processed online. For a complete list of Life Events and the correct procedures for processing your changes visit the Life Events Tool on the Retiree Benefits page of Jetnet.

If you are adding new dependents to your benefits as a result of a Life Event, you must…

- ❑ Submit to HR Services proof that these dependents qualify as your eligible dependents within 60 days of the date you request coverage.
    - Proof that the dependents you enroll qualify as your dependents may include documents such as: official government-issued birth certificates, adoption papers, marriage licenses, etc.,
    - A detailed explanation of acceptable documentation can be found in the Proof of Eligibility Requirements area of Jetnet.

Recognized Life Events

This section details events that are considered Recognized Life Events for which you are eligible to make benefit changes as consistent with that event.

Life Events Chart		
Life Event	**You may…**	**You must…**
Retire from the Company and become eligible for retiree medical benefits	Enroll yourself and eligible dependents in the Retiree Medical Benefit. After the initial 30 days of your retirement, you must contact HR Services.	1. Contact HR Services to enroll in your desired Retiree Medical Benefit Option 2. Pay monthly contributions (on time) - to obtain and maintain Retiree Medical Benefit coverage
	Defer your enrollment in the Retiree Medical Benefit to become a dependent under an active AMR spouse or to delay enrollment into the Retiree Medical plan. • If you are married to an active employee of a participating AMR Corporation subsidiary, you may consider coverage as a dependent on your spouse's plan to maintain a higher medical maximum benefit and other benefits that are not available after you retire.	Complete the Spouse change in job/benefit status life event within 60 days of the date you retire: 1. For your active spouse to enroll you in their active coverage

Life Events Chart		
Life Event	**You may…**	**You must…**
You get legally married (including legal opposite-sex and same-sex spouses, common law marriage), divorced or legally separated or declare a Company-recognized Domestic Partner (DP)	Make changes to the following coverage:	
	Medical, you may… • Add your spouse/DP to your Retiree Medical Option coverage effective the date you were married as long as the spouse/DP is under the age of 65.	Complete the Marriage Life Event on line in Center within 60 days following your marriage (or declare a Company-recognized Domestic Partner)
	Supplemental Medical Plan (excluding Pilots), you may… • Enroll your spouse/DP in your existing Supplemental Medical Plan coverage effective the date you were married (You must have already enrolled yourself in Supplemental Medical Plan coverage at the time you were eligible to enroll)	1. Contact HealthFirst (See Contact Information) within 60 days following your marriage (or declaring a Company-recognized Domestic Partner) 2. Follow the instructions to add your eligible spouse/ DP effective the date of your marriage.
Divorce, legally separate, or Your Company-recognized Domestic Partner (DP) relationship Ends	Make changes to the following coverage:	
	Medical, you may… • Stop coverage for your eligible former spouse/DP from your coverage Your eligible former spouse/DP will be solicited for continuation of medical coverage through COBRA.	1. Complete the divorce life event on line in Benefit Service Center within 60 days and inform them of your Life Event (You are responsible for repayment of any benefits paid to an ineligible person if you fail to notify the Company of your divorce, legal separation or termination of your Company-recognized Domestic Partner relationship)

Life Events Chart		
Life Event	**You may…**	**You must…**
Divorce, legally separate, or Your Company-recognized Domestic Partner (DP) relationship ends	**Supplemental Medical Plan** (excluding Pilots), you may… • Stop coverage for your eligible former spouse/DP from your coverage Your eligible spouse/DP will be solicited for continuation of Supplemental Medical Plan coverage through COBRA	1. Contact HealthFirst (See Contact Information) within 60 days and inform them of your Life Event and your intention to cancel coverage 2. Provide HealthFirst with an address where the COBRA administrator can send information to your former spouse/DP regarding continuation of coverage
You or your eligible spouse/ Company-recognized Domestic Partner (DP) becomes pregnant	This is NOT a Recognized Life Event, you are not permitted to make any changes in your benefit elections until the baby is born	
You or your eligible spouse/ Company-recognized Domestic Partner (DP) • **gives birth** • **adopts a child** • **has a child placed with you for adoption** • **you add eligible dependent(s) to your household**	**Medical**, you may… • Add your eligible dependent to your Retiree Medical Option coverage effective the date of the event (i.e. natural child's birth, date adopted child is placed with you) NOTE: Filing a maternity claim does not add a child to your medical coverage	1. Complete the Birth Life Event on line in Center within 60 days following of the birth, adoption, placement for adoption or addition to your household and inform them of your Life Event 2. Provide proper Proof Of Eligibility documents for the dependent
Your covered dependent no longer meets the Plan's eligibility requirement	**Medical**, you may… • Stop coverage for your no longer eligible dependent Your dependent will be solicited for continuation of medical coverage through COBRA.	1. Complete the Loss of Student Eligibility life event on line in Benefit Service Center within 60 days of the date your dependent is no longer eligible for coverage

Life Events Chart		
Life Event	**You may…**	**You must…**
You move to a new home address	You are not permitted to make any changes to your Retiree Medical Option — including your Network/ Claims Administrator — unless you move to area where your current option is not available. (See Change of Address under Special Life Event Considerations later in this section) .	1. Update your address online through Jetnet on the Update MY Information Page or contact HR Services for details on how to make the update 2. If enrolled in Supplemental Medical Plan, contact HealthFirst to change your address for your 3. Contact other organizations such as the American Airline Credit Union, C. R. Smith Museum and Medicare/Social Security Admin. – to update your address
You Die	A Survivor Support Services representative will assist your survivors with all benefits and privileges available to them, including Continuation of Coverage through COBRA, if applicable.	Your dependents should contact Survivor Support Services by calling for assistance and to report the death
Your spouse/ Company-recognized Domestic Partner (DP) or dependent dies	HR Services will assist you in making the appropriate changes to your benefits	Contact HR Services within 60 days of the date your spouse/DP or dependent's death.
Benefit coverage(s) are significantly improved, lowered or lessened by the Company (Plan Administrator/ Sponsor will determine whether or not a change is "significant")	Make changes to the applicable benefit coverage(s)	The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time

Life Events Chart		
Life Event	**You may…**	**You must…**
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMSCO) that requires you to provide health care coverage for a child	**Medical**… 1. If you are already covered by the Retiree Medical Option, you may add coverage for the eligible dependent(s) to your Retiree Medical Option coverage effective the date that AA accepts the QMSCO as valid 2. If you receive a QMSCO and are not already covered by the Retiree Medical Option, you must start coverage for the eligible dependent(s) and yourself effective the date that AA accepts the QMSCO as valid You are not permitted to make any other changes to your Retiree Medical Option until the QMSCO is removed	Contact HR Services within 60 days following the court order and inform them of your Life Event
You, your spouse or your dependent(s) enroll in Medicare or Medicaid	**Medical**, you may… • Stop coverage for the eligible applicable person You are not permitted to make any other changes to your Retiree Medical Option at this time	Contact HR Services within 60 days of the date you, your spouse or your dependent(s) enroll in Medicare or Medicaid
	Supplemental Medical Plan (excluding Pilots), you may… • Stop coverage for you and your eligible spouse/DP(as applicable)	1. Contact HR Services within 60 days of the date you, your spouse or your dependent(s) enroll in Medicare or Medicaid 2. Contact HealthFirst (See Contact Information) within 60 days and inform them of your, your spouse's or your dependent(s)' enrollment in Medicare or Medicaid

Special Life Event Considerations

The following section explains special circumstances, outside of the Recognized Life Events detailed above, that may happen in your life and how these changes may affect your benefits. Remember, you must take all of the steps described below for your Special Life Event within 60 days of the date it occurs.

Previously Deferred Retiree Medical Benefits Coverage

If, you and/or your eligible dependent(s) deferred Retiree Medical Benefits coverage because you or they had coverage elsewhere (external to the Company) and any of the following events occurs:

- Loss of eligibility for other coverage due to:
  - Legal separation
  - Divorce
  - Death
  - Termination of employment
  - Reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause)
- Employer contributions for the other coverage stopped
- Other coverage was COBRA and the maximum COBRA coverage period ended
- Exhaustion of the other coverage's lifetime maximum benefit
- Other employer-sponsored coverage is no longer offered
- Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your eligible dependents no longer reside, live, or work in its service area
- You have a new dependent via your marriage, your child's birth/adoption/placement for adoption with you

You have 60 days from the date of the Recognized event listed above to enroll yourself and/or your eligible dependents in one of the Retiree Medical Benefit Options offered to you.

Note, this is only applicable if you are not already enrolled in a Retiree Medical Benefit Option. If you are already enrolled, you cannot change your elected Retiree Medical Benefit Options at this time. See the Life Events Chart above for the specific life event and applicable changes available to you.

Special Dependent

To cover a special dependent (foster child or child for whom you become the legal guardian), you must complete a Statement of Eligibility for Special Dependent and return it to HR Services, regardless of the retiree medical option you select, along with a copy of the court decree or guardianship papers. For detailed criteria regarding coverage for a special dependent, see Eligibility in the Eligibility section.

Stepchild
You may add coverage for a stepchild if the child lives with you and if you — the retiree — either jointly or individually claims the stepchild as a dependent on your federal income tax return. See Determining a Child's Eligibility in the Eligibility section.

Stepchild of your Company-recognized Domestic Partner
You may add coverage for the stepchild of your Company-recognized Domestic Partner if the child lives with you and your Company-recognized Domestic Partner claims the child on his/her federal income tax return and the tax return indicates the same address as yours. See Eligibility in the Eligibility section.

Change of Address
If you are enrolled in the Retiree Value Plus(RVP) or Retiree HMO (RHMO) Option and you relocate to a location.

- If the option you are currently enrolled in(RVP or RHMO) is available, you will stay enrolled in the option you are currently enrolled in. There will be no change to your Retiree Medical Option at this time.
- If the option you are currently enrolled in (RVP or RHMO) is not available, you must choose the a Retiree Medical Plan Option that is available in your new location. However, if you change Retiree Medical Benefit options during the plan year, your deductibles and out-of-pocket maximums may not transfer to the new option.

If you are enrolled in the RSM Option, you stay in this option. There will be no change to your Retiree Medical Option at this time.

What Additional Retiree Benefits May I Be Eligible For?

In addition to Retiree Medical Benefits, another retiree benefit is available to you as a retiree of American Airlines. The following section details this additional benefit. In this section, you will find questions and answers specific to this additional benefit that may help you further understand it.

Contents of this Section:
Employee Assistance Program (EAP)

Long Term Care Insurance Plan

NOTE:
Former employees who retired on or after November 1, 2012, are no longer eligible to participate in the Retiree Life Insurance Benefit

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is available for retirees to obtain support for issues related to substance abuse, mental health and family crisis.

NOTE: Use of the EAP is purely voluntary. Irrespective of your use, your medical benefits are not adversely affected.

For information about coverage of substance abuse and mental health within your Retiree Medical Benefit, see Mental Health and Chemical Dependency Benefits within the "What Am I Eligible For?" section.

How do I contact the EAP?
To contact the EAP, call 1-800-555-8810.

Long-Term Care Insurance Plan

MetLife fully insures the Long-Term Care Insurance Plan. The Long-Term Care Insurance Plan is no longer available for new enrollment as of January 2nd, 2013.

MetLife has made the determination to no longer offer Long-Term Care Insurance. Individuals who are already enrolled in Long-Term Care
Insurance will be able to continue their coverage through MetLife.

How do I contact the MetLife about my Long-Term Care Insurance Plan?
To contact the EAP, call 1-888-526-8495.

What if I have questions?

This section provides useful reference materials including Contact Information, a Glossary and details about Plan Administration.

Contents of this Section:

Contact Information

- Medical, Mental Health and Chemical Dependency Coverage
- CheckFirst (Predetermination of Benefits)
- QuickReview (Pre-authorization for Hospitalization)
- Prescription Drugs
- Continuation of Coverage (COBRA)
- Other Information

Glossary

Plan Administration

- Administrative Information
- Plan Amendments
- Plan Funding
- Assignment of Benefits
- Claims — Retiree Standard Medical and Retiree Value Plus Options
- Appealing a Denial — Retiree Standard Medical and Retiree Value Plus Options
- Compliance with Privacy Regulations
- Your Rights Under ERISA

Archives

Contact Information

The following table lists names, addresses, phone numbers and Websites (when available) for important contacts related to Retiree Benefits.

Contact Information Chart		
For Information About:	**Contact:**	**At:**
Health and Welfare Benefits • General questions • Eligibility criteria • Information updates	HR Services American Airlines HR Services, P.O. Box 9741 Providence, RI. 02940	Phone: 1-800-447-2000 Website: www.jetnet.aa.com Chat live with HR Services: Click on the "Start a Chat" button at the top of the Benefit's page on Jetnet. Chat hours are 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday
Forms, Guides and Contact Information	Jetnet (Retiree Benefits page)	Website: www.jetnet.aa.com
Network/Claims Administrator • Retiree Standard Medical Option	Aetna P.O. Box 981106 El Paso, TX 79998-1106	**Phone:** 1-800-572-2908 **Website**: www.jetnet.aa.com/jetnet/go/ssoaetna.asp **Provider directory:** www.aetna.com/docfind/custom/americanairlines
• Retiree Value Plus Option **Network/Claims Administrator**	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	**Phone:** 1-877-235-9258 **Website:**www.jetnet.aa.com/jetnet/go/ssobcbs.asp **Provider directory:**www.bcbstx.com/americanairlines
• Retiree Standard Medical Option • Retiree Value Plus Option	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**Phone:** 1-800-955-8095 **Website:** www.jetnet.aa.com/jetnet/go/ssouhc.asp **Provider directory:** www.myuhc.com/groups/americanairlines

Contact Information Chart		
For Information About:	**Contact:**	**At:**
Retiree HMO	Humana Health Plans of Puerto Rico 383 F.D. Roosevelt Ave. Suite 301 San Juan, PR 00918 Puerto Rico	Phone: 1-800-314-3121 Website: www.humana.com
Maximum Medical Benefit Requests		
• Retiree Standard Medical Option • Retiree Value Plus Option	Aetna P.O. Box 981106 El Paso, TX 79998-1106	Phone: 1-800-572-2908
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	Phone: 1-877-235-9258
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	Phone: 1-800-955-8095
Retiree Medical Benefits Billing • Retiree Standard Medical Option • Retiree Value Plus Option • Retiree HMO	PayFlex Systems USA, Inc. P.O. Box 3039 Omaha, NE 68103-3039	Phone: 1-800-284-4885 Fax: 1-402-231-4310 Website: www.jetnet.aa.com/jetnet/go/SSOHealthHub.asp
Supplemental Medical Plan (Coverage pays benefits only after you have exhausted your Maximum Medical Benefit under the Retiree Medical Benefit Option)		
HealthFirst TPA	Claims Filing P.O. Box 130217 Tyler, TX 75713-0217	Phone: 1-800-477-2287 Fax: 1-903-509-5729
	Eligibility, Enrollment and Contributions P.O. Box 130187 Tyler, TX 75713-0187	Website: www.hfbenefits.com Email Customer Service: customerservice@hfbenefits.com

Contact Information Chart		
For Information About: CheckFirst	**Contact:**	**At:**
Predetermination of Benefits • Retiree Standard Medical Option • Retiree Value Plus Option	Aetna P.O. Box 981106 El Paso, TX 79998-1106	Phone: 1-800-572-2908
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	Phone: 1-877-235-9258
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	Phone: 1-800-955-8095
QuickReview		
Pre-authorization for Hospitalization	Aetna P.O. Box 981106 El Paso, TX 79998-1106	Phone: 1-800-572-2908
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	Phone: 1-877-235-9258
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	Phone: 1-800-955-8095
Prescription Drugs		
Mail Order Pharmacy Service	Express Scripts (formerly Medco) P.O. Box 3938 Spokane, WA 99220-3938	Phone: 1-800-988-4125 Website: www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions-Prior Authorization	Express Scripts (formerly Medco) 8111 Royal Ridge Parkway Suite 101 Irving, TX 75063	
Prescriptions - Retail	Express Scripts (formerly Medco) Member Services Phone Inquiries	

Contact Information Chart		
For Information About:	**Contact:**	**At:**
Filing Retail Prescription Claims	Express Scripts (formerly Medco) P.O. Box 2160 Lee's Summit, MO 64063-2160	Phone: 1-800-988-4125 Website: www.jetnet.aa.com/jetnet/go/ssomedco.asp
Continuation of Coverage (COBRA)		
Continuation of Coverage (COBRA) Administrator	Benefit Concepts Inc. P.O. Box 246 Barrington, RI 02806-0246	Phone: 1-866-629-0274 Website: www.benefitconcepts.com
Other Information		
Pension Benefits Administration Committee • Information about appeals	PBAC American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	1-817-967-1412

Glossary

IMPORTANT NOTICE: THIS GLOSSARY IS DESIGNED TO BE USED IN BOTH THE EMPLOYEE BENEFITS GUIDE (FOR ACTIVE EMPLOYEES) AND THE RETIREE BENEFITS GUIDE (FOR RETIRED EMPLOYEES). NOT ALL OF THE DEFINITIONS APPLY TO BOTH ACTIVE AND RETIRED EMPLOYEES—DIFFERENCES, IF ANY, BETWEEN DEFINITIONS FOR ACTIVE EMPLOYEES AND RETIRED EMPLOYEES WILL BE NOTED IN THE GLOSSARY ITEMS.

Accidental injury
An injury caused by an outside and unforeseen traumatic force, independent of all other causes.

Alternative and/or Complementary medicine
Diverse medical health care systems, practices and products that are not considered to be part of conventional medicine. Alternative and/or Complementary medicine have not been proven safe and effective through formal scientific studies and scientific clinical trials conducted by the
National Institutes of Health (National Center for Complementary and Alternative Medicine) or that are not recognized in Reliable Evidence as safe and effective treatments for the illness or injury for which they are intended to be used. Alternative and/or Complementary medicine lack proof of safety and efficacy through formal, scientific studies or scientific clinical trials conducted by the National Institute of Health or similar organizations recognized by the National Institute of Health. Some examples of Complementary and/or alternative medicine are:

- Mind-body interventions (meditation, mental healing, creative outlet therapy, etc.)
- Biological therapies (herbal therapy, naturopathic or homeopathic treatment, etc.)
- Manipulative or body-based treatment (body-work, massage, rolfing, etc.)
- Energy therapies (qi-gong, magnetic therapies, etc.)

These examples are not all inclusive, as new forms of alternative and/or Complementary medicine exist and continue to develop. Other terms for Complementary and/or alternative medicine include (but are not limited to) unconventional, non-conventional, unproven and irregular medicine or health care.

Alternative mental health care centers
These centers include residential treatment centers and psychiatric day treatment facilities (see definitions in this section).

Ancillary charges
Charges for hospital services, other than professional services and room and board charges, to diagnose or treat a patient. Examples include fees for X-rays, lab tests, medicines, operating rooms and medical supplies.

Assignment of benefits (medical, dental, vision coverages and other health benefits)
You may authorize the Network/Claims Administrator to directly reimburse your medical service provider for your eligible expenses by requesting that the provider accepts assignment of benefits. When you request assignment of benefits, you avoid paying the full cost of the medical service up front, filing a claim and waiting for reimbursement. Your medical service provider generally files your medical claim for you if he or she accepts assignment. However, not all Network/Claims Administrator will accept assignments for out-of-network providers.

Bereavement counseling
Counseling provided by a licensed counselor (usually a certified social worker, advanced clinical practitioner or clinical psychologist) of a hospice facility to assist the family of a dying or deceased plan participant with grieving and the psychological and interpersonal aspects of adjusting to the participant's death.

Chemical dependency treatment center
An institution that provides a program for the treatment of alcohol or other drug dependency by means of a written treatment plan that is approved and monitored by a physician. This institution must be:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral
- Accredited by the Joint Commission on Accreditation of Health Care Organizations
- Licensed, certified or approved as an alcoholism or other drug dependency treatment program or center by any state agency that has the legal authority to do so

Chiropractic care
Medically necessary diagnosis, treatment or care for an injury or illness when provided by a licensed chiropractor within the scope of his or her license.

Co-insurance
A percentage of eligible expenses. You pay a percentage of the cost of eligible expenses and the Medical Benefit Option or Retiree Medical Benefit Option pays the remaining percentage.

Company
Participating AMR Corporation subsidiaries.

Convalescent or skilled nursing facility
A licensed institution that:

- Mainly provides inpatient care and treatment for persons who are recuperating from illness or injury
- Provides care supervised by a physician
- Provides 24-hour nursing care by nurses who are supervised by a full-time registered nurse
- Keeps a daily clinical record of each patient
- Is not a place primarily for the aged or persons who are chemically dependent
- Is not an institution for rest, education or custodial care

Conventional Medicine
Medical health care systems, practices and products that are proven and commonly accepted and used throughout the general medical community of medical doctors, doctors of osteopathy and allied health professionals such as physical therapists, registered nurses and psychologists. Conventional medicine has been determined safe and effective, and has been accepted by the
National Institutes of Health, United States Food and Drug Administration, Centers for Disease Control or other federally recognized or regulated health care agencies, and has been documented by Reliable Evidence as both safe and effective for the diagnosis and/or treatment of the specific medical condition. Other terms for conventional medicine include (but are not limited to) allopathy, western, mainstream, orthodox and regular medicine.

Co-pays
The specific dollar amount you must pay for certain covered services when you use in-network providers.

Custodial care
Care that assists the person in the normal activities of daily living and does not provide any therapeutic value in the treatment of an illness or injury.

Deductible
The amount of eligible expenses a person or family must pay before a benefit or plan will begin reimbursing eligible expenses.

Dental
Dental refers to the teeth, their supporting structures, the gums and/or the alveolar process.

Detoxification
24-hour medically directed evaluation, care and treatment of drug-and alcohol addicted patients in an inpatient setting. This care is evaluated for coverage under the Medical Benefit and Retiree Medical Benefit. The services are delivered under a defined set of physician-approved policies and procedures or clinical protocols.

Developmental therapy
Therapy for impaired childhood development and maturation. Examples of developmental therapy include treatments that assist a child in walking, speech proficiency (word usage, articulation and pronunciation) and socialization skills. Developmental therapy is not considered rehabilitative unless the function had been fully developed and then lost due to injury or illness.

Durable medical equipment (DME)
Medical equipment intended for use solely by the participant for the treatment of his or her illness or injury. DME is considered to be lasting and would have a resale value. DME must be usable only by the participant and not the family in general. The equipment must be medically necessary and cannot be primarily for the comfort and convenience of the patient or family. A statement of medical necessity from the attending physician and a written prescription must accompany the claim. DME includes (but is not limited to): prosthetics, casts, splints, braces, crutches, oxygen administration equipment, wheelchairs, hospital beds and respirators.

Eligible medical expenses or eligible expenses
The benefit or plan covers the portion of regular, medically necessary services, supplies, care and treatment of non-occupational injuries or illnesses up to the usual and prevailing fee limits, when ordered by a licensed physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage.

Emergency
An injury or illness that happens suddenly and unexpectedly and could risk serious damage to your health or is life threatening if you do not get immediate care. Examples include poisoning, drug overdose, multiple trauma, uncontrolled bleeding, fracture of large bones, head injury, severe burns, loss of consciousness and heart attacks.

Experimental or investigational service or supply
A service, drug, device, treatment, procedure or supply is experimental or investigational if it meets any of the following conditions:

- It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.
- Reliable Evidence shows that the drug, device, procedure or medical treatment is the subject of ongoing phase I, II or III clinical trials or under study (or that the consensus of opinion among experts is that further studies or clinical trials are necessary) to determine its maximum tolerated dose, toxicity, safety or efficacy, both in diagnosis and treatment of a condition and as compared with the standard means of treatment or diagnosis.
- The drug or device, treatment or procedure has FDA approval, but is not being used for an indication or at a dosage that is accepted and approved by the FDA or the consensus of opinion among medical experts.

- Reliable Evidence shows that the medical service or supply is commonly and customarily recognized throughout the physician's profession as accepted medical protocol, but is not being utilized in accordance or in compliance with such accepted medical protocol and generally recognized standards of care.
- The drug, device, treatment or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure that is used with a patient informed consent document that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function.
- A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- The treatment or procedure is less effective than conventional treatment methods.
- The language appearing in the consent form or in the treating hospital's protocol for treatment indicates that the hospital or the physician regards the treatment or procedure as experimental.

Explanation of benefits (EOB)
A statement provided by the Network/Claims Administrator that shows how a service was covered by the Plan, how much is being reimbursed and what portion, if any, is not covered.

Freestanding surgical facility
An institution primarily engaged in medical care or treatment at the patient's expense and that is:

- Eligible to receive Medicare payments
- Supervised by a staff of physicians and provides nursing services during regularly scheduled operating hours
- Responsible for maintaining facilities on the premises for surgical procedures and treatment
- Not considered part of a hospital

Home health care agency
A public or private agency or organization licensed to provide home health care services in the state in which it is located.

Home health care
Services that are medically necessary for the care and treatment of a covered illness or injury furnished to a person at his or her residence.

Hospice care
A coordinated plan of care that treats the terminally ill patient and family as a family unit. It provides care to meet the special needs of the family unit during the final stages of a terminal illness. Care is provided by a team of trained medical personnel, homemakers and counselors. The hospice must meet the licensing requirements of the state or locality in which it operates.

Incapacitated child
A child who is incapable of self-support because of a physical or mental condition and who legally lives with you and wholly depends on you for support.
Individual annual deductible An annual deductible is the amount of eligible expenses you must pay each year before your medical option coverage will start reimbursing you. After you satisfy the deductible, your selected Medical Option or Retiree Medical Option pays the appropriate percentage of eligible covered medical services.

Infertility treatment or testing
Includes medical services, supplies and procedures for or resulting in impregnation and testing of fertility or for hormonal imbalances that cause male or female infertility (regardless of the primary reason for the hormone therapy). Infertility treatment or testing includes, but is not limited to: all forms of in-vitro fertilizations, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversals of tubal ligations or vasectomies, drug
therapy, including drug treatment for ovarian dysfunction and infertility drugs, such as Clomid, Pergonal, Lupron or Repronex.

Inpatient or hospitalization
Medical treatment or services provided at a hospital when a patient is admitted and confined, for which a room and board charge is incurred.

Life event
Certain circumstances or changes that occur during your life that allows you or your dependents to make specific changes in coverage options outside the annual enrollment period. The Internal Revenue Service dictates what constitutes life events.

Loss or impairment of speech or hearing
Those communicative disorders generally treated by a speech pathologist, audiologist, or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and that fall within the scope of his or her license or certification.

Mammogram or mammography
The X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube filter compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views of each breast. This also includes mammography by means of digital or computer-aided (CAD) systems.

Maximum medical benefit (applies to Retiree Medical Benefit only)
The maximum medical benefit is the most a benefit or plan will pay for eligible expenses during the entire time a person is covered by the benefit or plan.
When you have exhausted your maximum medical benefit your retiree medical coverage terminates and you do not receive the annual restoration of benefits (if applicable). You are not eligible for any future increases in the maximum medical benefit. Even if you have exhausted your maximum medical benefit, your covered eligible dependents may continue their existing medical coverage under the benefit or plan up to their maximum medical benefit (as long as they meet the eligibility requirements). If your selected medical coverage (for both the retiree and covered eligible dependents) is one of the self-funded medical coverages and you and/or your eligible dependents exhaust the maximum medical benefit under the self-funded medical coverage, neither you nor your eligible dependent may elect other retiree medical coverage, including the Retiree HMO. If you and your covered eligible dependents exhaust the maximum medical benefit, you may continue other coverages/benefits as applicable. The medical coverage is the only coverage that terminates for the affected individual.

Maximum Out-of-Network Reimbursement Program (MNRP) (applies only to the Retiree Value Plus Option)
This program is based upon federal Medicare reimbursement limits; that is Medicare-allowable (what the federal Medicare program would allow as covered expense) charge for all types of medical services and supplies. Under the Retiree Value Plus Option, the Eligible Expense for out-of-network services and supplies is not to exceed 140% of the Medicare fee allowance. Most health care facilities and medical providers accept MNRP as a valid reimbursement resource.
MNRP applies to all out-of-network medical services and supplies, including, but not limited to: hospital, physician, lab radiology, medical supply expenses and medication expenses administered, purchased or provided in a physician's office, clinic or other health care facility.

Medical benefit
The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of an illness or injury.

Medical necessity or medically necessary
A medical or dental service or supply required for the diagnosis or treatment of a non-occupational, accidental injury, illness or pregnancy. The benefit or plan determines medical necessity based on and consistent with standards approved by the Network/Claims Administrator's medical personnel. To be medically necessary, a service, supply, or hospital confinement must meet all of the following criteria:

- Ordered by a physician (although a physician's order alone does not make a service medically necessary)
- Appropriate (commonly and customarily recognized throughout the physician's profession) and required for the treatment and diagnosis of the illness, injury or pregnancy
- Unavailable in a less intensive or more appropriate place of service, diagnosis, or treatment that could have been used instead of the service, supply or treatment given
- Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications

Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening or seriously debilitating condition. The treatment must be considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical
professionals or publications.
A service or supply to prevent illness must meet the above conditions to be considered medically necessary. A service is not considered medically necessary if it is educational, experimental or unproven in nature.
In the case of hospital confinement, the length of confinement and hospital services and supplies are considered medically necessary to the extent the Network/Claims Administrator determines them to be:

- Appropriate for the treatment of the illness or injury
- Not for the patient's scholastic education, vocation or training
- Not custodial in nature
- A determination that a service or supply is not medically necessary may apply to all or part of the service or supply

Mental health disorder
A mental or emotional disease or disorder.

Multiple surgical procedures
One or more surgical procedures performed at the same time as the primary surgical procedure, which are medically necessary but were not the primary reason for surgery.

Network
A group of physicians, hospitals, pharmacies and other medical service providers who have agreed, via contract with the Network/Claims Administrator to provide their services at negotiated rates.

Nurse
This term includes all of the following professional designations:

- Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)

Nursing services are covered only when medically necessary and the nurse is licensed by the State Board of Nursing, and if the nurse is not living with you or related to you or your spouse.

Original Medicare
The term used by the Centers for Medicare and Medicaid Services (CMS) to describe the coverage available under Medicare Parts A and B.

Outpatient
Medical treatment or services provided at a hospital or clinic for a patient who is not admitted to the hospital for an overnight stay.

Over-the-counter (OTC)
Drugs, products and supplies that do not require a prescription by federal law.

Physician
A licensed practitioner of the healing arts acting within the scope of his or her license. The term does not include:

- You
- Your spouse
- A parent, child, sister or brother of you or your spouse

The term physician includes the following licensed individuals:

- Audiologist
- Certified social worker or advanced clinical practitioner
- Chiropractor
- Clinical psychologist
- Doctor of Osteopathy (DO)
- Doctor of Medicine (MD)
- Nurse anesthetist
- Nurse practitioner
- Physical or occupational therapist
- Physician Assistant (PA)
- Speech pathologist or speech language pathologist or therapist

Post-fund, post-funding, post-funded (applies to Retiree Medical Benefits only)
A mechanism by which retirees pay for the cost of their Retiree Medical Benefit. To post-fund their Retiree Medical Benefit means that these retirees are required to pay ongoing monthly contributions during their retirement in order to obtain and maintain Retiree Medical Benefit coverage. All employees who retired on or after November 1, 2012 are required to post-fund their Retiree Medical Benefit.

Pre-fund, pre-funding, pre-funded
A mechanism by which employees gained eligibility for and paid for their Retiree Medical Benefit. To pre-fund your Retiree Medical Benefit means that you elected to pre-pay contributions during your active working years. When you retired, if you had met the pre-funding requirements (and the other requirements for eligibility in the Retiree Medical Benefit), you were able to enter the Retiree Standard Medical Option at no further contribution cost to you.

Preferred Provider Organization (PPO) (applies to the Medical Benefits and Dental Benefit for active employees, and to the Retiree Medical Benefits)
A group of physicians, hospitals and other health care providers who have agreed to provide medical services at negotiated rates.

Prescriptions
Drugs and medicines that must, by federal law, be requested by a physician's written order and dispensed only by a licensed pharmacist. Prescription drugs also include injectable insulin and prenatal vitamins during pregnancy.

Primary care physician
An in-network physician who specializes in family practice, general practice, internal medicine or pediatrics and who may coordinate all of the in-network medical care for a participant in the Medical Benefit Options, HMO Options, Retiree Medical Benefit Options, and Retiree HMO Option. (An OB/GYN can also be considered a PCP.)

Primary surgical procedure
The principal surgery prescribed based on the primary diagnosis.

Prior authorization for prescriptions
Authorization by the prescription drug program administrator that a prescription drug for the treatment of a specific condition or diagnosis meets all of the medical necessity criteria.

Provider
The licensed individual or institution that provides medical services or supplies. Providers include physicians, hospitals, pharmacies, surgical facilities, dentists and other covered medical or dental service and supply providers.

Psychiatric day treatment facility
A mental health institution that provides treatment for individuals suffering from acute mental health disorders. The institution must:

- Be clinically supervised by a physician who is certified in psychiatry by the American Board of Psychiatry and Neurology
- Be accredited by the Program of Psychiatric Facilities of the Joint Commission on the Accreditation of Health Care Organizations
- Have a structured program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the program's treatment format.

Psychiatric hospital
An institution licensed and operated as set forth in the laws that apply to hospitals, which:

- Is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons, either by or under the supervision of a physician
- Maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided
- Is licensed as a psychiatric hospital
- Requires that every patient be under the care of a physician
- Provides 24-hour nursing service

The term psychiatric hospital does not include an institution, or that part of an institution, used mainly for the following:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial care
- Educational care

Qualifying event
A change in your status that causes you to lose eligibility for Medical, Dental, Vision and Health Care Flexible Spending Account coverages (these are for active employees and their dependents)—or for Retiree Medical Benefits (for retirees and their dependents) and would qualify you to be eligible for COBRA Continuation of Coverage. Qualifying events are defined by COBRA. For examples, see Continuation of Coverage in the Additional Rules for Retiree Medical Benefits section of this Retiree Benefits Guide.

Reliable Evidence
Reliable Evidence includes:

- Published reports and articles in the authoritative peer reviewed medical and scientific literature including: American Medical Association (AMA) Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Dispensing Information and National Institutes of Health, U.S. Food and Drug Administration
- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment or procedure
- Written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure
- Reliable Evidence does not include articles published only on the Internet

Residential treatment center
A facility that offers 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The center must be licensed by the state as a psychiatric residential treatment center and accredited by the Joint Commission on the Accreditation of Health Care Organizations.

Restoration of medical maximum benefit under the Retiree Standard Medical Option Only
Each January 1, you are eligible to have part of your medical maximum benefit automatically restored. The amount restored will be the lesser of:

- $3,500, or
- The amount necessary to restore your full medical maximum benefit

Restorative and rehabilitative care
Care that is expected to result in an improvement in the patient's condition and restore reasonable function. This is focused on a function that you had at one time and then lost, due to illness or injury. After improvement ceases, care is considered to be maintenance and is no longer covered.

School/Educational Institution
A school/educational institution, including a vocational or technical school, if the student is enrolled:

- In a program leading to a degree or certificate
- On a full-time basis (generally 12 credit hours at colleges and universities)

Secondary surgical procedure
An additional surgical procedure performed at the same time as the primary surgical procedure, which is medically necessary but was not included in the primary surgical procedure.

Special dependent
A foster child or child for whom you are the legal guardian.

Split Coverage (Applies to Retiree Medical Benefits only for retirees on or after 11/1/2012)
American Airlines Retirees who reach age 65 will no longer be eligible for Company-sponsored Retiree Medical Benefits. An eligible spouse/ Company-recognized Domestic Partner (DP), of such Retirees, that has not yet reached age 65 will be eligible to enroll in the current Company-sponsored Retiree Medical Benefit options available at that time. Other dependents, such as children, may also be eligible for enrollment in the Company-sponsored Retiree Medical Benefit if all dependent qualifications are met as outlined in the Dependent Eligibility section of this guide. For examples, and specific details see Retirees age 65 and Over in the "Am I Eligible?" section of this Retiree Benefits Guide.

Summary Plan Description
Document provided to participants outlining terms of employer sponsored group coverage. In our efforts to provide you with multimedia access to benefits information, American Airlines, Inc. has created online versions of the Summary Plan Descriptions for our benefit plans and they are included in this Guide. The Summary Plan Descriptions are also the formal legal plan documents. If there is any discrepancy between the online version and the official hard copy of this Guide, then the official hard copy, plus official notices of plan changes/updates will govern.

Timely pay, timely payment
This term applies to plans, benefits, or options for which you are required to pay ongoing contributions or premiums in order to maintain coverage under the plans, benefits, or options. Timely payment means payment of the full amount of contribution or premium due by the payment due date or before the end of the 30-day grace period for payment (as reflected on the invoice or payment coupon). Payments rejected due to insufficient funds (e.g., "bounced" checks) are also considered not timely paid.

Urgent/immediate care
Care required because of an illness or injury that is serious and requires prompt medical attention, but is not life threatening. Examples of situations that require urgent care include high fevers, flu, cuts that may require stitches or sprains.

Universal Eligibility (Applies to Retiree Medical Benefits only for retirees on or after 11/1/2012)
Effective November 1, 2012, eligibility requirements for Retiree Medical Benefits are the same for all workgroups unless otherwise stated under Workgroup Specific Eligibility in the Am I Eligible? section of this Retiree Benefits Guide.

Unproven Service, Supply or Treatment
Any medical or dental service, supply or treatment that has not been proven both safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications, or has not been proven both safe and effective by Reliable Evidence.

Usual and prevailing fee limits
The maximum amount that the Plan will consider as an eligible expense for medical or dental services and supplies. For purposes of the Plan, “usual and prevailing” shall be equivalent with the terms “usual and customary”, “reasonable and customary”, and “usual, reasonable and customary”. The primary factors considered when determining if a charge is within the usual and prevailing fee limits:

- The range and complexity of the services provided
- The typical charges in the geographic area where the service or supply is rendered/provided and other geographic areas with similar medical cost experience

The Plan Administrator utilizes a database of charge information about healthcare procedures and services, and this database is reviewed, managed, and monitored by FairHealth. Information about FairHealth and its work on this database is available at www.fairhealthus.org.

Information from this FairHealth database is utilized by American’s medical administrators in determining the eligible expense for medical or dental services and supplies provided by nonparticipating and out-of-network providers.
Usual and prevailing fee limits can also be impacted by the number of services or procedures you receive during one medical treatment. Under the Plan, when reviewing a claim for usual and prevailing fee determination, the Network/Claims Administrator looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (often referred to as “coding fragmentation” or “unbundling”) usually results in higher physician’s charges that if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

Plan Administration

The Plans listed below are sponsored by American Airlines, Inc. as that term is defined under ERISA Section 3(16)(B) and are part of the benefit program for Retirees of participating AMR Corporation subsidiaries.

Plan Name	Plan Number
The Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries This Plan includes: • Retiree Medical Benefits • Retiree Standard Medical Option • Retiree Value Plus Option • Retiree HMO Option (for Puerto Rico Retirees Only) •	515
The Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (does not apply to Pilot or Flight Engineer retirees)	503
Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (Not available for enrollment after November 30, 2012)	510

Administrative Information
American Airlines, Inc. (See below)

Plan Administrators	
American Airlines, Inc.	Mailing address: Mail Drop 5141-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616 Street address (do not mail to this address): 4333 Amon Carter Blvd. Fort Worth, Texas 76155
Long Term Care Insurance (MetLife) (Not available for enrollment after January 2, 2013)	Mailing address: 57 Greens Farms Road Westport, CT 06880
Plan Administrator for Second Level Claim Appeals	
Pension Benefits Administration Committee (PBAC)	Mailing Address: PBAC American Airlines Mail Drop 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616 Express Delivery address: PBAC American Airlines Mail Drop 5134-HDQ1 4333 Amon Carter Blvd. Fort Worth, TX 76155
Agent for Service of the Legal Process	
Managing Director, Health and Welfare American Airlines, Inc.	Mailing address: Mail Drop 5126-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616 Express Delivery address: Mail Drop 5126-HDQ1 4333 Amon Carter Blvd. Fort Worth, TX 76155
Network/Claims Administrator The Network/Claims Administrator for each benefit or plan vary and are listed in Contact Information	

Trustee	
State Street Bank & Trust (For the American Airlines, Inc. Health Benefits Trusts and the Supplemental Medical Plan Trusts)	State Street Bank & Trust 200 Newport Avenue North Quincy, Massachusetts 02171
Employer ID Number 13-1502798	
Plan Year January 1 through December 31	
Participating Subsidiaries American Airlines, Inc.	

Plan Amendments

The Pension Benefits Administration Committee (PBAC), under the authority granted to it by the Board of Directors through the Chairman, has the sole authority to interpret, construe, determine claims and adopt and/or amend retiree benefit plans, benefits and options ("Plans"). The PBAC, in consultation with actuaries, consultants, Employee Relations, Human Resources and the Legal Department, has the discretion to adopt such rules, forms, procedures and amendments it determines are necessary for the administration of the Plans according to their terms, applicable law, regulation, collective bargaining agreements or to further the objectives of the Plans. The PBAC may take action during a meeting if at least half the members are present or by a unanimous written decision taken without a meeting and filed with the Chairman of the PBAC.

The administration of the Plans shall be under the supervision of the Plan Administrator. The Employer hereby grants the PBAC the authority to administer and interpret the terms and conditions of the Plans and the applicable legal requirements related thereto. It shall be a principal duty of the PBAC to see that the administration of the Plans is carried out in accordance with its terms, for the exclusive purpose of providing benefits to Participants and their beneficiaries in accordance with the documents and instruments governing the Plans. The PBAC will have full power to administer the Plans in all of their details, subject to the applicable requirements of law. For this purpose, the PBAC's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by the Plans:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plans, including the establishment of any claims procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information
- To interpret and construe the terms of the Plans, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plans
- To decide all questions concerning the Plans and to determine the eligibility of any person to participate in or receive benefits under the Plans and to determine if any exceptional circumstances exist to justify any extensions

- To compute the amount of benefits that will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plans and the applicable requirements of law
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plans
- To allocate and delegate its responsibilities under the Plans and to designate other persons to carry out any of its responsibilities under the Plans, any such action to be by written instrument and in accordance with ERISA Section 405
- To delegate its authority to administer claims for benefits under the Plans by written contract with a licensed third party administrator, and
- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions and reports that are furnished by accountants, counsel or other experts employed or engaged by the PBAC.

Plan Funding

The coverage for Retiree Medical Benefits is self-funded through payment of required ongoing contributions during retirement. The company makes no contributions to the Retiree Medical Benefit for persons who retired on or after November 1, 2012.

Employee contributions as plan assets are held in Voluntary Employee Beneficiary Association (VEBA) trusts established under Section 501(c)(9) of the Internal Revenue Code. These VEBA funds are dedicated exclusively to providing benefits to retirees and their dependents and cannot be used for any purpose other than providing retiree health benefits.

Self-funded Retiree Medical Option benefits are paid from trust assets. The Network/Claims Administrator are independent companies that provide claim payment services. They do not insure these benefits.

The coverage for the Supplemental Medical Plan is self-funded through retiree contributions. Retiree contributions as plan assets are held in Voluntary Employee Beneficiary Association (VEBA) trusts established under Section 501(c)(9) of the Internal Revenue Code. There are three separate VEBA Supplemental Medical Plan trusts — one for non-union employees (post-tax contributions), one for employees represented by the Transport Workers Union, AFL-CIO (TWU-Represented) and one for employees represented by the Association of Professional Flight Attendants (APFA). These VEBA funds are dedicated exclusively to providing benefits to retirees (and their spouses) and cannot be used for any purpose other than providing these Supplemental Medical Plan benefits.

Self-funded Supplemental Medical Plan benefits are paid from trust assets. The Network/Claims Administrator is an independent company that provides claim payment services. It does not insure these benefits.

The Long Term Care Insurance Plan is fully insured and premiums are paid by the retiree participants. This coverage was no longer available for enrollment after November 30, 2012.

Assignment of Benefits
You may request that the Network/Claims Administrator pay your service provider directly by assigning your benefits.

You may assign Retiree Medical Benefit and Supplemental Medical Plan benefits for eligible expenses incurred for hospital care, surgery or medical treatment for illness or injury. You may only assign benefits to the person or institution that provides the services or supplies for which these benefits are payable.

Claims — Retiree Standard Medical and Retiree Value Plus Options

Confidentiality of Claims

The Company and its agents (including the Network/Claims Administrator) will use the information you furnish to substantiate your claim and determine benefits. The information may be forwarded to the Company medical director or other independent consultants for medical review or appropriate medical follow-up. In addition, certain individuals within the Company will have access to this information to carry out their duties to administer the coverages properly.

The Company treats your medical information as confidential and discloses it only as may be required for the administration of the Plans or as may be required by law.

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see Compliance with Privacy Regulations later in this section.

Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service provider (see Assignment of Benefits earlier in this section). Benefits are paid after the Network/Claims Administrator (or other administrator) receives satisfactory written proof of a claim. If any benefit has not been paid when you die or, if you are legally incapable of giving a valid release for any benefit, the Network/Claims Administrator (or other administrator) may pay all or part of the benefit to:

- Your guardian,
- Your estate,
- Any institution or person (as payment for expenses in connection with the claim), or
- Any one or more persons among the following relatives: your spouse, parents, children, brothers or sisters.

Payment of a claim to anyone described above releases the Plan Administrator from all further liability for that claim.

Claims are processed in order of receipt. Payment of claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

The right to benefits under the Plans may not be exchanged for, or substituted for, other benefits or cash compensation.

Right to Recovery
If claims payments are more than the amount payable under the Plans, the Network/Claims Administrator (or other administrator) may recover the overpayment. The Network/Claims Administrator (or other administrator) may seek recovery from one or more of the following:

- Any plan participant to or for whom benefits were paid,
- Any other self-funded plans or insurers,
- Any institution, physician or other service provider, or
- Any other organization.

The claims processor is entitled to deduct the amount of any overpayments from any future claims payable to you or your service providers.

Subrogation
Subrogation is third-party liability. Subrogation applies if the Plans have paid any benefits for your injury or illness and someone else (including any insurance carrier) is, or may be, considered legally responsible.

The Plans have the right to collect payment from the third party (or its insurance carrier) for the medical treatment of your injury or illness. The Plans subrogate (substitute) their own rights for your rights and have a lien of first priority on any recovery you receive. This means the Plans
must be paid first from any settlement or judgment you receive and the Plans shall have a lien of first priority over any recovery you receive that will not be reduced by any “make whole” or similar doctrine. The Plans may assert this right to pursue recovery independently of you.

As a condition for receiving benefits under the Plans, you agree to:

- Cooperate with the Plans to protect the Plans’ subrogation rights
- Provide the Plans with any relevant information they request
- Obtain consent of the Plans before releasing any party from liability for payment of medical expenses
- Sign and deliver documents regarding the Plans’ subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plans’ subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plans.

- The Plans' claims and lien shall not be reduced by any "make whole" or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plans.
The Plans will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plans will not pay your or others' legal costs associated with subrogation.

Claim Processing Requirements

Time Frame for Initial Claim Determination
For claims for medical benefits, the processing rules vary by the type of claim. For urgent care claims and pre-service claims (claims in which the service has not yet been rendered and/or that require approval of the benefit or precertification before receiving medical care), the claims processor or benefit administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- Seventy-two hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification), or
- Fifteen days after receipt of a pre-service claim.

For post-service claims (claims that are submitted for payment after you receive medical care),the claims processor or benefit administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For urgent care claims, if you fail to provide the claims processor or benefit administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the claims processor or benefit administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The claims processor or benefit administrator's receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the Network/Claims Administrator or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Network/Claims Administrator or benefit administrator must notify you before the end of the first 15- or 30-day period

of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your or your authorized representative's failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the Network/Claims Administrator or benefit administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan's procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and
- Is a communication that names you, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested.

Urgent Care Claims
Urgent care claims are those that, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function, or
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.
- An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

Concurrent Care Claims
If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.
Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

If You Receive an Adverse Benefit Determination on a Health/Welfare Benefit Plan Claim
The claims processor or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request
- Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim
- The Network/Claims Administrator is required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale

All Other Claims

All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the claims processor. After the claims processor has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the claims processor shall notify you within a reasonable period of time not to exceed90 days after receipt of the acceptance or denial of the claim. The 90-day period during which acclaim for benefits is reviewed may be extended by the case manager or claims processor for up to 90 days, provided the claims processor both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 90-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 90-day period provided the claims processor notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for disability benefits is denied, in whole or in part, the claims processor shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial
- Specific references to the Plan provisions on which the denial is based
- A description of any information or material necessary to perfect the claim
- An explanation of why this material is necessary
- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review, and
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request.

Effect of Failure to Submit Required Claim Information

If the claims processor determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the claims processor's request for information or upon a demonstration to the satisfaction of the claims processor that under the circumstances the claims processor's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the claims processor, taking into consideration the cause or reason for your failure or refusal, the length of the period and other facts or circumstances the claims processor deems relevant.

Appealing a Denial — Retiree Standard Medical and Retiree Value Plus Options

Important Information about Health Care Provider's Appeals

As a participant in the American Airlines, Inc.-sponsored health and welfare benefit plans, you have the right (under federal law known as ERISA) to appeal adverse benefit determinations through the American Airlines Inc. two-tiered appeal processes, as described in this section of the Guide.

However, your network health care providers, through their provider contracts with the Network/Claims Administrator, also have the option to appeal adverse benefit determinations —to the extent that the adverse benefit determinations affect their benefit payments from the Network/Claims Administrator. Your network health care providers may appeal directly to the Network/Claims Administrator — with or without your knowledge and/or consent. These "provider appeals" are separate and distinct from your appeal rights under ERISA, unless the providers specify that their provider appeals are being filed with the Network/Claims Administrator on your behalf.

If the provider specifies in its appeal that the appeal is being filed on your behalf, the appeal will be considered your ERISA First Level Appeal filed with the Network/ Claims Administrator. If the provider does not specify in its appeal that the appeal is being filed on your behalf, the provider's appeal will not be considered as your ERISA First Level Appeal. Thus, if you then decide to appeal the adverse benefit determination, you must file both the First Level and Second Level Appeals, as described in this section of the Guide (or if the appeal is an urgent care appeal, you must file under the "urgent care appeal" process, as described in this section of the Guide).

Procedures for Appealing an Adverse Benefit Determination

As a participant in the Company-sponsored health and welfare benefit plans, you have the right to appeal adverse benefit determinations. Adverse benefit determinations include denial, withholding and reduction of benefits described in the plans, and eligibility/enrollment determinations that prevent you or your dependents from obtaining coverage under the plans. Adverse benefit determinations also include rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

American Airlines, Inc., as Sponsor and Administrator for the Company-sponsored health and welfare benefit plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the claims processor or benefit administrator that rendered the adverse benefit determination. Second Level Appeals are conducted by the Pension Benefits Administration Committee (PBAC) at American Airlines, Inc.

This two-tiered appeal process applies to adverse benefit determinations made on all self-funded benefits or plans, as follows:

- Retiree Standard Medical Option
- Retiree Value Plus Option
- Supplemental Medical Plan

and for administrative, eligibility and enrollment issues on any and all benefits or plans offered through the benefit program for Retirees.

With respect to adverse benefit determinations made on fully insured benefits, as follows:

- Retiree HMO and Long Term Care Insurance Plan,

the appeal process is defined by the respective insurers (thus, it might not be a two-tiered process). The PBAC cannot render a decision involving fully insured benefits (except for administrative, eligibility and enrollment issues, as stated previously). The insurers make the final appeal determinations for their respective insured coverages/benefits. Each insurer has its own appeal process and you should contact the respective insurer for information on how to file an appeal (see Information earlier in this section).

This two-tier appeal process is mandatory for all claims, unless otherwise stated. The one exception to this mandatory two-tier process is an appeal for an urgent care claim. For urgent care claim appeals, only Second Level Appeals are required. No First Level Appeals are necessary.

Retirees must use both levels of appeal (or the Second Level Appeal for urgent care claims) and must exhaust all administrative remedies to resolve any claim issues.

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the claims processor or benefit administrator. You or your authorized representative has180 days following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the claims processor or benefit administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination.

To file a First Level Appeal with the claims processor or benefit administrator, please complete an Application for First Level Appeal and include with the Application all comments, document, records and other information relating to the denied/withheld benefit. (The Application for First Level Appeal provides information about what to include with your appeal.

The claims processor or benefit administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing,

- For pre-service claims – within 30 days of receipt of your First Level Appeal
- For post-service claims – within 60 days of receipt of your First Level Appeal
- For urgent care claims – within 72 hours of receipt of your First Level Appeal
- For all other claims for all benefits other than medical, within 60 days of receipt of your First Level Appeal, if the claims processor or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical benefits, it may have an additional 60 to complete your First Level Appeal (the claims processor or benefits administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal with the PBAC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the Pension Benefits Administration Committee ("PBAC") at American Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the PBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the PBAC, please complete an Application for Second Level Appeal and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal).

The PBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 30-day time period allotted for completion of both levels of appeal
- For post-service claims, within the 60-day time period allotted for completion of both levels of appeal
- For urgent care claims, within the 72-hour time period allotted for completion of both levels of appeal.

Example: A participant appeals an adverse benefit determination (post-service claim). For both levels of appeal – First and Second Levels, the combined time taken by the claims processor or benefit administrator and the PBAC to review and complete the appeals must be no more than 60days. If the First Level Appeal review is completed by the claims processor or benefit administrator in 15 days, then the PBAC has the remaining 45 days (for a total of 60 days) to complete its review and render its decision.

Upon its receipt, your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the PBAC. Appointed officers of American Airlines, Inc. are on the PBAC. In some cases, the PBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the claims processor or benefit administrator, if appropriate, will be reviewed by the PBAC or its designee(s).

The Second Level of Appeal is mandatory for all other claims, unless otherwise stated in this Guide. American Airlines, Inc. encourages all retirees to use both levels of appeal to exhaust all avenues to resolve any claim issues in the quickest manner possible.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
  - You are entitled to receive, free of charge, new or additional evidence considered, relied upon or generated by the plan or issuer in connection with your appeal; you shall be afforded a reasonable opportunity to respond to such evidence or rationale
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for urgent care, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
  - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method.

You must use and exhaust Plans' administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plans' prescribed procedures in a timely manner will also cause you to lose your right to sue under

ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Compliance with Privacy Regulations

Notice of Privacy Rights (Health Care Records)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice applies to all active and retired Plan participants of participating AMR Corporation subsidiaries.

This Notice is effective as of February 17, 2010, and applies to health information received about you by the health care components of the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (particularly, the Standard Medical Options, the Value Option, the Out-of-Area Option, the Value Plus Option, the Core Option, the HMOs, Dental Benefits, Vision Insurance Benefits, Health Care Flexible Spending Accounts Benefit, Limited Purpose Health Care Flexible Spending Account, Health Savings Account), the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, TransWorld Airlines Retiree Health and Life Benefits Plan and any other group health plan for which American Airlines, Inc. (“American”) serves as Plan Administrator (collectively, the “Plan”).

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the “Privacy Regulations”) and as amended by the Genetic Information Nondiscrimination Act (“GINA”) and the American Recovery and Reinvestment Act (“ARRA”)As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan’s privacy procedures with respect to your health information that is created or received by the Plan (your “Protected Health Information” or “PHI”). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan’s duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan’s privacy practices. The following uses and disclosures of your PHI may be made by the Plan:

- For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claims for benefits are covered under the Plan and disclosures to obtain reimbursement under

insurance, reinsurance or stop-loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by AMR Corporation and its subsidiaries for any of the purposes described above. ARRA requires disclosures for purposes of payment to meet its minimally necessary standard.

- For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you (for example, if your doctor requests information on what other drugs you are currently receiving).
- For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances. ARRA requires disclosures for purposes of the Plan's operations to meet its minimally necessary standard. The Plan is prohibited from disclosing any of your PHI that constitutes genetic information (as defined by GINA) for underwriting purposes.
- When Required by Law. The Plan may also be required to disclose or use your PHI for certain other purposes (for example, if certain types of wounds occur that require reporting or a disclosure to comply with a court order, a warrant, a subpoena, a summons or a grand jury subpoena).
- For Workers' Compensation. The Plan may disclose your PHI as authorized by you or your representative and to the extent necessary to comply with laws relating to Workers' Compensation and similar programs providing benefits for work-related injuries or illnesses if either, (1) the health care provider is a member of the employer's workforce and provides health care to the individual at the request of the employer, the PHI is provided to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace and the information is required for the employer to comply with OSHA or with laws with similar purposes, or (2) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.
- Pursuant to Your Authorization. Any other use or disclosure of your PHI will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.
- For Appointment Reminders and Health Plan Operations. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you,

such as case management, disease management, wellness programs or retiree assistance programs.
- To the Plan Sponsor. Information may be provided to the Sponsor of the Plan, provided that the Sponsor has certified that this information will not be used for any other benefits, retiree benefit plans or employment-related activities.

Other Uses or Disclosures of Protected Health Information
Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:
- the information is directly relevant to the family's or friend's involvement with your care or payment for that care and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your authorization or any opportunity to agree or object under the following circumstances:
- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.
- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. State laws may provide you with additional rights or protections

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. The Plan is required to comply with your request not to disclose to another plan any PHI related to any claim for which you paid in full. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: Managing Director, Human Resources Delivery.

To Access. You have the right to request access to your PHI and to inspect and copy your PHI in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any

information compiled in reasonable anticipation of or for the use of civil, criminal or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. You may also direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by you.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer:

Managing Director, Human Resources
Delivery at American Airlines
Mail Drop 5144-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a written form to request amendment of the PHI in your designated record set. Requests for amendment of PHI in a designated record set should be made to the following officer:

Managing Director, Human Resources
Delivery at American Airlines
Mail Drop 5144-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (such disclosures occurring after January 1, 2014, will be required to be included in the accounting); (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14,2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Obtain a Paper Copy of This Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Plan's Privacy Officer by calling the Managing Director, Human Resources Delivery or by writing to American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

To Request Confidential Communication. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the following officer: Managing Director, Human Resources Delivery, American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

A Note About Personal Representatives
You may exercise your rights through a personal representative (e.g., having your spouse call for you). Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A signed authorization completed by you,
- A court order of appointment of the person as the conservator or guardian of the individual, or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard
When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1)disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the Secretary of the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7)uses or disclosures that are required for the Plan's compliance with legal regulations; and (8)uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

The Plan may use or disclose "summary health information" or a limited data set on and after February 17, 2010 to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a "Limited Data Set" that may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, Mail Drop 5134-HDQ, P.O. Box 619616, DFW Airport, TX 75261-9616, describing when you believe the violation occurred and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. You may obtain the address of the appropriate regional office of the Office for Civil Rights from the Privacy Complaint Official. If you would like to receive further information, you should contact the Privacy Official, the Managing Director, Human Resources Delivery at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616 or the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, Mail Drop 5134-HDQ1, P.O. Box 619616, DFW Airport, TX75261-9616. This notice will first be in effect on February 17, 2010. and shall remain in effect until you are notified of any changes, modifications or amendments.

How AMR Corporation and Its Subsidiaries, Including American Airlines, May Use Your Health Information

American Airlines, Inc. (“American”), administers many aspects of the American Group Health Plans (the “Plans”), which are listed below, on behalf of AMR Corporation and its Subsidiaries, including American Airlines and American Eagle. American, as the plan sponsor and/or plan administrator of the Plans may use and disclose your personal medical information (called “Protected Health Information”) created and/or maintained by the Plans that it receives from the Plans as permitted and/or required by, and consistent with the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Regulations found at 45 CFR Part 164, Subpart A. This includes, but is not limited to, the right to use and disclose a participant’s PHI in connection with payment, treatment and health care operations.

The American Airlines Group Health Plans include the health plan components of:

- The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 515),
- The Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503)
- The Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries (Plan 515)
- TransWorld Airlines, Inc. Retiree Health and Life Benefits Plan
- Any other Group Health Plan for which American serves as Plan Administrator.

This Applies To
The information in this section applies only to health-related benefit plans that provide "medical care," which means the diagnosis, cure, mitigation, treatment or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body, transportation primarily for and essential to medical care and insurance covering medical care. This means that, for the Plans listed above, only the health-related benefits, including medical, prescription drug and mental health, are subject to the limitations described in this section. The EAP is included only to the extent that it is involved in the administration of medical benefits.

This Section Does Not Apply To
By law, the HIPAA Privacy rules and the information in this section, do not apply to the following benefit plans:

- Life insurance plans
- Workers' compensation plans, which provide benefits for employment-related accidents and injuries
- Property and casualty insurance.

In addition, AMR Corporation and its subsidiaries may have personal medical information about you that is used for routine employment activities. Medical information held or used by AMR

Corporation and its subsidiaries in its employment records for employment purposes is not subject to the HIPAA Privacy rules.

This includes, but is not limited to, medical information, files or records related to compliance with government occupational and safety requirements, the Americans with Disabilities Act

(ADA) or other employment law requirements, occupational injury, disability insurance eligibility, sick leave requests or justifications, drug or alcohol screening results, workplace medical surveillance, fitness-for-duty test results or other medical information needed to meet Federal Aviation Administration (FAA), Department of Transportation (DOT) or other company policy or government requirements. Information used by the EAP in its role in administering employment-related programs, such as drug and alcohol testing, is not subject to the HIPAA Privacy rules.

The Plans will disclose PHI to the employer Plan Sponsor (American Airlines or other current or former AMR subsidiary) only upon receipt of a certification by the employer that the plan documents have been amended to incorporate all the required provisions as described below. To the extent that PHI is maintained by one of the Plans, American and all other participating current or former subsidiaries of AMR Corporation for which American administers the Plans have agreed to:

- Not use or further disclose the information other than as permitted or required by this Employee or Retiree Benefits Guide, as it may be amended by American from time-to-time or as required by law
- Ensure that any agents, including a subcontractor, to whom the Plans give PHI, agree to the same restrictions and conditions that apply to the employer Plan Sponsor with respect to such information
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or retiree benefit plan of the employer Plan Sponsor, unless that use or disclosure is permitted or required by law (for example, for Workers' Compensation programs) or unless such other benefit is part of an organized health care arrangement with the plan
- To the extent that the employer Plan Sponsor becomes aware that there is any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures, to report such improper uses or disclosures to the Plan
- Make available PHI in accordance with individual rights to review their PHI
- Make available PHI for amendment and consider incorporating any amendments to PHI consistent with the HIPAA rules
- Upon request and to the extent mandated by applicable law, make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules
- Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Plan
- Agree to the same restrictions and conditions that apply to the Plan with respect to such information and enter into Business Associate agreements that comply with the standards for such agreements in the Privacy Regulations
- Enter into limited data set use agreements when the Plan discloses data de-identified in compliance with the requirements for a limited data set as provided in the Privacy Regulations pursuant to a Limited Data Set use or disclosure agreement that meets the standards of the Privacy Regulations
- Terminate any Business Associate agreement or Limited Data Set agreement in the event the Plan becomes aware of a pattern of non-compliance with the terms of the agreement
- Provide the individual who is the subject of the PHI with the opportunity to request restrictions on the PHI's disclosure in accordance with the Plan's policy on requesting restrictions on disclosure of PHI
- Provide the individual who is the subject of the PHI with the opportunity to request confidential communication of PHI from the Plan to the individual in accordance with the Plan's policies and procedures
- Incorporate any amendments or corrections to PHI when such amendment is determined tube required by the Plan's policy on amendment of PHI
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plans

- If feasible, return or destroy all PHI received from the Plans that the employer Plan Sponsor still maintains in any form. The employer Plan Sponsor will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if the return or destruction is not feasible, but the Plans must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible, and
- Ensure that there is an adequate separation between the Plans and the employer Plan Sponsor as will be set forth below.

Separation of AMR Corporation and Its Subsidiaries, Including American Airlines and the Group Health Plans

The following employees or classes of employees or other persons under the control of American Airlines or another AMR subsidiary shall be given access to PHI for the purposes related to the Plan:

- Health Strategy employees involved in health plan design, vendor selection and administration of the Plans and including the Plan Managers and administrative assistants, secretarial and support staff; as well as any Retirement Strategy employees involved in health plan issues
- Pension Benefits Administration Committee (PBAC), its delegated authority and PBAC Advisory Committee members, due to their role in governing health plan matters, including reviewing and approving plan design changes, rendering appeal decisions and other health plan administrative matters
- Benefits Compliance and the PBAC Appeals group personnel involved in receiving, researching and responding to health plan member appeals filed with the PBAC
- Employee Services personnel and HR Services personnel who assist with day-to-day health plan operations, including Vendor Relations personnel; Retirement Counselors, who assist with retiree medical coverage questions; employees involved in receiving, reviewing and processing Qualified Medical Child Support Orders; and all call center personnel, case coordinators and support staff who assist employees and retirees by answering questions, researching issues and resolving health plan problems, including those administering the Travel program; Leave of Absence coordinators working with health plan enrollment issues; Survivor Support counselors, who assist with health plan issues for survivors; and administrative assistants, secretarial and support staff for the employees listed
- Instructors who train Employee Services and HR Services personnel and thus have access to the call center systems
- HR Records Room personnel responsible for managing benefit plan record storage Certain HR Operations Support (HR Ops Support) personnel, but only those involved in investigating health plan fraud or abuse

- Executive Compensation employees, including secretarial and support staff, who assist Company executives and certain other employees with health plan enrollment and payment issues on a day-to-day basis
- Occupational Health Services/Clinical Services employees, including the Corporate Medical Director, EAP Manager, EAP nurses and support staff providing services through the Employee Assistance Program (EAP), including review and approval of mental health and substance abuse claims under the Plans, but only to the extent of their involvement with the Group Health Plans
- Legal department employees, including Employment Attorneys, ERISA counsel, Labor Attorneys and Litigation Attorneys and any other attorneys involved in health plan legal matters, and including paralegals and administrative assistants, Legal Records Room personnel who manage record storage, and Legal IT personnel
- Human Resource (HR) Quality Assurance personnel responsible for financial management of the health plans, including the HR Controller; HR Delivery Operations personnel; health plan Benefits Analysts monitoring financial trends; and their administrative assistants, secretarial and support staff
- Financial Reporting Group employees involved in audits and financial reporting for the group health plans and including the secretarial and support staff for these employees
- Employee Relations personnel, but only those involved in grievance processes or mediation/arbitration processes
- Internal Audit employees, but only for purposes of auditing administrative processes related to the group health plans and including the secretarial and support staff for these employees
- Benefits & Travel Technology personnel who maintain key human resource and benefits systems used to transmit, store or manage PHI and including the secretarial and support staff for these employees
- Information Technology Services (ITS) management personnel, including certain team leads and other designated personnel managing IT infrastructure for systems used by HR and Benefits, including administrative staff, key vendor managers and certain management personnel responsible for disaster recovery procedures
- American Eagle personnel involved in benefit plan administration for that subsidiary
- Privacy Compliance Council and HIPAA Subcommittee members, due to their role in understanding and investigating the flow of PHI for the Group Health Plans, in order to ensure compliance with HIPAA and other privacy rules; and
- On a need-to-know basis, appropriate personnel employed by the employer Plan Sponsor as independent contractors who have executed Business Associate agreements with the Plan to provide other necessary administrative services to the Plan that include, but are not limited to:

- Insurance agents retained to provide consulting services and obtain insurance quotes
- Actuaries retained to assess the Plan's ongoing funding obligations
- Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities
- Consulting firms engaged to design and administer Plan benefits
- Financial accounting firms engaged to determine Plan costs; and
- Claims processing companies engaged to assist the Plan Administrator in the processing of claims made against the Plan.

Access to and use of PHI by such employees and other persons described above is restricted to administration functions for the Plans performed by American or another employer Plan Sponsor, including payment and health care operations.

American and other AMR subsidiaries shall provide an effective mechanism for resolving any issues of non-compliance by such employees or persons. American Airlines' Rules of Conduct as outlined in the Employee Policy Guide, including disciplinary procedures, will apply to such issues of employee non-compliance.

Non-compliance Issues
If the persons described above do not comply with the requirements included in this portion of the Plan, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for the individuals involved in the violation, which sanctions are included in the policy on sanctions for violation of the privacy policies and procedures. The Plan's Policy Regarding Sanctions for Violation of the HIPAA Privacy Policies and Procedures shall be followed along with the Group Health Plan's Policy and Procedure on Mitigation of Damages for Violative Disclosure of Protected Health Information in the event of any violation of the Plan's HIPAA Privacy Provisions in this Article.

Organized Health Care Arrangement
The Plan is part of an organized health care arrangement with the following other health plans maintained by AMR Corporation and its subsidiaries. The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries with respect to the benefits and benefit options providing health care benefits; the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation subsidiaries with respect to the benefits and benefit options providing retiree medical benefits, and the Retiree HMO offered hereunder, the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, the TransWorld Airlines Retiree Health and Life Benefits Plan and any other Group Health plan for which American serves as Plan Administrator.

The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement for the purposes described in the regulations and in the section entitled “Notice of Privacy Rights — Health Care Records” above.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of the Plan’s benefits that relate to an individual to whom health care is provided. A disclosure for payment will be limited to the minimally necessary information unless the disclosure occurs in the form of the standard for the electronic transactions. An authorization is not required to permit a disclosure or use for payment unless the disclosure involves psychotherapy notes or the use of the information for marketing. Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, co-insurance, deductibles and co-payments as determined for an individual’s claim)
- Coordination of benefits
- Adjudication of health benefit claims (including appeals and other payment disputes)
- Subrogation of health benefit claims
- Establishing retiree contributions
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Billing, collection activities and related health care data processing
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance)
- Determining medical necessity, experimental or investigational treatment or other coverage reviews or reviews of appropriateness of care or justification of charges (including hospital bill audits)Processing utilization review, including pre-certification, pre-authorization, concurrent review, retrospective review, care coordination or case management
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for such purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan), and
- Obtaining reimbursements due to the Plan.

Health Care Operations
A disclosure for Health Care Operations will be limited to the amount minimally necessary. Health Care Operations include, but are not limited to, the following activities:

- Quality assessment
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions
- Rating providers and plan performance, including accreditation, certification, licensing or credentialing activities
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance)
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs
- Business planning and development, such as conducting cost-management and planning related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies
- Business management and general administrative activities of the Plan, including but not limited to:
    - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
    - Participant service, including the provision of data analyses for participants or the plan sponsors
    - Resolution of internal grievances, and
    - The sale, transfer, merger or consolidation of all or part of the Plan with another covered entity or an entity that following such activity will become a covered entity and due diligence related to such activity.

Treatment
Disclosures for treatment are not limited by the minimally necessary requirement if the disclosures are made to, or the requests are made by a health care provider for the treatment of an individual. Treatment means the provision, coordination or management of health care and related services by one or more health care provider(s). Treatment includes:

- The coordination or management of health care by a health care provider and a third party,
- Consultation between health care providers about an individual patient, or
- The referral of a patient from one health care provider to another.

Limited Data Set

The Plan may disclose PHI in the form of a limited data set as provided in 45CFR §164.514(e) provided that the disclosure is in accordance with such provisions.

Your Rights Under ERISA

Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We believe that the Plan that has been developed is only good if you receive the benefits to which you are entitled. We encourage you to come to us if you have any questions or problems. In addition, as already noted, the Plan documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, there are steps you can take to enforce the above rights. For instance, if

you request a copy of Plan documents or the latest annual report from the Plan 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 you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If
it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 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.

For general information contact:

American Airlines Human Resources
P.O. Box 9741
Providence, RI 02940-9741
HR Services:
Phone: 800-447-2000
Fax 1-888-891-3625

E-mail/Chat by clicking the "Chat with HR Services" link on my.aa.com.

For information about your claims, contact the appropriate Network/Claims Administrator or benefits plan administrator at the addresses and phone numbers located under Information earlier in this section.

Archives

Prior versions of your Retiree Benefits Guide are available at
http://www.aacareers.com/ebg/Archive/default.asp