HEALTH AND LIFE BENEFITS GUIDE FOR RETIREES OF TWA

Click the links below to view the latest plan changes.

See the December 2007 Summary Material Modifications

See the December 2006 Summary Material Modifications, Clarifications, and Women's Cancer Rights Documents

See the March 2006 Technical corrections

See the December 2005 Summary of Material Modifications

 Chat with HR Services

SUMMARY OF MATERIAL MODIFICATIONS FOR HEALTH AND WELFARE BENEFIT PLANS SPONSORED BY AMERICAN AIRLINES, INC.

December 15, 2008

This document serves as notice to the **TWA Retiree** participants of changes to the American Airlines, Inc.-sponsored health and welfare benefit plans listed below. This Summary of Material Modifications describes the changes that affect your benefit plans and updates your Summary Plan Descriptions. This Summary of Material Modifications, together with the Retiree Benefit Guide, makes up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in the Health and Life Benefits Guide for Retirees of TWA ("TWARBG")). These changes are effective January 1, 2009, unless otherwise stated elsewhere in this document.**

These changes apply to the TWA Retiree Health and Life Benefits Plan (Plan 511, EIN #13-1502798; referred to herein as the "TWA Retiree Plan"), and the American Airlines, Inc. Retiree Dental Insurance Plan (Plan 512, EIN #13-1502798).

Effective January 1, 2009, American Airlines will no longer be offering TRICARE Supplement Insurance as a medical option under the TWA Retiree Plan. In Section II. Addition of TRICARE Supplement Insurance Option as a Medical Benefit Option for TWA Retiree Participants" on pages 1 – 5 of the SMM effective 1/1/06, delete the section in its entirety.

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the following employee benefit plans:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (referred to as the "Plan", the "Retiree Medical Benefit")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries
- TWA Retiree Health and Life Benefits Plan.

These plans provide coverage for reconstructive surgery, as follows:

- 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 treatment of lymphademas; and
- Prostheses.

This information is also available in your Employee Benefits Guide – in both the CD-ROM version (if applicable to your work group) sent to you in July – August, 2005, and via Jetnet on e-HR.

END OF ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE FOR RETIREES OF PARTICIPATING AMR CORPORATION SUBSIDIARIES

June 30, 2008

This document serves as notice to the **TWA Retiree** participants of clarifications to the Summary Plan Description – the Health and Life Benefits Guide for Retirees of TWA ("TWARBG"). These clarifications, together with the TWARBG, make up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in your TWARBG).**

These clarifications apply to:

- TWA Retiree Health and Life Benefits Plan(Plan 511, EIN #13-1502798; referred to herein as the "TWA Retiree Plan")

- American Airlines, Inc. Retiree Dental Insurance Plan (Plan 512, EIN #13-1502798)

In "Administration," "Information About Claims," "Filing an Appeal" (page 75), the following paragraph is inserted after the second paragraph on the page:

> *This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document. The one exception to this mandatory two-tiered 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. Employees 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 in the quickest manner possible.*

END OF CLARIFICATIONS TO THE RETIREE BENEFITS GUIDE

SUMMARY OF MATERIAL MODIFICATIONS FOR HEALTH AND WELFARE BENEFIT PLANS SPONSORED BY AMERICAN AIRLINES, INC.

December 15, 2007

This document serves as notice to the TWA Retiree participants of changes to the American Airlines, Inc.-sponsored health and welfare benefit plans listed below. This Summary of Material Modifications describes the changes that affect your benefit plans and updates your Summary Plan Descriptions. This Summary of Material Modifications, together with the Retiree Benefit Guide, makes up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in the Health and Life Benefits Guide for Retirees of TWA ("TWARBG")). These changes are effective January 1, 2008, unless otherwise stated elsewhere in this document.**

These changes apply to the TWA Retiree Health and Life Benefits Plan (Plan 511, EIN #13-1502798; referred to herein as the "TWA Retiree Plan"), and the American Airlines, Inc. Retiree Dental Insurance Plan (Plan 512, EIN #13-1502798).

Modification to the Administration of the Retail Prescription Drug Benefit (page 20)

You must present your Medco prescription drug card at the time of purchase in order to receive the *discounted* medication rates. If you *do not* present your Medco prescription drug card at the time of purchase, you will pay the *non-discounted price* at that time. If you pay the non-discounted price, reimbursement from the plan will be based on the discounted rate – which means that you will be financially responsible for the difference between the non-discounted price and the discounted price, in addition to paying the 30 percent co-insurance (after your deductible has been met). See example as follows:

If you . . .	The cost of your prescription is . . .	The amount Medco considers when paying your claim is . . .	Plan pays . . .	You pay . . .
Purchase your prescription **showing** your Medco card	**$100** *(which is the discounted amount for that particular drug)*	**$100**	**$70** *(which is the 70% co-insurance)*	**$30** *(which is your 20% co-insurance)*
Purchase your prescription **without showing** your Medco card	**$250** *(which is the non-discounted price for that particular drug)*	**$100**	**$70** *(which is the 70% co-insurance)*	**$180** *(which is your 20% co-insurance **plus** the $150*

If you . . .	The cost of your prescription is . . .	The amount Medco considers when paying your claim is . . .	Plan pays . . .	You pay . . .
				difference between the non-discounted price of the drug and the discounted price)

Contribution Rate Change for TriCare Supplement in "Section II. Addition of TriCare Supplement Insurance Option as a Medical Benefit Option for TWA Retiree Participants," "Enrollment" (page 3) of the SMM effective 1/1/06, the following paragraph should be added at the end of that section:

In compliance with federal law, effective January 1, 2008, American Airlines will no longer provide any employer subsidy for employees who elect the TriCare Supplement Option. Premiums for this option must be 100 percent employee-paid.

END OF SUMMARY OF MATERIAL MODIFICATIONS

CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE FOR RETIREES OF PARTICIPATING AMR CORPORATION SUBSIDIARIES

This document serves as notice to the TWA Retiree participants of clarifications to the Summary Plan Description – the Health and Life Benefits Guide for Retirees of TWA ("TWARBG"). These clarifications, together with the TWARBG, make up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in your TWARBG).**

These clarifications apply to:

- TWA Retiree Health and Life Benefits Plan(Plan 511, EIN #13-1502798; referred to herein as the "TWA Retiree Plan")
- American Airlines, Inc. Retiree Dental Insurance Plan (Plan 512, EIN #13-1502798)

In "TWA Retiree Medical," "TWA Retiree Medical Under Age 65" (page 17), the following clarification applies to the retail pharmacies row of the chart:

Features	In-Network Benefits	Out-of-Network Benefits
Prescriptions – Retail[2] (for acute care prescriptions only)	**For up to a 30-day supply:** • **Generic: $10 co-payment** • **Brand (generic not available): 30% co-insurance; co-insurance applies to out-of-pocket maximum** • **Brand (generic available, but brand requested): $10 plus difference in cost between brand and generic when generic is available and brand is requested** Psychotherapeutic prescription drugs are covered the same as any other retail prescription drug purchased at a pharmacy	**No change**

In "TWA Retiree Medical Plan," "If You Have Other Coverage/Other Plans" (page 48), add the following bullet to the list of other plans:

- *Other individual insurance policies*

In "TWA Retiree Medical Plan," "Filing Medical Claims," "Medicare Crossover" (page 52), the following paragraph should be added at the end of that section:

> *To learn more or to take advantage of this Medicare Crossover Process, access the form on Jetnet (then "Retiree Benefits", then "Resources", then "Form Finder") or contact HR Employee Services (see Contact Information on page 1).*

In "TWA Retiree Medical Plan," "Continuation of Coverage" (page 54), the following paragraphs should be added at the beginning of the 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* Contact Information *on page 1), either by phone or by email, or by mail and ask for a HIPAA certificate of creditable coverage.*

In "Administrative Information," "Information About Claims," "Filing an Appeal" (page 75), the following clarifications apply:

> The following sentence should be added to the second paragraph: *For urgent care claims, only Second Level Appeals are required – no First Level Appeals are necessary.*

In "Administrative Information," "Glossary of Terms" (pages 89-90), the following clarification applies:

> Under "Medical necessity or medically necessary," the third paragraph should read as follows: *A service or supply for an illness or injury 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.*

END OF CLARIFICATIONS TO THE RETIREE BENEFITS GUIDE

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the following employee benefit plans:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (referred to as the "Plan", the "Eagle Plan", the "Retiree Medical Benefit")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries
- TWA Retiree Health and Life Benefits Plan.

These plans provide coverage for reconstructive surgery, as follows:

- 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 treatment of lymphademas; and
- Prostheses.

This information is also available in your Health & Life Benefits Guide for Retirees of TWA – in both the online version (through *Jetnet)* as well as the printed version sent to you in 2002.

END OF ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

December 2006
Summary Material Modifications Document / Employee Benefit Guide Clarifications Document / Women's Cancer Rights Notice

(Click the links below to view each document)

Summary Material Modifications

Employee Benefits Guide Clarifications

Women's Cancer Rights Notice

SUMMARY OF MATERIAL MODIFICATIONS FOR HEALTH AND WELFARE BENEFIT PLANS SPONSORED BY AMERICAN AIRLINES, INC.
December 15, 2006

This document serves as notice to the TWA Retiree participants, of changes to the American Airlines, Inc.-sponsored health and welfare benefit plans listed below. This Summary of Material Modifications describes the changes that affect your benefit plans, an updates your summary plan descriptions. This Summary of Material Modifications, together with the Retiree Benefit Guide, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s) (the Summary Plan Descriptions are contained in the Health and Life Benefits Guide for Retirees of TWA ("TWARBG"). These changes are effective January 1, 2007, unless otherwise stated elsewhere in this document.**

These changes apply to the TWA Retiree Health and Life Benefits Plan (Plan 511, EIN #13-1502798, referred to herein as the "TWA Retiree Plan"), and the American Airlines, Inc. Retiree Dental Insurance Plan (Plan 512, EIN #13-1502798).

I. Availability of the Nurse Advocate Program and the Cancer Resource Network in the TWA Retiree Plan EFFECTIVE DECEMBER 1, 2006

In the "Important Contacts" section (page 80), the following entries are added:

Nurse Advocate Program *For all self-funded TWA Retiree Plan medical coverage (not for HMO or TriCare Supplement)*	***UnitedHealthcare***	***800.638.9599***
Cancer Resource Network *For all self-funded TWA Retiree Plan medical coverage (not for HMO or TriCare Supplement)*	***UnitedHealthcare***	***800.638.9599***
NurseLine *For all self-funded TWA Retiree Plan medical coverage (not for HMO or TriCare Supplement)*	***UnitedHealthcare***	***800.638.9599***

In "TWA Retiree Medical Under Age 65", immediately following "Special Provisions and Limits" (page 17), the following section is added:

Custom Care Coordination from UnitedHealthcare

For participants in self-funded TWA Retiree Plan health coverage—Under Age 65 coverage, UnitedHealthcare offers Custom Care Coordination—access to health professionals who can answer your health questions, refer you to health resources for information, and help you navigate the health care system:

- *Nurse Advocates—nurses who can provide information to help you make better health care choices*
- *Cancer Resource Network—health professionals who specialize in cancer care and treatment information, who can work with you and your family to help you to access the best treatment*

For these Retiree Medical Benefit Options (not for HMOs or TriCare Supplement), UnitedHealthcare also offers NurseLine—telephone access to nurses who can answer your health questions, and provide treatment options and information

UnitedHealthcare offers these Custom Care Coordination programs to you at no cost, and your participation is voluntary. For more information about these Custom Care Coordination resources, contact UnitedHealthcare (see Important Contacts).

II. Eliminate Plan Coverage for Sexual Performance Medications, Devices, and/or Treatment

In "Excluded Expenses" (pages 32-35), immediately following the exclusion entitled, "Sex changes", the following exclusion is added:

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 dysfunction or other sexual dysfunction, or for the purpose of producing, restoring, or enhancing sexual performance/experience.*

END OF SUMMARY OF MATERIAL MODIFICATIONS

CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE FOR RETIREES OF PARTICIPATING AMR CORPORATION SUBSIDIARIES

This document serves as notice to the TWA Retiree participants of clarifications to the summary plan description—the Health and Life Benefits Guide for Retirees of TWA ("TWARBG"). These clarifications, together with the TWARBG, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s) (the Summary Plan Descriptions are contained in your TWARBG).**

These clarifications apply to the following plans:

TWA Retiree Health and Life Benefits Plan(Plan 511, EIN #13-1502798; referred to herein as the "TWA Retiree Plan")

American Airlines, Inc. Retiree Dental Insurance Plan (Plan 512, EIN #13-1502798)

In "Covered Expenses for both the TWA Retiree Medical Plan Under Age 65 and the TWA Medicare Supplement Plan" (page 23), the entry entitled, "Acupuncture" is deleted in its entirety and replaced with the following:

> ***Acupuncture:*** *Medically necessary treatment (performed by a Certified Acupuncturist) for diagnosed illness or injury, 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.)*

Throughout the TWARBG, any and all references to the American Airlines, Inc. Medical Department (also referred to as "AA Medical" or "AA Medical Department") is changed to reflect the new name of the department, as follows:

> *AA Medical and Occupational Health Services*

In "Continuation of Coverage" (page 55), the following statement is added to the end of this section:

> *TriCare Supplement Continuation*
>
> *You have the ability to continue coverage under the TriCare Supplement Medical Option, as this coverage provides portability. Contact ASI/TriCare for more information.*

In “TWA Retiree Life Insurance Benefits”, “Retiree Life Insurance”, the section entitled, “The following term life insurance benefits are extended only to retired TWA Pilots” (page 57), a scrivener’s error exists with respect to the reference to life insurance for retired pilots who worked for Ozark Airlines. This scrivener’s error caused the following to be stated in the TWARBG:

> *If you worked as a pilot for Ozark Airlines, Inc. for 10 or more years and retired, you receive life insurance in the amount equal to one times your annual earnings prior to retirement, rounded to the nearest multiple of $1000, with a maximum coverage of $70,000 and a minimum coverage of $5000.*

When American Airlines, Inc. acquired certain assets of TransWorld Airlines, Inc. (“TWA, Inc.”) in April, 2001, such asset acquisition *did not include* TWA, Inc.’s employee benefit plans for active or retired employees. American Airlines, Inc. also did not acquire responsibility for any benefit plan that TWA, Inc. may have previously acquired. However, American Airlines, Inc. did create a new health and life benefit plan for TWA Retirees, which included benefits equivalent to those provided to retirees in the TWA, Inc.-sponsored retiree plan.

The italicized paragraph above was a scrivener’s error and describes a benefit that did not exist in the TWA, Inc.-sponsored retiree benefit plan, and American Airlines, Inc. did not agree to establish any such benefit via any agreement with the Allied Pilot Association (“APA”) during or after the integration of TWA, Inc. pilots into the APA (in 2001-2002). As such, this italicized paragraph that was included due to a scrivener’s error is deleted from the TWA Retiree Plan effective from and after January 1, 2002 (the inception date of the TWA Retiree Plan).

MetLife, the insurer for the Retiree Dental Insurance Plan, requested the following corrections be made in the coverage chart, as it was determined that some of the existing entries in the chart are not reflective of the insurance policy provisions (this occurred as a scrivener’s error). Thus, corrected entries are to be made in the RBG. In “Retiree Dental Insurance Plan”, “Covered Expenses” (added via December 15, 2005 SMM—pages 10-11), the chart in this section is deleted in its entirety and replaced with the following:

What's Covered	How Often/Limitations
Type A—Preventive Services	
Cleanings	One cleaning per six-month period, not to exceed two cleanings per calendar year
Exams	One exam per six-month period, not to exceed two exams per calendar year
Fluoride Treatments	One fluoride treatment per calendar year for covered dependent children under age 19
X-Rays	Full mouth x-rays: one per 60 months Bitewing x-rays: one set per calendar year for covered adults; one set per six-month period for covered children—not to exceed two sets of x-rays per calendar year
Type B—Basic Restorative Services	
Fillings	When dentally necessary; no limitations
Crown, Denture, and Bridge	When dentally necessary; no limitations

Repair	
Denture Relines and Rebases	Limited to 36 months (covered only after six months following the initial installation)
Lab and Other Tests	When dentally necessary; no limitations
Simple Extractions	When dentally necessary; no limitations
Space Maintainers	Space maintainers for dependent children under age 19
Type C—Major Restorative Services	
Bridges and Dentures	Initial placement to replace one or more natural teeth that are lost while covered by the Retiree Dental Insurance Plan Dentures and bridgework replacement—one every five years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns, Inlays, Onlays	Crowns, inlays, onlays replacement—once every five years
Endodontics	Root canal treatment limited to once per tooth per 24 months
General Anesthesia	When dentally necessary in connection with oral surgery, extractions, or other covered dental services
Oral Surgery	When dentally necessary; no limitations
Periodontics	Periodontic scaling and root planing, once per quadrant, per 24 months; Periodontic surgery, once per quadrant, per 36 months
Periodontic Maintenance	Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments per calendar year
Surgical Extractions	When dentally necessary; no limitations

END OF CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the following employee benefit plans:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (referred to as the "Plan", the "Eagle Plan", the "Retiree Medical Benefit")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries
- TWA Retiree Health and Life Benefits Plan

These plans provide coverage for reconstructive surgery, as follows:

- 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 treatment of lymphademas; and
- Prostheses

This information is also available in your Employee Benefits Guide—in both the CD-ROM version (if applicable to your work group) sent to you in July-August, 2005, and on *Jetnet*.

END OF ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

March 15, 2006
(Click on the links below to view the sections of this document.)

NOTICE AND DOCUMENTATION OF TECHNICAL CORRECTIONS TO THE HEALTH AND LIFE BENEFITS GUIDE FOR RETIREES TWA, CORRECTIONS TO THE DECEMBER 15, 2005 SUMMARY OF MATERIAL MODIFICATIONS, AND TRIENNIAL HIPAA NOTICE OF PRIVACY PRACTICES (March 15, 2006)

This document serves as notice to retiree participants in the TWA Retiree Health and Life Benefit Plan of technical corrections made to your summary plan descriptions and summaries of material modifications. This Notice Summary of Material Modifications, together with the Health and Life Benefits Guide for Retirees of TWA and Summaries of Material Modifications, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s). The Summary Plan Descriptions are contained in the Health and Life Benefits Guide for Retirees of TWA ("TWARBG").**

- TWA Retiree Health and Life Benefits Plan (Plan 511, EIN #13-1502798)
- American Airlines, Inc. Retiree Dental Insurance Plan (Plan 512, EIN #13-1502798)

I. TECHNICAL CORRECTIONS TO THE TWARBG

Throughout the TWARBG:
Health International changed its corporate name to SHPS—it is the same company—only the name has changed. **Thus, all references to "Health International" are revised to "SHPS".**

Throughout the TWARBG:
Any and all references to "PAID Prescriptions" and "Merck-Medco" **are revised to "Medco"**.

TWARBG, Page 2:
Under "Change or Discontinuance of Plan", the second paragraph is revised, as follows:
The Company reserves the right to alter, amend, modify, or terminate the TWA Retiree Health and Life Benefits 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 Employee Services (see Contact Information).

TWARBG, Page 80:
Under "Important Contacts", the following revisions are made:

FOR INFORMATION ABOUT	CONTACT:	PHONE NUMBER:
Prescription Drugs—Retail	Medco Member Services—Phone Inquiries	**(800) 988-4125** **Website:** www.medco.com
Prescription Drugs—Filing Retail Prescription Claims	**Medco** PO BOX 14711 Lexington, KY 40512	**(800) 988-4125**
Prescription Drugs—Mail Order	**Medco** PO BOX 3938 Spokane, WA 99220-3938	**(800) 988-4125** **Website:** www.medco.com
QuickReview	**SHPS** 14770 North 78th Way Scottsdale, AZ 85260	**(800) 638-9599**

II. TECHNICAL CORRECTIONS TO THE SUMMARY OF MATERIAL MODIFICATIONS ("SMM") DATED DECEMBER 15, 2005S

TWA Retiree SMM, Page 8:
Under "III. Medicare Part D for Retiree Participants/Dependents with Medicare", a new paragraph is inserted, as follows, immediately following the last paragraph of this section:
If you reach age 65 (or earlier, if you are Medicare-eligible) but your spouse is under age 65 (and not Medicare-eligible), your prescription drug coverage under the TWA Retiree Health and Life Benefit Plan ends when you reach age 65 (or become Medicare-eligible), but your spouse retains his/her prescription drug coverage (with Medco) until such time that he/she reaches age 65 (or earlier, if he/she becomes Medicare-eligible). If you are under age 65 (and not Medicare-eligible) but your spouse is age 65 or over (or earlier, if he/she is Medicare-eligible), you retain your prescription drug coverage under the TWA Retiree Health and Life Benefit Plan (with Medco) (until such time that you reach age 65, or earlier if you become Medicare-eligible), but your spouse's TWA Retiree Health and Life Benefit Plan prescription drug coverage ends. Your (or your spouse's) prescription drug coverage (with Medco) ends because you (or your spouse) are eligible to enroll in Medicare Part D.

TWA Retiree SMM, Page 7:
Under "Which Plan is Primary", the following is added as the last paragraph of this section:
If you reach age 65 (or earlier, if you are Medicare-eligible) but your spouse is under age 65 (and not Medicare-eligible), your prescription drug coverage under the TWA Retiree Health and Life Benefit Plan ends when you reach age 65 (or become Medicare-eligible), but your spouse retains his/her prescription drug coverage (with Medco) until such time that he/she reaches age 65 (or earlier, if he/she becomes Medicare-eligible). If you are under age 65 (and not Medicare-eligible) but your spouse is age 65 or over (or earlier, if he/she is Medicare-eligible), you retain your prescription drug coverage under the TWA Retiree Health and Life Benefit Plan (with Medco) (until such time that you reach age 65, or earlier if you become Medicare-eligible), but your spouse's TWA Retiree Health and Life Benefit Plan prescription drug coverage ends. Your (or your spouse's) prescription drug coverage (with Medco) ends because you (or your spouse) are eligible to enroll in Medicare Part D.

TWA Retiree SMM, Page 5:
Under "Prescription Drug Benefits", "Important News for Medicare Eligible Retirees/Dependents", the following paragraph is added as the last paragraph of this section:
If you reach age 65 (or earlier, if you are Medicare-eligible) but your spouse is under age 65 (and not Medicare-eligible), your prescription drug coverage under the TWA Retiree Health and Life Benefit Plan ends when you reach age 65 (or become Medicare-eligible), but your spouse retains his/her prescription drug coverage (with Medco) until such time that he/she reaches age 65 (or earlier, if he/she becomes Medicare-eligible). If you are under age 65 (and not Medicare-eligible) but your spouse is age 65 or over (or earlier, if he/she is Medicare-eligible), you retain your prescription drug coverage under the TWA Retiree Health and Life Benefit Plan (with Medco) (until such time that you reach age 65, or earlier if you become Medicare-eligible), but your spouse's TWA Retiree Health and Life Benefit Plan prescription drug coverage ends. Your (or your spouse's) prescription drug coverage (with Medco) ends because you (or your spouse) are eligible to enroll in Medicare Part D, and the TWA Retiree Health and Life Benefit Plan will coordinate benefits (as the secondary payor) with Medicare Part D as the primary payor.

SUMMARY OF MATERIAL MODIFICATIONS FOR HEALTH AND WELFARE BENEFIT PLANS SPONSORED BY AMERICAN AIRLINES, INC.
December 15, 2005

This document serves as notice to retiree participants of the TWA Retiree Health and Life Benefits Plan of changes to the American Airlines, Inc.-sponsored health and welfare benefit plans listed below. This Summary of Material Modifications describes the changes that affect your benefit plans, and updates your summary plan descriptions. This Summary of Material Modifications, together with the Retiree Benefit Guide, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s) (the Summary Plan Descriptions are contained in the Health and Life Benefits Guide for Retirees of TWA ("TWARBG"). These changes are effective January 1, 2006, unless otherwise stated elsewhere in this document.**

- TWA Retiree Health and Life Benefits Plan (Plan 511, EIN #13-1502798, referred to herein as "TWA Retiree Medical Under Age 65 Plan", "TWA Retiree Medical Age 65 and Over Plan")

- American Airlines, Inc. Retiree Dental Insurance Plan (Plan 512, EIN #13-1502798, referred to herein as "RDIP")

I. Clarification of Contribution Payment Requirements for Participants

Under the "Eligibility and Enrollment" section, "Contributions Toward Coverage", a third paragraph is added to this section, as follows:

Whether you are enrolled in the TWA Retiree Medical Under Age 65 Plan, the TWA Retiree Medical Age 65 and Over Plan, the TriCare Supplement Insurance, or the American Airlines, Inc. Retiree Dental Insurance Plan, you are required to timely pay the required ongoing monthly contributions in order to maintain your coverage. If you fail to make timely payment of the required contributions (including but not limited to, failure to pay; failure to timely pay; failure to pay by reason of insufficient funds in your bank account from which you pay your contributions by automatic bank draft, electronic payment, etc.; failure to pay by reason of dishonored ("bounced") check), your coverage may be terminated without the possibility of reinstatement.

"Pay", "Paid", "Payment", "Timely pay", "Timely paid", "Timely payment" means payment of the entire amount of the required monthly contribution due—postmarked (or electronically receipt-registered, if payment is made via bank draft or electronically) on or before the payment due date (reflected on the payment invoice or coupon), or before the end of the 30-day grace period allowed for payment. These terms also mean that payment must be in a form of a financial instrument with valid and transferable monetary value. Payments rejected due to insufficient funds are not timely paid.

II. Addition of TriCare Supplement Insurance Option as a Medical Benefit Option for TWA Retiree Participants

In the "Important Contacts" section (page 80), the following information is added:

TriCare Supplement Insurance Option *Enrollment, member services, etc. inquiries*	***ASI*** *2301 Research Blvd., Ste 300 Rockville, MD 20850-6265*	***(800) 638-2610, Ext. 255*** ***(800) 311-3124 (fax)*** ***Web site:*** *www.asicorptricaresupp.com* ***Email:*** *custsvc@asicorporation.com*
TriCare Supplement Insurance Option *Claim inquiries*	***ASI*** *PO Box 2510 Rockville, MD 20847*	***(800) 638-2610, Ext. 255*** ***(800) 310-5514 (fax)***
DEERS *(Eligibility for TriCare)*	***Defense Manpower Data Center Support Office (DMDC)*** *Attn: COA 400 Gigling Road Seaside, CA 93955-6771*	***(800) 538-9552*** ***(800) 866 363-2883*** *(for TTY/TTD)* ***(831) 655-8317*** *(Attn: CSO) (fax)* ***Email:*** *addrinfo @osd.pentagon.mil* ***Online:*** *https://www.dmdc.osd*

Immediately following the "TWA Retiree Medical Under Age 65 Plan" section (page 19), the following sections are added:

TriCare Supplement Insurance

Effective January 1, 2006, TWA retiree participants under age 65 have a new option for medical coverage—the TriCare Supplement Insurance Option.

Military retirees under age 65, retired military reservists under age 65, and their eligible dependents may be eligible for TriCare health coverage sponsored by the federal government. TriCare-enrolled retirees under age 65 may elect to enroll in TriCare Supplement Insurance Option as a new retiree medical benefit Option for 2006. TriCare Supplement Insurance Option coordinates with your TriCare coverage and reimburses many out-of-pocket expenses not paid by TriCare.

Additional Requirements for the TriCare Supplement Insurance

In addition to meeting the TWA Retiree Medical Under Age 65 Plan eligibility requirements outlined in the "Eligibility and Enrollment" section, if you voluntarily elect to participate in the TriCare Supplement Insurance as an under age 65 retiree, you must also meet all the following eligibility requirements:

- *Be under age 65 (unless ineligible for Medicare)*
- *Meet all other eligibility requirements, as set forth in the provisions of the "TWA Retiree Medical Plan Eligibility"*
- *Have not reached your maximum medical benefit under a Company-sponsored medical coverage*
- *Did not elect to waive, or elect to voluntarily and permanently opt out of the TWA Retiree Health and Life Benefits Plan*
- *Are enrolled in the Defense Enrollment Eligibility Reporting System (DEERS—see Contact Information Section) the database of beneficiaries, worldwide, who are entitled to TriCare benefits, including*

  - *Spouse or surviving spouse of an active duty member*
  - *Retirees of the uniformed services or their spouses and surviving spouses*
  - *Spouses of reservists who are ordered up to active duty for more than 30 days (they are covered only during the reservist's active-duty tour), or a reservist who died while on active-duty tour*
  - *Former spouses of active-duty or retired military who were married to a service member or former service member who had performed at least 20 years of creditable service for retirement purposes at the time a divorce or annulment occurred*
  - *Spouses or surviving spouses of 100% disabled veterans. Such spouses would be eligible for CHAMP/VA)*
  - *Unmarried dependent children of TriCare-eligible employees*

To determine your TriCare eligibility, contact the Defense Manpower Data Center Support Office (see Contact Information section in this Guide).

Enrollment

If you are eligible for TriCare and wish to enroll in the TriCare Supplement Insurance Option, you must go online and enroll via Jetnet. If you have questions about enrollment, contact HR Employee Services (Important Contacts). It is important to note that if you elect to enroll in the TriCare Supplement Insurance Option, your election is for the entire plan year—that is, you can not change your retiree medical coverage election outside the annual enrollment period (October of each year).

TriCare Supplement Insurance Option

For those retirees who are eligible for TriCare medical coverage,

- *Spouse or surviving spouse of an active-duty member,*
- *Retirees of the uniformed services or their spouses and surviving spouses,*
- *Spouses of reservists who are ordered up to active duty for more than 30 days (they are covered only during the reservist's active-duty tour), or a reservist who died while on active-duty tour,*

- *Former spouses of active-duty or retired military who were married to a service member or former service member who had performed at least 20 years of creditable service for retirement purposes at the time a divorce or annulment occurred,*
- *Spouses or surviving spouses of 100% disabled veterans. Such spouses would be eligible for CHAMP/VA), and*
- *Unmarried dependent children of TriCare-eligible employees,*

TriCare medical coverage (offered through the federal government) may be a preferred option for you and your family. If you (or you and your family) are enrolled in TriCare, you have the option of electing the TriCare Supplement Insurance Option as your medical coverage under the TWA Retiree Medical Under Age 65 Plan. TriCare Supplement Insurance insured by the Hartford Life and Accident Insurance Company and administered by ASI, is designed to coordinate with your federal government-sponsored TriCare medical coverage, and may provide an overall richer coverage than the traditional coverage offered by the TWA Retiree Medical Under Age 65 Plan.

TriCare and the TriCare Supplement Insurance include a network of physicians, hospitals, and other medical service providers; TriCare and the TriCare Supplement Insurance determine your medical coverage. If you elect TriCare Supplement Insurance, your TriCare Supplement Insurance Option replaces medical coverage offered through the TWA Retiree Medical Under Age 65 Plan. Your benefits, including prescription drugs prescribed by physicians and dentists, as well as mental health care, treatment for alcohol/chemical dependency, are determined according to the terms and provisions of TriCare and the TriCare Supplement Insurance. Some of the TriCare Supplement Insurance features are:

- *No preexisting condition exclusion*
- *No plan deductibles*
- *Protection from excess charges*
- *Guaranteed acceptance in the TriCare Supplement Insurance*
- *Freedom of choice to utilize any TriCare authorized civilian doctor or specialist*
- *Comprehensive coverage*
- *Prompt processing of claims*
- *Portability—you may choose to continue your TriCare Supplement Insurance if you leave your employment for any reason*
- *No claim forms required*
- *Administration services provided by Association and Society Insurance Corporation (ASI)*
- *No separate precertification or preauthorization requirement*
- *Between TriCare and TriCare Supplement Insurance, most eligible charges are reimbursed in full*

TriCare Supplement Insurance offered through the TWA Retiree Health and Life Benefits Plan is completely independent of American Airlines, Inc. and as such, American Airlines, Inc. cannot influence or dictate the coverage provided under this option. While this section of the Guide has provided you with overview information about the TriCare Supplement Insurance, you must carefully review the ASI/Hartford TriCare Supplement Insurance documents to determine the provisions, limitations, and exclusions of this insurance, as those documents govern your coverage and benefits under the TriCare Supplement Insurance. If you elected this as your retiree medical coverage option, ASI/Hartford will provide you with the plan document/summary plan description that will detail the coverages, terms, and provisions of the TriCare Supplement Insurance. (See Important Contacts for ASI and Hartford.)

Domestic Partners are not eligible to participate in the TriCare Supplement Insurance Option.

Portability of the TriCare Supplement Insurance

If you are under age 65 and your TriCare Supplement Insurance terminates under the TWA Retiree Medical Under Age 65 Plan,, you may have the ability to continue your TriCare Supplement Insurance. For information on portability, contact ASI/Hartford (see Important Contacts).

When You Reach Age 65

At age 65, your TriCare Supplement Insurance ends, and your *(and your eligible covered dependents') coverage terminates under the TriCare Supplement Insurance. You and your covered spouse automatically revert to TWA Retiree Medical Age 65 and Over Plan coverage. If you participated in the TriCare Supplement Insurance as a result of your eligibility for TriCare (the US Government-sponsored health*

coverage), you may prefer to voluntarily and permanently opt out of the TWA Retiree Medical Age 65 and Over Plan in favor of TriCare for Life (the US Government-sponsored health coverage for age 65 and over participants. See "Waiving ("Opting Out" of) TWA Retiree Medical Plan, below.

Waiving ("Opting Out" of) the TWA Retiree Medical Age 65 and Over Plan

Certain age 65 and over retirees *(those who have retiree status from the military or certain federal government jobs) may be eligible for retiree medical benefits sponsored by the United States Government—**this coverage is known as "TriCare for Life".** Because the combination of Medicare and TriCare for Life coverages often provides a richer benefit (in some cases, 100% coverage) than the TWA Retiree Medical Age 65 and Over Plan, the retiree and his/her spouse may elect to permanently opt out of the TWA Retiree Medical Age 65 and Over Plan in favor or TriCare for Life.*

Any retiree electing to opt out of the TWA Retiree Medical Age 65 and Over Plan in favor of TriCare for Life should give careful thought and consideration to his/her decision, as once the retiree and his/her spouse opt out of the TWA Retiree Medical Ag65 and Over Plan, they cannot re-enter at a later date.

To opt out of the Retiree Medical Benefit in favor of TriCare for Life, the age 65 and over retiree and his/her spouse should obtain a Retiree Medical waiver form from Jetnet (or contact HR Employee Services), complete/date/sign it (both the retiree and spouse must sign) and return it to HR Employee Services. HR Employee Services will process your opt-out request, and terminate your Retiree Medical Benefit upon receipt of the properly executed form. If you prefunded for your Retiree Medical Benefit and a balance of your contributions remains in your prefunding account, you will receive a refund of the balance of the value of your prefunding contributions (with associated investment experience).

Keep in mind that Domestic Partners are not eligible to participate in TriCare for Life.

Under "If you Have Other Coverage" (page 49), the following is added to the end of this section:

TriCare Supplement Insurance Option Coordination of Benefits

If your Retiree Medical Benefit is the TriCare Supplement Insurance Option, your TriCare coverage is your primary coverage, and your TriCare Supplement Insurance Option is your secondary coverage. Consult the coordination of benefits information in your TriCare Supplement Insurance summary plan description (this document is available from ASI, the administrator of the TriCare Supplement Insurance Option).

In "Which Plan is Primary" (page 48), a sixth bullet is added at the end of this section, as follows:

If your retiree medical coverage is the TriCare Supplement Insurance Option, TriCare is your primary coverage, and TriCare Supplement Insurance is your secondary coverage. If your Retiree Medical Benefit is the TriCare Supplement Insurance Option, the coordination of benefits is determined by the terms and provisions of this insurance. Consult the summary plan description provided by ASI for further information on coordination of benefits.

In the "Plan Administration" section (page 69), "Plan Information", a third entry is added to the "Plan Name", as follows:

The TWA Retiree Health and Life Benefits Plan

This plan includes:

- *TWA Retiree Medical Plan Under Age 65 and TWA Medicare Supplement Plan*
- *TWA Retiree Life Insurance*
- *TriCare Supplement Insurance Option*

Under "Plan Administration" (page 69-70), a new final sentence is added to the second paragraph, as follows:

The TriCare Supplement Insurance Option is fully insured and underwritten by the Hartford Life and Accident Insurance Company, and administered by the Association and Society Insurance Corporation (ASI). Premiums for this insurance are paid by retiree and Company contributions.

In compliance with federal law, effective January 1, 2008, American Airlines will no longer provide any employer subsidy for employees who elect the TriCare Supplement Option. Premiums for this option must be 100 percent employee-paid.

III. Medicare Part D for Retiree Participants with Medicare

IMPORTANT NEWS FOR MEDICARE ELIGIBLE RETIREES/DEPENDENTS: Effective January 1, 2006, irrespective of whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, for those under age 65 retiree participants/dependents who are Medicare-eligible) ends, and your primary prescription drug coverage will be Medicare Part D. As such, it is very important that you enroll in Medicare Part D coverage immediately—as soon as you become eligible. Your coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as noted above) will become your secondary coverage, and will coordinate benefits with Medicare Part D in the same manner that it coordinates with Medicare Parts A and B (or Medicare+Choice). Keep in mind that if you or your dependent(s) is(are) eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if you do not enroll in all or part of the Medicare program, your benefits under the TWA Retiree Health and Life Benefits Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

In the "TWA Medicare Supplement Plan (Age 65 and Over)" section, the "Prescription Drug—Retail" and "Prescription Drug—Mail Order" entries in the chart are deleted, and a new entry is added as follows:

FEATURE	BENEFITS
Prescription Drug Coverage	80%, coordinating with Medicare Part D as the primary coverage and the TWA Retiree Health and Life Benefits Plan as the secondary coverage

Under the "Key Plan Provisions—TWA Medicare Supplement Plan (Age 65 and Over)" (page 22), the following entries are added at the end of this section:

Medicare Part D Prescription Drug Coverage

This summary provides some general information about Medicare Part D, but does not explain all of the program's benefits and features. If you have specific questions, contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available at www.medicare.gov (see Important Contacts).

Medicare Part D, which becomes effective for enrollees on January 1, 2006, helps pay for both brand name and generic drugs at participating pharmacies in your area. You pay a monthly premium for this coverage, just like you do for Medicare Part B. For 2006, Medicare Part D will have a $250 deductible that you must satisfy before Medicare will pay benefits for your prescription expenses. After this deductible is met, you will still pay a portion of your prescription costs, by paying a copayment or coinsurance. Depending on the Medicare Part D plan you choose, you may a lesser copayment or coinsurance for generic drugs than for brand name drugs. Some Medicare Part D plans may offer mail-order purchase of your medications. www.medicare.gov (see Important Contacts) provides more complete information about Medicare Part D, and you should carefully review this information, along with the information you receive from Medicare Part D prescription drug providers, to choose the plan that best meets your needs.

IMPORTANT NEWS FOR MEDICARE ELIGIBLE RETIREES/DEPENDENTS: Effective January 1, 2006, irrespective of whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, for those under age 65 retiree participants/dependents who are Medicare-eligible) ends, and your primary prescription drug coverage will be Medicare Part D. As such, it is very important that you enroll in Medicare Part D coverage immediately—as soon as you become eligible.

Your coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as noted above) will become your secondary coverage, and will coordinate benefits with Medicare Part D in the same manner that it coordinates with Medicare Parts A and B (or Medicare+Choice). Keep in mind that if you or your dependent(s) is(are) eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if you do not enroll in all or part of the Medicare program, your benefits under the TWA Retiree Health and Life Benefits Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

In the "Prescription Drug Benefits" section, the following paragraphs are added at the end of this section (page 44):

IMPORTANT NEWS FOR MEDICARE ELIGIBLE RETIREES/DEPENDENTS: Effective January 1, 2006, irrespective of whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, for those under age 65 retiree participants/dependents who are Medicare-eligible) ends, and your primary prescription drug coverage will be Medicare Part D. As such, it is very important that you enroll in Medicare Part D coverage immediately—as soon as you become eligible.

Your coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as noted above) will become your secondary coverage, and will coordinate benefits with Medicare Part D in the same manner that it coordinates with Medicare Parts A and B (or Medicare+Choice). Keep in mind that if you or your dependent(s) is(are) eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if you do not enroll in all or part of the Medicare program, your benefits under the TWA Retiree Health and Life Benefits Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

To file a prescription drug claim under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as explained above), you must have already filed with Medicare Part D and received your Medicare Part D Explanation of Benefits (EOB). Submit to UnitedHealthcare

- ***Your prescription receipt from the pharmacy***
- ***Your Medicare Part D EOB***
- ***Your completed prescription claim form for Medicare Part D expenses (available on Jetnet).***

Upon receipt of your complete claim, UnitedHealthcare will process your claim under your retiree medical coverage, coordinating benefits with Medicare Part D. For more information on coordination of benefits, see pages 45-49.

If your selected Retiree Medical Benefit Option is the TriCare Supplement Insurance Option, follow the Medicare Part D claim instructions provided to you by Hartford/ASI.

In the "Medicare Coverage" section ("Medicare Coverage") (page 45), the second and third paragraphs are revised, as follows:

You may choose to be covered under Original Medicare, or under a Medicare+Choice Health Plan. Original Medicare includes Part A (hospital coverage) and Part B (medical coverage). Effective January 1, 2006, Medicare Part D (prescription drug coverage) becomes effective for those who have enrolled in the coverage.

This summary provides some general information about Medicare Parts A and B, Medicare+Choice, and Medicare Part D, but does not explain all of the program's benefits and features. If you have specific questions, contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available at www.medicare.gov (see Contact Information).

In the “Medicare Coverage” section, a new subsection is added immediately after the “Medicare+Choice” subsection (page 46), as follows:

Medicare Part D Prescription Drug Coverage

This summary provides some general information about Medicare Part D, but does not explain all of the program’s benefits and features. If you have specific questions, contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available at www.medicare.gov (see Important Contacts).

Medicare Part D, which becomes effective for enrollees on January 1, 2006, helps pay for both brand name and generic drugs at participating pharmacies in your area. You pay a monthly premium for this coverage, just like you do for Medicare Part B. For 2006, Medicare Part D will have a $250 deductible that you must satisfy before Medicare will pay benefits for your prescription expenses. After this deductible is met, you will still pay a portion of your prescription costs, by paying a copayment or coinsurance. Depending on the Medicare Part D plan you choose, you may a lesser copayment or coinsurance for generic drugs than for brand name drugs. Some Medicare Part D plans may offer mail-order purchase of your medications. www.medicare.gov (see Important Contacts) provides more complete information about Medicare Part D, and you should carefully review this information, along with the information you receive from Medicare Part D prescription drug providers, to choose the plan that best meets your needs.

IMPORTANT NEWS FOR MEDICARE ELIGIBLE RETIREES/DEPENDENTS: Effective January 1, 2006, irrespective of whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, for those under age 65 retiree participants/dependents who are Medicare-eligible) ends, and your primary prescription drug coverage will be Medicare Part D. As such, it is very important that you enroll in Medicare Part D coverage immediately—as soon as you become eligible.

Your coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as noted above) will become your secondary coverage, and will coordinate benefits with Medicare Part D in the same manner that it coordinates with Medicare Parts A and B (or Medicare+Choice). Keep in mind that if you or your dependent(s) is(are) eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if you do not enroll in all or part of the Medicare program, your benefits under the TWA Retiree Health and Life Benefits Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

In “If You Have Other Coverage”, “Other Plans” (page 47), the second bullet is revised as follows:

- *Government or tax-supported programs, including Medicare (Parts A and B, Medicare+Choice, and Medicare Part D) and Medicaid*

Under “Which Plan Is Primary” (page 88), the first bullet under “The following general rules determine which plan is primary:” is revised as follows:

If you are covered by Medicare (any and all parts of Medicare, including Parts A, B, Medicare+Choice, and/or 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.

In “Which Plan Is Primary”, the final paragraph is revised as follows:

If you or your spouse is eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if 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 receiving Medicare benefits.

In the “Retiree Point of Service Option”, “Prescription Drug Benefits” (pages 82-85), the following paragraphs are added to the end of this section, as follows:

In the “If You Have Other Coverage” section, “When Medicare is Primary”, (page 48), the paragraph is revised as follows:

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/her employer. The TWA Retiree Health and Life Benefits Plan coordinates benefits with Original Medicare (Parts A, B, and D) if you are eligible for such coverage. Coordination applies regardless of whether you select Original Medicare or Medicare+Choice.

In “Filing Medical Claims” (page 52), the “**IMPORTANT:** Because Original Medicare does not cover prescription drug expenses, you must file these claims yourself.” Statement is deleted.

IV. Addition of American Airlines, Inc. Retiree Dental Insurance Plan Summary Plan Description

Since many TWA Retiree Health and Life Benefits Plan participants are also participants in the American Airlines, Inc. Retiree Dental Insurance Plan, the following summary plan description is added to the TWARBG, immediately after the “Continuation of Coverage” section (page 55), as follows:

Retiree Dental Insurance Plan

The Retiree Dental Insurance Plan was offered to TWA Retiree Health and Life Benefits Plan participants and their eligible dependents in November, 2001—this was a one-time offer of enrollment, and if you did not enroll in this plan during the “one time only” enrollment period, you do not participate this coverage. If you, at any time since the January 1, 2002 effective date of the Retiree Dental Insurance Plan, allowed the coverage to terminate for any reason (including failure to timely pay the required ongoing monthly premium to maintain this coverage), you are not eligible reenter/reenroll in the plan.

The Retiree Dental Insurance Plan provides dental coverage for you and your eligible dependents. This dental coverage pays benefits for routine dental care and treatments for disease, defect, and injury.

You have the option to select any dentist. The Plan provides both in-network and out-of-network benefits. However, you can increase your out-of-pocket savings when you choose to visit an in-network participating Preferred Dentist Program (PDP) dentist. The MetLife PDP provides dental coverage at affordable group rates. As a member of this Plan, you will have access to over 47,000 highly qualified participating dentists who agree to accept negotiated fees.

Retiree Dental Insurance Benefits

Under the Retiree Dental Insurance Plan, services for most preventive and routine care are covered at 100%. Services such as fillings, simple extractions, labs and other tests are covered at 60%, while major restorative services are covered at 35%, once a $50 individual or $100 family annual deductible has been met.

Benefits Summary		
Type of Service	**In-Network[1]**	**Out-of-Network[2]**
Type A – Preventive	100% when performed by a PDP	100% Reasonable and Customary Fees
Type B – Basic Restorative	60% when performed by a PDP	60% Reasonable and Customary Fees
Type C – Major Restorative	35% when performed by a PDP	35% Reasonable and Customary Fees
Annual Deductible[3] (applies to Type B and C Services)		
	In-Network	**Out-of-Network**
Individual	$50	$50
Family	$100	$100
Annual Maximum Benefit[3]		
	In-Network	**Out-of-Network**
Per Person	$1,000	$1,000

How the Retiree Dental Insurance Plan Works

You can take advantage of savings under this Plan for services that are not covered by the Retiree Dental Insurance Plan. When you participate in the Preferred Dentist Program (PDP) and visit a network dentist, savings are passed on to you and your family through discounted fees on certain services that are not covered under the Plan. Your cost for these non-covered services will be less due to the reduced fees the participating dentist has agreed to charge.

Take a look at a hypothetical example that shows how visiting a PDP dentist can save you money. This example assumes you have met your annual deductible.

Example of Savings When You Visit a Participating PDP Dentist			
Type B Service: (Filling)		**Amount**	
PDP Fee Schedule Amount:		$65	
Dentist's Usual Charge:		$80	
Reasonable and Customary Allowable Amount:		$75	
When you visit a participating dentist (In-Network)		**When you visit a non-participating dentist (Out-of-Network)**	
PDP Fee Schedule Amount:	$65	**Dentist's Usual & Prevailing Fee:**	$80
Amount the plan pays (60% of the $65 PDP Fee Schedule):	-$39	**Amount the Plan pays (60% of the $75 Reasonable and Customary Amount):**	-$45
Your Out-of-Network Cost:	**$26**	**Your Out-of-Pocket Cost:**	**$35**

"In-Network Benefits": When you or your eligible dependent visits a participating Preferred Dentist Program (PDP) dentist, plan benefits are based on a negotiated fee schedule. You are responsible for the difference between the negotiated PDP fee for a given service and the percentage of the PDP fee that your Plan covers for that service, subject to your deductible.

[2] "Out-of-Network Benefits": When you or your eligible dependents visit a non-participating dentist, plan benefits are based on the Reasonable and Customary (R & C) charges of dentists in your area, as determined by MetLife for your plan. You are responsible for the difference

between your dentist's charge for a given service and the percentage of Reasonable and Customary fee that your Plan covers, subject to your deductible. See *Glossary* for more information on Reasonable and Customary fees.

[3] The annual deductible applies to both in-network and out-of-network benefits. You do not have to satisfy a separate deductible for each. In addition, the annual maximum applies to in-network and out-of-network coverage. There is not a separate maximum for each. In order to meet a family deductible, two members of the family have to completely satisfy the individual deductible.

In this example, you would save $9 ($35 minus $26) — or 26% — by using a participating PDP dentist.

Terms You Should Know

The following is information you need to know about Retiree Dental coverage and circumstances that determine how benefits are paid:

Dentally necessary: Only dental services that are dentally necessary are covered by the Retiree Dental Insurance Plan. Cosmetic services are not covered. See the *Glossary* on page **Error! Bookmark not defined.** for the definition of "dentally necessary."

Predetermination of benefits: If your dentist estimates that charges for a procedure will be substantial, you should request predetermination of benefits before you receive treatment. However, it is recommended that you obtain predetermination for any proposed procedure. To request predetermination from MetLife, your dentist may complete the standard Dental Claim Form, indicating that it is for predetermination of benefits.

Alternative treatment: If you undergo a more expensive treatment or procedure when a less expensive alternative is available, the Retiree Dental Insurance Plan pays benefits based on the less expensive procedure that is consistent with generally accepted standards of appropriate dental care.

When expenses are incurred: For purposes of determining Retiree Dental Insurance Plan coverage and benefits, the dental expense is deemed to be incurred at the time of the initial treatment or preparation of the tooth.

The Preferred Dentist Program (PDP): The Retiree Dental Insurance Plan offers a network of over 70,000 participating dentists nationwide (general dentists and specialists) who provide fee discounts to Retiree Dental Insurance Plan participants. You are not required to use PDP network dentists, but will benefit from cost savings when you do. You can request a customized directory of participating dentists in your area by calling MetLife (see *Contact Information* on page **Error! Bookmark not defined.**).

Injury by others: If you are injured by someone else and the Retiree Dental Insurance Plan pays a benefit, the insurance company has the right to recover payment from the third party (see *Subrogation,* page **Error! Bookmark not defined.**).

Coordination of benefits: If you or a covered dependent has coverage under any other group dental plan, the Retiree Dental Insurance Plan coordinates benefits with the other plan. (See *Coordination of Benefits* in this Retiree Dental Insurance Plan section.)

Covered Expenses

To be covered by the Retiree Dental Insurance Plan, a dental expense must be dentally necessary and provided by a duly qualified and licensed dentist or physician (unless specifically excluded). Charges for covered items must be within the reasonable and customary fee limits. The following dental services and supplies are covered by the Retiree Dental Insurance Plan:

What's Covered	How Often/Limitations
Type A – Preventive	
Cleanings	One cleaning per six-month period, not to exceed two cleanings per calendar year

What's Covered	How Often/Limitations
Exams	One exam per six-month period, not to exceed two exams per calendar year
Endodontics	Root canal treatment limited to once per tooth per 24 months
Fluoride Treatments	One fluoride treatment per calendar year for covered dependent children under age 19
General Anesthesia	When dentally necessary in connection with oral surgery, extractions, or other covered dental services
Oral Surgery	When dentally necessary: No limitations
Periodontics	Periodontal scaling and root planing once per quadrant, every 24 months Periodontal surgery once per quadrant, every 36 months
Periodontic Maintenance	Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a calendar year.
Space Maintainers	Space maintainers for dependent children under age 19
Surgical Extractions	When dentally necessary: No limitations
X-rays	Full mouth x-rays: one per 60 months Bitewing x-rays: one set per calendar year for covered adults; one set per six-month period for covered children — not to exceed two sets of x-rays per calendar year
Type B – Basic Restorative	
Fillings	When dentally necessary: No limitations
Simple Extractions	When dentally necessary: No limitations
Crown, Denture and Bridge Repair	When dentally necessary: No limitations
Relines and Rebases	Relines and rebases to dentures, limited to 36 months (covered only after six months following the initial installation)
Labs and Other Tests	When dentally necessary: No limitations
Type C – Major Restorative	
Crowns/Inlays/Onlays	Crowns/Inlays/Onlays replacement: once every five years
Bridges and Dentures	Initial placement to replace one or more natural teeth that are lost while covered by the Retiree Dental Insurance Plan Dentures and bridgework replacement: one every five years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed

Dentures and bridgework: Full and partial dentures and fixed bridgework, including:

- Installation of the initial appliance to replace natural teeth extracted, including adjustments within six months of installation
- Replacement if the appliance is more than five years old and cannot be repaired (Appliances that are over five years old but can be made serviceable will be repaired, not replaced)
- Installation of the appliance for teeth missing as a result of a congenital anomaly. (Charges are limited to the allowance for a standard prosthetic device.)

The total allowance for both a temporary and permanent denture or bridge is limited to the maximum benefit for a permanent denture or bridge. Charges are determined from the date the first impression is taken.

Extractions, necessary surgery, and related anesthetics: These services are considered covered dental treatments. However, fractures and dislocations of the jaw is included under the Retiree Medical Benefit Options.

Fillings and crowns: Silver (amalgam) or porcelain fillings and plastic restorations subject to the following:

- Porcelain crowns are covered only for the 10 front upper and 10 front lower teeth
- Porcelain or plastic facings on crowns posterior to the second bicuspid are not covered
- Gold fillings and crowns are covered only when the tooth cannot be restored with other materials
- Crowns may only be replaced if the existing crown is more than five years old, regardless of the reason for the replacement.

Oral examinations, x-rays, and laboratory tests: The following are covered if necessary to determine dental treatment:

- Full mouth x-ray once in any 60-month period
- Routine x-rays not more than once per six-month period, not to exceed two sets of x-rays per calendar year
- Other x-rays necessary to propose diagnosis or examine progress of treatment.

Periodontal treatment: Necessary periodontal treatment of the gums and supporting structures of the teeth and related anesthetics are covered.

Preventive treatment:

- Exams – once per six-month period, not to exceed two exams per calendar year
- Routine x-rays – once per six-month period, not to exceed two sets of x-rays per calendar year
- Teeth cleaning – once per six-month period, not to exceed two cleanings per calendar year
- Fluoride treatments once a year for children under age 19 (not covered on or after the child's 19th birthday)
- Space maintainers for dependent children under age 19.

Root canals: Root canals and other endodontic treatments are covered. The charge for root canal therapy is considered to have been incurred on the date the tooth is opened.

Benefit Limitations

The fact that a dentist recommends a dental service does not mean that benefits will be paid under the Retiree Dental Insurance Plan. Retiree Dental Insurance Plan benefits will be based on the most cost-effective materials and methods of treatment that meet generally accepted dental care standards. MetLife's dental consultants may review dental services to determine whether the dental service is necessary in terms of generally accepted dental care standards for the purpose of determining the extent to which dental expense benefits are payable under the Retiree Dental Insurance Plan.

Excluded Expenses

The following expenses are not eligible for reimbursement under the Retiree Dental Insurance Plan:

- Diagnosis, evaluation, or treatment of Temporomandibular Joint Disorders ("TMJD")
- Services, treatments, and supplies received before Retiree Dental Insurance Plan coverage began
- Services and treatments not performed by a licensed dentist, except for cleaning and scaling of teeth and fluoride treatments performed by a licensed dental hygienist that is supervised and billed by a licensed dentist
- Cosmetic services, surgery, treatment, or supplies
- Treatments, services, and supplies covered by any Workers' Compensation laws, occupational disease laws, or employer liability laws, or which an employer is required by law to furnish in whole or in part

- Services, treatment, and supplies received through a medical department or similar facility maintained by your employer
- Home health aids used to prevent decay, such as toothpaste and fluoride gels
- Appliances or treatment for bruxism (grinding teeth), including but not limited to, occlusal guards and night guards
- Duplicate appliances or duplicate prosthetic devices
- Services, treatment, and supplies received where no charge would have been made in the absence of dental expense benefits, or which are not required to be paid
- Materials or services that are experimental under generally accepted dental standards
- Services, treatments, or supplies received as a result of dental disease, defect, or injury due to an act of war, or a warlike act in time of peace, which occurs while this coverage is in effect
- Instruction for oral care, such as hygiene or diet
- Periodontal splinting
- Benefits otherwise provided under your employer's plan, or any other plan that your employer or affiliate contributes to or sponsors
- Implants
- Charges for broken appointments, or for completing dental forms
- Sterilization supplies
- Services, treatment, and supplies furnished by a family member
- For Type C Expenses:
    - Replacement of a lost, stolen, or missing crown, bridge, or denture
    - Initial installation of a denture or bridgework to replace one or more natural teeth lost before this dental coverage started
    - Replacement of an existing crown, removable denture, or fixed bridgework, unless it is needed because the existing crown, removable denture, or fixed bridgework can no longer be used and was installed at least five years prior to its replacement
    - Replacement of existing immediate temporary full denture by a new permanent full denture unless

the existing denture cannot be made permanent, AND

the permanent denture is installed within 12 months after the existing denture was installed

- Orthodontia
- Sealants
- Myofunctional therapy or correction of harmful habits
- Fluoride treatments for dependent children over age 19.

Filing Claims

MetLife is both the insurer and claims processor for the Retiree Dental Insurance Plan. Do not file claims with Ceridian — Ceridian's only function, with respect to the Retiree Dental Insurance Plan, is to perform the direct billing services for payment of premiums.

Completing the Dental Claim Form

The following is a summary of how to file claims for dental expense benefits:

- Complete the top portion of the Dental Expense Claim Form available on *Jetnet*. Follow the instructions that accompany the form and then present the form to your dentist, who completes the remaining portion.

- Mail the completed claim form to MetLife at the address on the form.
- All dental claims payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid. Payments may, however, be sent directly to your dentist or other dental provider if your provider accepts *Assignment of Benefits* (see page **Error! Bookmark not defined.**). If you assign benefits to the service provider, the EOB will be mailed to you and the payment mailed to your provider.

Claim Filing Deadline

You must submit all dental claims within two years of the date the expenses were incurred. Claims submitted more than 24 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 under the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Cancellation/Termination of Retiree Dental Insurance Plan Benefits

Coverage under the Retiree Dental Insurance Plan is provided under a group insurance policy (Policy Form G2130-S) issued by MetLife. Coverage terminates when your dental contributions cease or upon termination of the Group Contract by the Policyholder upon prior written notice to MetLife. The group policy may be discontinued by MetLife for non-payment of premium or if eligibility requirements are not met. There is a 31-day limit for the following services that are in progress:

- Completion of a prosthetic device, and
- Crown or root canal therapy after individual termination of coverage.

Coordination of Benefits for the Retiree Dental Insurance Plan

When You Have Other Coverage

Your Retiree Dental Insurance Plan includes a coordination of benefits (COB) provision that determines which plan is primary and how benefits will be paid when you or your dependent(s) are covered by more than one plan.

"Plan" means a plan that provides benefits or service for dental and is either a:

- Group insurance plan
- Group blanket plan but not including a school accident type of plan
- Group practice plan
- Group service plan
- Group prepayment plan
- Governmental program required by law, excluding Medicaid but including any No-Fault coverage required by law, OR
- Any other plan that covers people as a group.

Each policy or contract will be treated as a separate contract.

Which Plan Is Primary

When more than one plan covers a person, one plan is primary and another is considered secondary. The two plans will coordinate benefits with each other so the amount reimbursed is not more than 100% of the actual expenses. The order of benefit determination will be based on the following:

- Any plan that does not include a coordination of benefits provision is automatically considered as the primary plan

- As a Retiree, this Plan will determine your benefits first, unless benefits are payable under Medicare
- Any dependent who is still employed will have his or her plan considered as primary
- Any dependent child who is covered under more than one plan by his or her parents will have his or her primary plan determined by the parent whose birthday is earlier in the year. These parents must be married, or if not married, a court decree awards joint custody, without specifying that one party is not responsible for providing health care coverage

  Example: If one parent's birthday is January 8, and the other parent's birthday is March 3, then the plan covering the parent with the January 8 birthday will be considered primary
- If both parents have the same birthday (regardless of the year of birth), the plan that has covered the parent for the longer period of time will be considered primary
- If terms of a court decree specify one parent is responsible for health care and the plan is aware of those terms, that plan will be primary
- If none of the above rules determine the order of benefits, the plan that has covered the person for the longer period of time will be considered primary

When your Retiree Dental Insurance Plan is primary, it means that this Plan's benefits are determined first, and any other plan is considered secondary.

Additional Rules

The following sections apply to the Retiree Dental Insurance Plan.

- Eligibility under Qualified Medical Child Support Order See page 8
- Coordination with Medicare See page 45
- Continuation of Coverage See page 53**Error! Reference source not found.**

V. Restatement of the Employee Benefits Management Structure

In the "Plan Amendments" section (page 145), the first paragraph is revised as follows:

> *The Benefits Strategy Committee ("BSC"), as appointed by the Chief Executive Officer, has the sole authority to adopt new employee benefit plans ("Plans") and terminate existing Plans. The Pension Benefits Administration Committee ("PBAC"), as appointed by the Chief Executive Officer, has the sole authority to interpret, construe, and determine claims under the Plans. The PBAC also has the authority to amend the Plans or make recommendations to the BSC for material amendments to the Plans.*

END OF SUMMARY OF MATERIAL MODIFICATIONS

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the following employee benefit plans:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (referred to as the "Plan", the "Eagle Plan", and the "Retiree Medical Benefit")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries
- TWA Retiree Health and Life Benefits Plan

These plans provide coverage for reconstructive surgery, as follows:

- 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 treatment of lymphademas; and
- Prostheses

This information is also available in your Retiree Benefits Guide—in the hard copy, the CD-ROM version (if applicable to your retiree group) sent to you in July-August, 2005, and on *Jetnet*.

SMM for 2006, TWU EBG, 12012005

HEALTH AND LIFE BENEFITS GUIDE
FOR RETIREES OF TWA

INTRODUCTION

Protection against the expenses that so often accompany sickness or the death of a loved one is important to all of us.

On the following pages, you will find a description of the TWA Retiree Health and Life Benefits Plan, which provides retiree medical and life insurance benefits to those employees who retired from Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express and elect coverage under the TWA Retiree Health and Life Benefits Plan. The TWA Retiree Health and Life Benefits Plan includes the TWA Retiree Medical Plan and the TWA Retiree Life Insurance Plan.

The TWA Retiree Medical Plan is self-funded by American Airlines, Inc. Claims are processed by UnitedHealthcare, but reimbursements for covered health care expenses are paid from the general assets of the Company. Life insurance benefits are insured and administered by MetLife. Please consult the Important Contacts listing for important telephone numbers and addresses.

We believe these retiree benefits represent valuable protection for you and your covered eligible dependents.

Change or Discontinuance of Plan

Except as noted below in the section entitled "Special Note to Retirees," the Company expects to continue the TWA Retiree Health and Life Benefits Plan, but it necessarily reserves the right to amend the plan, in whole or in part, at any time or from time to time, and to suspend or terminate the plan, in whole or in part, at any time, by action of the Board of Directors.

The Company reserves the right to alter, amend, modify, or terminate the TWA Retiree Health and Life Benefits Plan, any program described in this benefits guide, or any part thereof at its discretion. Changes will not affect claims for services or supplies received before the change.

All benefit plans offered to employees or retirees of any AMR affiliated company are under the jurisdiction of the Pension Benefits Administration Committee (PBAC) of American Airlines, Inc. Only the American Airlines, Inc. PBAC is authorized to change this plan. From time to time, you may receive updated information concerning plan changes. Neither this guide nor updated materials are contracts or assurances of compensation, employment, or benefits of any kind.

The PBAC, under the authority granted to it by TWA Airlines LLC and American Airlines, Inc., has the sole authority to adopt and/or amend benefit plans. The PBAC, in consultations 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 employee benefit plans according to their terms, applicable law and regulation, or to further the objectives of the employee welfare plans. The PBAC may act by a majority of its members present during a meeting at which 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.

Special Note to Retirees

In connection with the bankruptcy proceedings of Trans World Airlines, Inc., American Airlines, Inc. and TWA Airlines LLC agreed with the Official Retirees' Committee to continue your health, dental and life benefits unchanged through December 31, 2001. You previously received a Summary Plan Description (SPD) describing these benefits. Effective January 1, 2002, these benefits will change. This benefits guide describes the retiree health and life coverage that will become effective January 1, 2002. As discussed above in Change or Discontinuance of Plan, all benefit plans are reviewed annually by American Airlines, Inc., and coverage as well as premium amounts may be adjusted. For a description of the TWA retiree dental plan, please refer to the SPD provided by the insurer, MetLife.

Important Terms

Throughout this guide, important terms are italicized and are defined in the Glossary of Terms. Intermittently, the terms provide direct links to the glossary.

About This Guide

This TWA Health and Life Benefits Guide ("guide") is the Summary Plan Description (SPD) for the TWA Retiree Health and Life Benefits Plan ("the plan") as it pertains to TWA retiree medical and life insurance coverage. The provisions of this guide apply to eligible retirees and eligible dependents, including spouses, who are covered under the TWA Retiree Medical and Life Insurance Plans.

The Company reserves the right to alter, amend, modify, or terminate this plan, any program described in this guide, or any part thereof at its discretion. Changes will not affect claims for services or supplies received before the change. Only the Pension Benefits Administration Committee (PBAC) is authorized to change this plan. From time to time, you may receive updated information concerning plan changes. Neither this guide nor updated materials are contracts or assurances of compensation or benefits of any kind. In the event of a conflict between the provisions of this guide and the provisions contained in any insurance policies for fully-insured programs, the policy shall govern in all cases with respect to TWA retirees covered by such policy.

ELIGIBILITY AND ENROLLMENT

TWA Retiree Medical Plan Eligibility

Eligibility for particular benefits for you and your eligible dependents under the TWA Retiree Medical Plan varies depending on your age and the age of your eligible dependents, including your spouse.

For You - Under Age 65

If you are under age 65, you are eligible to participate in the TWA Retiree Medical Plan Under Age 65 as long as you:

- retired from Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express; and
- you were covered by the TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001.

IMPORTANT: For more information about your coverage if your spouse is an active employee or retiree of American Airlines, Inc. or an AMR Corporation subsidiary other than TWA Airlines LLC, review the Retirees Married to Employees or Retirees

For Your Spouse - Under Age 65

If your spouse is under age 65 and is otherwise an eligible dependent, your spouse is eligible to participate in the TWA Retiree Medical Plan Under Age 65 as long as your spouse:

- was covered by a group medical plan sponsored by either Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express on the day prior to the date of the retiree's retirement; and
- was covered by the TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001.

For Your Eligible Dependents, Other than Your Spouse

Your eligible dependents, other than your spouse, are eligible to participate in the TWA Retiree Medical Plan Under Age 65 as long as either you or your spouse are enrolled in the TWA Retiree Medical Plan Under Age 65 and eligible dependents:

- otherwise meet the definition of eligible dependent.
- were covered by a group medical plan sponsored by either Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express on the day prior to the date of the retiree's retirement; and
- were covered by the TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001.

For You - Age 65 and Over

If you reached age 65 before January 1, 2002, or later reach age 65, you are eligible to participate in the TWA Medicare Supplement Plan as long as you:

- retired from Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express;

- were covered by the TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001;
- if you reached age 65 on or after January 1, 2002, were covered by the TWA Retiree Medical Plan Under Age 65 immediately prior to reaching age 65; and
- timely elect to participate in the TWA Medicare Supplement Plan.

IMPORTANT: For more information about your coverage if your spouse is an active employee or a retiree of American Airlines, Inc. or an AMR Corporation subsidiary other than TWA Airlines LLC, turn to Retirees Married to Employees or Retirees

For Your Spouse - Age 65 and Over

If your spouse reached age 65 before January 1, 2002, or later reaches age 65, your spouse is eligible to participate in the TWA Medicare Supplement Plan as long as your spouse:

- was covered by a group medical plan sponsored by either Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express on the day prior to the date the retiree retired;
- was covered by the TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001;
- if your spouse reaches age 65 on or after January 1, 2002, was covered by the TWA Retiree Medical Plan Under Age 65 immediately prior to reaching age 65; and
- timely elects to participate in the TWA Medicare Supplement Plan.

Electing Coverage

Regardless of your age or the age or your eligible dependents, if you waive your coverage under the TWA Retiree Medical Plan for 2002, or at any other time, you will not be given another opportunity to enroll.

Contributions Toward Coverage

Effective January 1, 2003, you are required to contribute toward the cost of the TWA Retiree Medical Plan Under Age 65. The contribution amount is based on a per person per month amount for you and your eligible dependents, including your spouse. Contributions may be adjusted periodically, as medical costs increase.

You are required to contribute toward the cost of the TWA Medicare Supplement Plan (Over Age 65 Plan The contribution amount is based on a per person per month amount for you and your spouse. Contributions may be adjusted periodically, as medical costs increase.

Whether you are enrolled in the TWA Retiree Medical Under Age 65 Plan, the TWA Retiree Medical Age 65 and Over Plan, the TriCare Supplement Insurance, or the American Airlines, Inc. Retiree Dental Insurance Plan, you are required to timely pay the required ongoing monthly contributions in order to maintain your coverage. If you fail to make timely payment of the required contributions (including but not limited to, failure to pay; failure to timely pay; failure to pay by reason of insufficient funds in your bank account from which you pay your contributions by automatic bank draft, electronic payment, etc.,; failure to pay by reason of dishonored (“bounced”) check), your coverage may be terminated without the possibility of reinstatement.

“Pay”, “Paid”, “Payment”, “Timely pay”, “Timely paid”, “Timely payment” means payment of the entire amount of the required monthly contribution due—postmarked (or electronically receipt-registered, if payment is made via bank draft or electronically) on or before the payment due date (reflected on the payment invoice or coupon), or before the end of the 30-day grace period allowed for payment. These terms also mean that payment must be in a form of a financial instrument with valid and transferable monetary value. Payments rejected due to insufficient funds are not timely paid.

Eligible Dependents

An "eligible dependent" is an individual (other than the retiree covered under this plan) who is related to the retiree in one of the following ways:

- **Spouse**, provided he or she is not covered as an employee or retiree under a medical plan sponsored by American Airlines or a participating AMR Corporation subsidiary (See "For Your Spouse -- Under Age 65" and "For Your Eligible Dependents Other than Your Spouse" in this section);

- **Unmarried Child** under age 19 (See the definition of child in this section.);
- **Unmarried Incapacitated Child** age 19 or over (See the definition of incapacitated child in this section.); or
- **Unmarried Child age 19 through 22**, if the child is registered as a full-time student at a school in a program of study leading to a degree or certification (proof of continuing eligibility will be required from time to time) and the child maintains his or her legal residence with you and is wholly dependent on you for maintenance and support.

IMPORTANT: If you elect to drop coverage for an eligible dependent, you may not later reinstate this coverage.

Child

For the purpose of determining eligibility, the term "child" includes your:

- Natural child;
- Legally adopted child; or
- Stepchild or Special Dependent if the child lives with you and you claim the child as a dependent on your federal income tax return. A "special dependent" is a foster child or child for whom you are the legal guardian.

An eligible dependent may not be an eligible dependent of more than one retiree (see the Coordination of Benefits section.

Incapacitated Child

For the purposes of determining eligibility, an "incapacitated child" is a child who is age 19 or over if:

- he or she is mentally or physically incapable of self-support before reaching age 19 (or age 23 if registered as a full-time student before reaching age 23);
- you file an application with UnitedHealthcare to continue the child's coverage within 31 days after the date coverage would otherwise end (UnitedHealthcare must approve the application in order for coverage to be continued under the TWA Retiree Medical Plan. Call Employee Services at 1-800-447-2000 to request an application.);
- Except for the maximum age limitation, the child continues to meet the criteria for dependent coverage under this plan; and
- You provide additional medical proof of incapacity as may be required by UnitedHealthcare from time to time. Coverage will be terminated and cannot be reinstated if you do not provide proof of incapacity or UnitedHealthcare determines your child is no longer incapacitated, and the child does not maintain legal residence with you or is not wholly dependent on you for maintenance and support.

Qualified Medical Child Support Order (QMCSO)

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

Parents and Grandchildren

Neither your parents nor grandchildren are eligible dependents, regardless of whether they live with you or receive maintenance or support from you. If you are your grandchildren's legal guardian, refer to the definition of child above for more information.

When Children's Eligibility Ends

Each eligible dependent, except for your spouse, is eligible for coverage while either you or your spouse are participating in the TWA Retiree Health Plan Under Age 65. Once you and your spouse both reach age 65, coverage for your eligible dependents, excluding your spouse, will end. In addition, your child or incapacitated child will no longer be eligible for coverage upon the death or ineligibility of both you and your spouse. When coverage for your child or incapacitated child ends, they may be able to elect Continuation of Coverage.

Retirees Married To Employees or Retirees

Retirees married to active employees: If you are married to an active employee of American Airlines or a participating subsidiary of AMR Corporation, you may be covered as your spouse's dependent and begin using your retiree coverage at a later time. In order to suspend your TWA retiree medical benefits, you must complete the Authorization to Suspend

TWA Retiree Medical Coverage form and send it to CONEXIS at the address on the form or in the Important Contacts section of this guide. This form is available on the Retiree Web site. To re-activate the retiree health coverage, you must contact AA Employee Services at 1-800-447-2000 within 60 days of the date your coverage under the active AA benefit ceases. You must have been continuously covered under an AMR plan to reactivate the TWA retiree health plan. As your spouse's dependent, the amount of medical maximum that you consume will reduce the amount of medical maximum benefit remaining in this plan.

Once Retiree Dental Plan coverage is dropped, it cannot be reinstated at a later date.

If you lose your dependent status (because you divorce or the active employee dies), or when the active employee retires or terminates employment, you may begin TWA retiree health coverage described under this plan, provided you are otherwise eligible (you must have been continuously covered under an AMR benefit). You must contact Employee Services at 1-800-447-2000 within 60 days of the loss of coverage to reactivate your TWA Retiree Health Plan. When both you and your spouse are retired, your coverage is maintained on an individual basis - that is, you file your claims separately.

Once Retiree Dental Plan coverage is dropped, it cannot be reinstated at a later date.

Retirees married to retirees of participating AMR Corporation subsidiaries: If you and your spouse are each eligible for medical coverage as retirees, you MUST return to the TWA Retiree Health Plan. You must contact Employee Services at 1-800-447-2000 within 60 days of your spouse's retirement date. CONEXIS will then bill you the monthly premium.

Eligible dependent children: If both spouses are concurrently covered by the TWA Retiree Medical Plan, children who are eligible dependents are covered as dependents of the parent whose birthday occurs first in the calendar year, unless the parents elect otherwise. Contact Employee Services at 1-800-447-2000 to make this adjustment. If one spouse is covered as an active employee under the Flexible Benefits Plan, the Benefits Plan for Pilots and Flight Engineers, or the Benefits Plan for Flight Attendants, the children are covered under the parent who is an active employee. Children cannot be covered under both parents' health plans.

Eligibility During Disability

If you become disabled after you have begun using your TWA Retiree Medical Plan coverage, your eligibility is not affected by your disability.

Eligibility After Age 65

When you reach age 65, Medicare becomes your primary coverage. If you are otherwise eligible, you will have a one-time opportunity to elect to purchase the TWA Medicare Supplement Plan. The TWA Medicare Supplement Plan is secondary to Medicare. When your spouse reaches age 65, Medicare becomes your spouse's primary coverage. If your spouse is otherwise eligible, he or she will also have a one-time opportunity to enroll and purchase the TWA Medicare Supplement Plan. However, coverage for your other eligible dependents ends when both you and your spouse reach age 65. For more information about eligibility and your contributions toward coverage after age 65, see "For You – Age 65 and Over" in this section.

Dependents of Deceased Retirees

Coverage for Your Spouse

After your death, coverage for your spouse depends on your spouse's age at the time of your death.

- **If your spouse is under age 65 at the time of your death:** Coverage for your spouse continues until your spouse reaches age 65, remarries or, if applicable, no longer makes the required contribution for coverage, whichever occurs first. When your spouse reaches age 65, your spouse will have a one-time opportunity to enroll in the TWA Medicare Supplement Plan if he or she is otherwise eligible for the TWA Medicare Supplement Plan.
- **If your spouse is age 65 or over at the time of your death and your spouse is covered under the TWA Medicare Supplement Plan:** Coverage for your spouse continues as long as he or she continues to make the required contributions or remarries, whichever occurs first.

When your spouse's coverage ends, he or she may be eligible to elect COBRA Continuation Coverage.

Coverage for Your Children

After your death, coverage for your eligible dependents, other than your spouse, ends upon the death of your spouse if he or she is participating in the TWA Retiree Medical Plan, your spouse reaches age 65, your spouse remarries, your child becomes eligible for Medicare, your child ceases to qualify as an eligible dependent, or, if applicable, no longer makes the required contribution, whichever occurs first. Your child may be eligible to elect COBRA Continuation Coverage.

When Coverage Begins

If you are eligible for coverage under the TWA Medical Plan Under Age 65, your coverage, as described in this guide, will become effective January 1, 2002.

If you reached age 65 before January 1, 2002 and you are otherwise eligible for coverage under the TWA Medicare Supplement Plan, your coverage, as described in this guide, will become effective January 1, 2002, provided you make a timely election and pay the required contributions. If you reach age 65 on or after January 1, 2002 and you are otherwise eligible for coverage under the TWA Medicare Supplement Plan, your coverage, as described in this guide, will become effective on your 65th birthday.

When Eligible Dependent Coverage Becomes Effective

Coverage for your spouse will become effective on the day your coverage becomes effective and will be dependent on your spouse's age. Coverage for your eligible dependents, other than your spouse, will become effective on the day your coverage becomes effective as long as they are eligible for coverage under the TWA Retiree Medical Plan Under Age 65.

When Coverage Ends

Coverage will end at the earliest of the following situations:

- Coverage for you or your eligible dependents ends when he or she exhausts his or her individual medical maximum benefit.
- Coverage for your eligible dependents, other than your spouse, ends when both you and your spouse die. However, your surviving spouse may keep TWA Retiree Medical Plan coverage for a period of time after your death, as explained above.
- Coverage for your eligible dependents, other than your spouse, ends when you and your spouse reach age 65.
- Coverage for your eligible dependent ends if he or she no longer meets the eligibility requirements.

For more information refer to COBRA Continuation Coverage in this guide.

Retiree Dental Plan Eligibility

To be eligible for Retiree Dental, you must be eligible for the Retiree Medical Plan, even if you are not enrolled in Retiree Medical Plan coverage. You must have retired from the U. S. payroll and have a U. S. residence. Eligibility for the Retiree Dental Plan does not require you to have dental coverage as an active employee; it does require you to elect Retiree Dental Plan coverage from the time you are first eligible (your date of retirement). Once you join the Retiree Dental Plan, you must continue to pay the premiums in order to continue your eligibility. Once you discontinue premium payments, you cannot join the plan again at a later date.

At retirement, you may elect to pay for the active employee dental plan coverage for 18 months through Cobra. At the end of the 18-month period, you may then join the Retiree Dental Plan. However, if the 18-month Cobra continuation period ends before you are eligible for Retiree Medical and Dental, you will not be allowed to join the Retiree Dental Plan when you become eligible for Retiree Medical.

If you are the spouse of an active AMR employee who is enrolled in the active employee dental plan with family coverage, you may waive Retiree Dental Plan coverage, until such time as you are no longer covered under the active plan. You then have 60 days to contact Ceridian to begin the Retiree Dental Plan Coverage.

TWA Retiree Life Insurance Eligibility

You are eligible for TWA retiree life insurance if you retired from Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), or Ozark Air Lines, Inc. if you were eligible for retiree basic life insurance and were covered under the TWA Airlines LLC Universal Welfare Benefit Plan on

December 31, 2001. Your coverage, which is currently fully paid for by the Company, became effective January 1, 2002. However, your eligible dependents will not be covered for retiree life insurance.

IMPORTANT: Only Company paid life insurance, as described in the Retiree Life Insurance section of this guide, will be extended to eligible retirees.

TWA RETIREE MEDICAL PLAN

The TWA Retiree Medical Plan includes two components:

- Coverage for eligible retirees and eligible dependents, including spouses, who are **under** age 65; and
- Coverage for retirees or spouses who are age 65 and **over**.

Features for each component are described below.

TWA Retiree Medical Plan Under Age 65

The TWA Retiree Medical Plan for retirees and/or spouses who are under age 65, and eligible dependents, is a "Preferred Provider Organization (PPO)" style plan where you receive a higher level of benefit if you use a network ("preferred") provider. These "in-network" providers and facilities have agreed to provide services at negotiated fees lower than most in your area. If you use an in-network provider or facility, the TWA Retiree Medical Plan Under Age 65 will pay a greater portion of most covered expenses. If you use a non-participating, "out-of-network" provider or facility, the benefits you receive for covered expenses will be less because they will be considered "Out-of-Network Benefits."

The In-Network Benefits for covered expenses will also apply if:

- You receive medical care in a location where your PPO network is not available; or
- Your home of record is in an area where no PPO network is available.

TWA Retiree "Under Age 65" Medical Plan Features

NOTE: All items shown in the "Feature" column are subject to a determination of medical necessity, except routine exams and chiropractic care.

TWA RETIREE UNDER AGE 65 MEDICAL PLAN FEATURES		
FEATURE	**IN-NETWORK BENEFITS**	**OUT-OF-NETWORK BENEFITS**
Coinsurance Rate	90[1]/10%, except 100% after 10% copayment for physician office visit charge.	70%[1]/30% Based on Usual and Prevailing Fee Limits
Deductible for Individual Family	$200/$600 (3 individuals)	$600/$1,800 (3 individuals)
Deductible Carry Over	NONE	NONE
Out-of-Pocket Maximum (separate from mental health & chemical dependency programs)	$1,000 individual/$3,000 family plus deductible (3 individuals) Applies for calendar year in which limit is met.	$3,000 individual/$9,000 family plus deductible (3 individuals) Applies for calendar year in which limit is met.
Durable Medical Equipment	90%[1]	70%[1]
Diagnostic X-ray & Lab	90%[1]	70%[1]
*Subject to Deductible		
Anesthesia	90%[1]	70%[1]
Ambulance	90%[1]	70%[1]
NOTE: Ancillary services will be considered at the in-network benefit if you have utilized an in-network physician or hospital. This includes fees for radiology, pathology, anesthesia and ambulance.		

Physician Office Visit Charge	100% after $10 copayment	70%[1]
Chiropractic Care	90%[1]; limited to 20 visits per year	70%[1]; limited to 20 visits per year
Podiatry	90%[1] $10 copayment on office visit charge	70%[1]

NOTE: If services other than an office visit are rendered there may be additional charges (i.e., a patient goes to an in-network physician for an office visit and the physician performs blood tests and a chest x-ray). If the in-network deductible is satisfied ($200), the patient would be responsible for the $10copayment for the office visit plus the 10% coinsurance since the diagnostic services would now be reimbursed at 90% of the negotiated rate.

Example:

OV-$50 (negotiated rate) . . . patient owes . . .	$10.00
Lab-$20 @ 10% =	+ 2.00
X-ray-$75 @ 10% =	+ 7.50
Total Patient Responsibility	**$19.50**

NOTE: This requires hospital precertification through QuickReview before any hospital admission. If emergency admission, please call within 48 hours or the next business day following that admission.

Pre-admission Testing	100%	70%[1]
Inpatient Hospital Charges	90%[1, 2]	70%[1, 2]
Physician Inpatient Hospital Visits; Surgery	90%[1]	70%[1]
Outpatient Surgery or Accidental Injury (Hospital Surgeon)	90%[1]	70%[1]
Emergency Room Physician; Outpatient Hospital	90%[1]	70%[1] – **Note: If hospital is in-network, then the physician will also be paid as in-network.**
Preventive Health Care (includes annual routine exams, immunizations, pap smears, mammograms, PSA tests and proctosigmoidoscopies)	$10 copayment for office visits; 90% coinsurance for hospital-based services	50%[1]
Free Standing Surgical Facility	90%[1]	70%[1]
Second Surgical Opinion	100% (when authorized by UnitedHealthcare)	70%[1] (when authorized by UnitedHealthcare)
Supplemental Accident (within 90 days of injury)	100% of first $250 in physician and hospital charges per person per calendar year 90%[1] of excess	100% of first $250 in physician and hospital charges per person per calendar year 70%[1] of excess
Physical Therapy & Occupational Therapy	90%[1]	70%[1]
Skilled Nursing Facility	90%[1] (based on semi-private room charge) Maximum of 60 days per calendar year	70%[1] (based on semi-private room charge) Maximum of 60 days per calendar year
Home Health Care	90%[1:] 60 visits maximum per person per calendar year	70%[1:] 60 visits maximum per person per calendar year
Hospice Care	90%[1] Lifetime maximum: $10,000 per person	70%[1]: $10,000 per person
Medical Maximum Benefit	$1,000,000 Lifetime maximum	$1,000,000 Lifetime maximum per

	per person	person

[1] **Subject to deductible**
[2] **Includes in-hospital expenses for newborns**

UNDER AGE 65 PRESCRIPTION DRUG PROGRAM		
FEATURES	**IN-NETWORK BENEFITS**	**OUT-OF-NETWORK BENEFITS**
Prescriptions – Retail (for acute care prescriptions only)	For up to a 30-day Supply: • **Generic** $10 copayment • **Brand (generic not available)** 30% coinsurance • **Brand (generic available but brand requested)** $10 plus cost difference between brand and generic when generic is available and brand is requested. • **Psychotherapeutic Drugs** Covered the same as any other prescription drug purchased at a retail pharmacy.	None
Prescriptions – Mail Service (for maintenance prescriptions)	For up to a 90-day supply: • **Generic** $25 copayment per prescription (or cost of the drug if the prescription cost is les than $25.) • **Brand (generic not available)** 25% of the cost of the drug up to a $150 maximum per prescription or refill. If a generic drug is available and you choose a brand name drug, you pay the generic copayment, plus the cost difference between the brand and generic drug. • **Brand (generic available but brand requested)** $25 plus difference in cost between brand and generic when generic is available and brand is requested • **Psychotherapeutic prescription drugs** Available for the mail order copayment amounts.	None

Example of Cost Variance (Brand Name Drug is Chosen When Generic Is Available)			
Sample Drug Cost		**Your Cost**	
Brand Name Drug	$120	Copayment for Brand Name Drug	$25
Generic Version of Brand Name Drug	$ 65	Plus difference in cost	$55
Difference in Cost	**$ 55**	**Your out-of-pocket expense**	**$80**

Under Age 65 Mental Health & Chemical Dependency Program

(For more information, refer to Covered Mental Health and Chemical Dependency Care.)

INPATIENT BENEFITS	IN-NETWORK BENEFITS[1]
Deductible[2]	None
Family Payment	90%
Physician Payment	90%
Out-of-Pocket Maximum For covered Expenses [3]	$1,000/$3,000[3]
Outpatient Benefits	**In-Network Benefits[1]**
Deductible[2]	None
Family Payment	90%
Physician Payment (subject to maximum shown below)	90% (no out-of-pocket maximum)

[1] Out-of-network benefits are subject to usual & prevailing fee limits

[2] Individual/family deductible (separate from the medical deductibles)

[3] Individual/family out-of-pocket maximums per calendar year are separate from the medical out-of-pocket maximum

Special Provisions and Limits for "Under Age 65" Mental Health & Chemical Dependency Program:

- For a listing of in-network providers, call UnitedHealthcare.
- If you are under age 65, inpatient benefits must be pre-authorized by QuickReview (administered by UnitedHealthcare).
- One inpatient treatment for a maximum of 30 days per calendar year (60 days maximum per lifetime) per person.
- Employee Assistance Program (EAP) through American Airlines must pre-certify all chemical dependency treatment or no coverage is provided.
- Only one chemical dependency rehabilitation per lifetime is covered under the plan.
- Combined outpatient mental heath and chemical dependency benefit of 35 visits per calendar year.

Custom Care Coordination from UnitedHealthcare

For participants in self-funded TWA Retiree Plan health coverage—Under Age 65 coverage, UnitedHealthcare offers Custom Care Coordination—access to health professionals who can answer your health questions, refer you to health resources for information, and help you navigate the health care system:

- **Nurse Advocates—nurses who can provide information to help you make better health care choices**
- **Cancer Resource Network—health professionals who specialize in cancer care and treatment information, who can work with you and your family to help you to access the best treatment**

For these Retiree Medical Benefit Options (not for HMOs or TriCare Supplement), UnitedHealthcare also offers NurseLine—telephone access to nurses who can answer your health questions, and provide treatment options and information.

UnitedHealthcare offers these Custom Care Coordination programs to you at no cost, and your participation is voluntary. For more information about these Custom Care Coordination resources, contact UnitedHealthcare (see Important Contacts).

Key Plan Provisions - TWA Retiree Medical Plan “Under Age 65”

The following are key features of the TWA Retiree Medical Plan Under Age 65. See Covered Medical Expenses for specific covered expenses.

Individual annual deductible: Your annual deductible is the amount of eligible medical expenses you must pay each year before the plan will start reimbursing you. After you satisfy the deductible, the plan pays the appropriate percentage of the usual and prevailing fee or the contracted rate for eligible medical expenses.

Annual out-of-pocket maximum: After you satisfy the annual out-of-pocket maximum for eligible medical expenses under the plan, the plan pays 100% of eligible medical expenses for the rest of the calendar year.

Medical maximum benefit: This amount is the most you or your covered eligible dependents can receive in medical benefits during the entire period you or your covered eligible dependents are covered under this plan. All expenses incurred under the Retail and Mail Service Prescription Programs count against your or your covered eligible dependents' medical maximum benefit. All medical expenses incurred by you or your covered eligible dependents while either an active employee, retiree or dependent under a group medical plan sponsored by American Airlines, Inc. and any participating AMR subsidiary (including TWA Airlines LLC), Trans World Airlines, Inc.; Ozark Air Lines, Inc. and Trans World Express will reduce the medical maximum benefit for you or your covered eligible dependents in this plan.

Medically necessary: Medical care is covered by the plan when it is medically necessary. Please note that just because a physician orders a service does not mean it is medically necessary. See Glossary of Terms.

Usual and prevailing fee limits: The amount of benefits paid for out-of-network eligible medical expenses is based on the usual and prevailing fee limits for a particular service or supply in that geographic location. See Glossary of Terms for more information.

CheckFirst: You should use CheckFirst to determine whether a proposed medical service is covered under the plan and if your provider's fee falls within the usual and prevailing fee limits. See the CheckFirst section of this guide for more information.

QuickReview: If you are under age 65, you are required to request pre-authorization before hospitalization. It is also recommended that you pre-authorize outpatient surgery. The QuickReview program authorizes the medical necessity of your surgery and hospitalization, as well as the length of your hospital stay. Contact SHIPS, the QuickReview program administrator, for pre-authorization. See the QuickReview section of this guide beginning for more information.

Accidental injury benefit: If you and/or a covered eligible dependent are injured in a non-work related accident, the plan pays 100% of the first $250 of hospital and physician charges per person each calendar year. Treatment must be received within 24 hours of the accident. After the first $250, you must satisfy a deductible. If two or more members of your family are injured in the same accident, only one individual deductible applies to all injured family members for expenses in connection with that accident during the year in which the accident occurs. Individual annual deductibles still apply to each person for expenses not related to the accident.

Preventive care: Annual routine exams, immunizations, pap smears, mammograms, PSA tests and proctosigmoidoscopies are covered according to the plan guidelines, as explained in the Covered Medical Expenses section of this guide.

Prescription drug benefits: The TWA Retiree Medical Plan covers prescription drugs purchased at any Medco network pharmacy. A special mail service program is available which allows you to purchase drugs that you take on an ongoing basis (such as medications to treat chronic illnesses) at a discount. For more information, see Prescription drugs in Covered Medical Expenses or Prescription Drug Benefits.

TWA Medicare Supplement Plan (Age 65 and Over)

NOTE: All items shown in the "Feature" column are subject to a determination of medical necessity, except routine annual exams and chiropractic care.

TWA Medicare Supplement Plan “Age 65 and Over” Features

Provisions of the TWA Medicare Supplement Plan for eligible retirees and spouses age 65 and over are:

FEATURE	BENEFITS
Annual Deductible	$750 per individual
Annual Out-of-Pocket Maximum	$2,000 per individual (includes deductible)
Pre-existing Condition Limitation	None
Lifetime Maximum	$1,000,000 per individual
Office Visit	• **Illness/Injury** 80%[1]
Preventive Health Care	• **Mammograms, Pap smears, PSA tests and Proctosigmoidoscopes** 80%[1]
Independent X-rays and Lab	80%[1]
Emergency	• **Physician's Office** 80%[1] • **Emergency Room/Urgent Care Facility** 80%[1] • **Ambulance** 80%[1]
Hospital	• **Inpatient** 80%[1] • **Physician's Visits** 80%[1] • **Pre-admission Testing** 80%[1]
Outpatient Surgical Facility	80%[1]
Surgery	• **Surgeon's Fees** 80%[1] • **Second Opinion Consultation** 80%[1]
Outpatient Rehabilitation (Includes Physical, Speech, Occupational Therapy, and Chiropractic Care	80%[1] (*Chiropractic care is limited to 20 visits per year).*
Special Services	• **Skilled Nursing Facility** 80%[1] up to 60 days per year • **Home Health Care**

	80%[1] up to 60 visits per year • **Hospice Care** 80%[1] I$10,000 lifetime maximum for hospice care
Durable Medical Equipment	80%[1]
External Prosthetic Appliances	80%[1]
Mental Health & Chemical Dependency	• **Inpatient** 80%[1] (30 days acute care per calendar year) • **Outpatient** 80%[1] (35 visits per calendar year0
Vision Care	Not Covered
Prescription Drug Coverage	80%, coordinating with Medicare Part D as the primary coverage and the TWA Retiree Health and Life Benefits Plan as the secondary coverage.
[1] Subject to Deductible **[2] Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, except for prescription drugs and mental health and chemical dependency treatment which will continue to be paid at the specified levels.**	

Key Plan Provisions - TWA Medicare Supplement Plan (Age 65 and Over)

The following are key features of the TWA Medicare Supplement Plan. See the Covered Medical Expenses section for specific covered expenses.

Individual annual deductible: Your annual deductible is the amount of eligible medical expenses you must pay each year before the plan will start reimbursing you. After you satisfy the deductible, the plan pays the appropriate percentage of the usual and prevailing fee limits for eligible medical expenses.

Annual out-of-pocket maximum: After you satisfy the annual out-of-pocket maximum for eligible medical expenses under the plan, the plan pays 100% of eligible medical expenses within usual and prevailing fee limits for the rest of the calendar year. Under this TWA Medicare Supplement Plan, the annual deductible counts toward the annual out-of-pocket maximum.

Medical maximum benefit: This amount is the most you or your spouse can receive in medical benefits during the entire period you or your spouse are covered under this plan. All expenses incurred under the Retail and Mail Service Prescription Programs count against your or your spouse's medical maximum benefit. All medical expenses incurred by you or your spouse while either an active employee, retiree or dependent under a group medical plan sponsored by American Airlines, Inc. and any participating AMR subsidiary (including TWA Airlines LLC), Trans World Airlines, Inc., Ozark Air Lines, Inc. and Trans World Express will reduce the medical maximum benefit for you or your spouse in this plan.

Medically necessary: Medical care is covered by the plan when it is medically necessary. Please note that just because a physician orders a service does not mean it is medically necessary. See Glossary of Terms for more information.

CheckFirst: You should use CheckFirst to determine whether a proposed medical service is covered under the plan and if your provider's fee falls within the usual and prevailing fee limits. See the section of this guide for more information.

Preventive care: Annual routine exams, immunizations, pap smears, mammograms, PSA tests and proctosigmoidoscopies are covered according to the plan guidelines, as explained in the Covered Medical Expenses section of this guide.

Prescription drug benefits: The TWA Retiree Medical Plan covers prescription drugs purchased at any PAID Prescriptions network pharmacy, administered by Medco.

A special mail service program is available which allows you to purchase prescription drugs that you take on an ongoing basis (such as medications to treat chronic illnesses) at a discount. For more information, see Prescription Drugs in Covered Medical Expenses or Prescription Drug Benefits.

Medicare Part D Prescription Drug Coverage

This summary provides some general information about Medicare Part D, but does not explain all of the program's benefits and features. If you have specific questions, contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available at www.medicare.gov (see Important Contacts).

Medicare Part D, which becomes effective for enrollees on January 1, 2006, helps pay for both brand name and generic drugs at participating pharmacies in your area. You pay a monthly premium for this coverage, just like you do for Medicare Part B. For 2006, Medicare Part D will have a $250 deductible that you must satisfy before Medicare will pay benefits for your prescription expenses. After this deductible is met, you will still pay a portion of your prescription costs, by paying a copayment or coinsurance. Depending on the Medicare Part D plan you choose, you may a lesser copayment or coinsurance for generic drugs than for brand name drugs. Some Medicare Part D plans may offer mail-order purchase of your medications. www.medicare.gov (see Important Contacts) provides more complete information about Medicare Part D, and you should carefully review this information, along with the information you receive from Medicare Part D prescription drug providers, to choose the plan that best meets your needs.

IMPORTANT NEWS FOR MEDICARE ELIGIBLE RETIREES/DEPENDENTS: Irrespective of whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, for those under age 65 retiree participants/dependents who are Medicare-eligible) ends, and your primary prescription drug coverage will be Medicare Part D. As such, it is very important that you enroll in Medicare Part D coverage immediately—as soon as you become eligible.

Your coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as noted above) will become your secondary coverage, and will coordinate benefits with Medicare Part D in the same manner that it coordinates with Medicare Parts A and B (or Medicare+Choice). Keep in mind that if you or your dependent(s) is(are) eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if you do not enroll in all or part of the Medicare program, your benefits under the TWA Retiree Health and Life Benefits Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

Covered Medical Expenses for both the TWA Retiree Medical Plan Under Age 65 and the TWA Medicare Supplement Plan

Listed below in alphabetical order is a description of eligible medical expenses that are covered under the TWA Retiree Medical Plan when medically necessary. For a list of items that are excluded, refer to the Excluded Expenses section.

Acupuncture: Medically necessary treatment (performed by a Certified Acupuncturist) for diagnosed illness or injury, 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 medically necessary physician's office visits, allergy testing, shots, and serum. See excluded allergy care.

Ambulance: Professional ambulance services and air ambulance once per illness or injury to and from:

- The nearest hospital qualified to provide medically necessary treatment in the event of an emergency; and
- The nearest hospital, or convalescent or skilled nursing facility, for inpatient care.

Ambulance services are only covered in 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 include charges for hospital services, supplies, and operating room use. 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 only when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst pre-determination procedure.

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: These facilities are covered up to the most common semi-private room rate for inpatient hospital expenses, up to 60 days per year following discharge from the hospital for a covered inpatient hospital confinement of at least three consecutive days. To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital and be recommended by your physician for the condition, which caused the hospitalization.

Eligible expenses include room and board, services, and supplies (but not 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 stay must be approved by SHIPS through the QuickReview program if you are under age 65. Your stay is not covered for custodial care.

Cosmetic Surgery: Medically necessary expenses for cosmetic surgery are only covered 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 under the TWA Retiree Medical Plan.

Dental Care: Dental expenses covered as medical care are limited to physician's services or x-ray examinations involving one or more teeth, the tissue around them, the alveolar process, or the gums only when the care is for:

- Accidental injuries to sound natural teeth and gums caused by external means;
- Services for treatment of fractures and dislocations of the jaw; or
- Cutting procedures of the mouth (other than extractions, dental implants, and repair or care of the teeth and gums).

Detoxification: Detoxification is covered as a medical condition when alcohol and drug addiction problems are sufficiently severe to require immediate inpatient medical and nursing care services. If you are under age 65, contact UnitedHealthcare for your QuickReview authorization.

Durable Medical Equipment (DME): Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The TWA Retiree Medical 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 natural growth. Replacement of a DME resulting from normal wear and tear is not covered. Coverage includes only the initial purchase of eye glasses or contact lenses required because of cataract surgery.

Emergency Room: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. If you are under age 65, you must contact SHIPS within 48 hours of an emergency resulting in admission to the hospital for your QuickReview authorization.

Facility Charges: Charges for the use of an outpatient surgical facility are covered when the facility is either an outpatient surgical center affiliated with a hospital or a free standing surgical facility.

Hearing Care: Covered expenses include medically necessary hearing exams and up to one basic hearing aid for each ear per year. Cochlear implants are covered if medically necessary.

Hemodialysis: Removal of certain elements from the blood through selective diffusion for treatment of kidney failure.

Home Health Care: Home health care is covered when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. It is subject to review by the claims processor, who requires the physician to provide an approved treatment plan before paying benefits, and may periodically review the plan. If you are under age 65, you should call QuickReview to be sure home health care is considered medically necessary. Custodial care is not covered.

Hospice Care: Expenses covered in connection with hospice care include both facility and outpatient care.
Benefits are payable for eligible medical expenses necessary for the care and treatment of a terminally ill participant if they are included in an approved written treatment plan and are provided by a hospice agency or hospice center. If you are under age 65, you must contact UnitedHealthcare for your QuickReview authorization.

Inpatient Hospital Expenses: Hospital room and board charges are covered, up to the most common semi-private room rate. If the hospital does not have semi-private rooms, the plan considers the eligible expense to be 90% of the hospital's lowest private room rate. This benefit applies to all inpatient hospital admissions, including hospitalization for mental health and chemical dependency care and convalescent or skilled nursing facility confinements. Physician's charges are separate from inpatient room and board charges. If you are under age 65, you must contact SHIPS for your QuickReview authorization.

Intensive Care, Coronary Care, or Special Care Units (including Isolation Units): Coverage includes medically necessary services and supplies.

Mammograms: Medically necessary diagnostic mammograms are covered regardless of age. Routine mammograms for female retirees and participating eligible dependents are covered, 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 one to two years for women ages 40 to 49, as recommended by your physician; and
- Once every year for women age 50 or over.

Mastectomy: Certain reconstructive and related services are covered following a medically necessary mastectomy, including:

- Reconstruction of the breast on which surgery was performed;
- Reconstruction of the other breast to produce symmetrical appearance;
- Prostheses; and
- 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; and
    - Colostomy bags.

Non-sterile or disposable supplies, such as band-aids and cotton swabs, are not covered.

Multiple Surgical Procedures: Reimbursement for multiple procedures performed at the same time is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage and to be sure the charges are within the usual and prevailing fee limits, use the CheckFirst pre-determination program.

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 are covered only if it is medically necessary to perform oral surgery in a hospital setting rather than a dentist's office. If medically necessary, the plan will pay room and board, anesthesia, and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the medical plan except as specified under "Dental care".

Outpatient Surgery: Charges for services and supplies for a medically necessary surgical procedure performed on an outpatient basis at a hospital, free-standing surgical facility, or physician's office are covered. If you are under age 65, you should contact UnitedHealthcare for your QuickReview pre-authorization to ensure the procedure is medically necessary.
Physical or Occupational Therapy: Coverage includes medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a Physician.

Physician's Services: Covered services include office visits and other medical care, treatment, surgical procedures, and postoperative care for medically necessary diagnosis or treatment of an illness or injury.

Pregnancy: 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 or she practices.

You should contact UnitedHealthcare for your QuickReview pre-authorization within the first 16 weeks of pregnancy to pre-authorize your hospitalization and to take advantage of the prenatal program. Refer to the QuickReview section for more information about this program.

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 maternity hospital stay of 48 hours or less (96 hours or less for a cesarean section). However, federal law does not require a minimum stay of this length, and you, in consultation with your physician, may decide on a shorter hospital stay.

Charges in connection with pregnancy for covered eligible dependents who are children are covered only if due to certain complications of pregnancy (such as ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis).

Prescription Drugs: Medically necessary prescription drugs that are approved by the FDA for treatment of your condition are covered. For more information, refer to the Prescription Drug Benefits section. Prescription drugs related to infertility treatment, weight control, and oral contraceptives are not covered. For other exclusions, refer to the Exclusions section.

Medications are also covered for the following special situations:

- Medications administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit; and
- Medications administered while you are covered as a patient in a hospital, extended care facility, convalescent hospital, or similar institution which operates an on-premises pharmacy. These are covered as part of the facility's ancillary charges.

Preventive Care: Covered preventive care includes annual routine exams, immunizations, pap smears, mammograms, PSA tests and proctosigmoidoscopies.

Prostheses: Coverage includes prostheses (such as a leg, foot, arm, hand, or breast) medically necessary because of illness, injury, or surgery. Replacement of a prosthesis is only covered when medically necessary because of a change in the patient's condition, either an improvement or deterioration, or due to natural growth. Replacement of a prosthesis resulting from normal wear and tear is not covered.

Radiology (X-Ray) and Laboratory Expenses: Covered services include examination and treatment by x-ray, radium, or other radioactive substances, diagnostic laboratory tests, and/or mammography screenings for women.

Reconstructive Surgery: Surgery following an illness or injury, including contralateral reconstruction of asymmetry of bilateral body parts (such as breasts or ears).

Speech Therapy: Restorative and rehabilitative care and treatment for loss or impairment of speech are covered when the treatment is medically necessary because of an illness (other than a mental, psychoneurotic, or personality disorder), injury, or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must have been performed before the therapy. For other speech therapy exclusions, refer to the Exclusions section.

Surgery: Covered when medically necessary and performed in a hospital, free standing surgical facility, or physician's office. Covered surgery includes medically necessary surgery for congenital abnormalities (such as birth defects) that are functional in nature. If you are under age 65, contact SHIPS to pre-authorize your surgery and/or hospitalization through QuickReview. To determine how an assistant surgeon or multiple surgical procedures will be covered, contact UnitedHealthcare (CheckFirst).

Temporomandibular Joint Dysfunction (TMJ): Eligible expenses under the TWA Retiree Medical Plan include 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; and
- Manipulation or heat therapy.

Crowns, bridges, and orthodontic procedures are not covered for treatment of TMJ.

Transplants: Expenses for transplants or replacement of tissue or organs are covered if they are medically necessary and not experimental 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 TWA Retiree Medical Plan, expenses for both individuals are covered by the plan.
- If the donor is not covered under the TWA Retiree Medical Plan and the recipient is covered under the TWA Retiree Medical Plan, 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 TWA Retiree Medical Plan but the recipient is not covered under the TWA Retiree Medical 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 maximums applicable to the recipient.

If you are under age 65, you must contact UnitedHealthcare as soon as possible for your QuickReview pre-authorization before contemplating or undergoing a proposed transplant.

Transportation Expenses: Regularly scheduled commercial transportation by train or plane is covered when necessary for your emergency travel to and from the nearest Hospital that can provide inpatient treatment not available locally. Only one round-trip ticket is covered for any illness or injury and will be covered only if medical attention is required en route. For information on ambulance services, see "Ambulance".

Tubal Ligation and Vasectomy: These procedures are covered; however, reversal of these procedures is not covered.

Urgent Care: Charges for services and supplies provided at an urgent care clinic.

Wigs and Hairpieces: Retirees and eligible dependents are covered up to a $350 lifetime maximum 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, or severe burns. This benefit is subject to the usual and prevailing fee limits, deductibles, coinsurance, and out-of-pocket limits.

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.

Covered Mental Health and Chemical Dependency Care

In addition to the covered expenses described above, the plan covers certain medically necessary mental health and chemical dependency care.

Mental Health Care
Covered expenses include 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: When you are hospitalized in a psychiatric hospital for a mental health disorder, expenses during the period of hospitalization are covered.

Alternative Mental Health Care Center: Treatment in an alternative mental health care center is covered. A day of treatment is defined as not more than 8 hours in a 24-hour period. This may also be called alternative hospitalization.

Outpatient Mental Health Care: Expenses for outpatient mental health care, including prescription drugs, are covered.

Chemical Dependency Care

To be eligible for reimbursement under the TWA Retiree Medical Plan, the chemical dependency rehabilitation program must be approved in advance by the Employee Assistance Program (EAP) and the treatment must be considered medically necessary. You will not receive reimbursement for treatment without this advance approval. The telephone numbers for the EAP are listed below.

Employee Assistance Program (EAP)	Main Phone Number:	1-800-555-8810
	Eastern Region	(718) 476-4033
	Western Region	(310) 646-3501
	Flight/HDQ/SRO	(817) 963-1155
	Southwest/DFW	(972) 425-7161
	Central Region	(773) 686-4179
	Tulsa/AFW	(918) 292-2464
	Florida/MIA/SJU	(305) 526-7979

Chemical Dependency Rehabilitation: Covered chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient, or a combination. You are covered for one Chemical Dependency Rehabilitation program during your lifetime (regardless of whether the program is inpatient, outpatient or both). The plan does not cover expenses for a family member to accompany the patient being treated, although many treatment centers include family care at no additional cost.

Detoxification: Chemical dependency rehabilitation does not include detoxification. Detoxification is considered a medical procedure and is reimbursed under the plan's regular medical provisions. If you are under age 65, you must call UnitedHealthcare for your QuickReview approval of detoxification.

TWA RETIREE MEDICAL PLAN EXCLUSIONS (EXCLUDED EXPENSES)

No benefits are paid for expenses in connection with the following items (listed alphabetically):

Allergy Testing: Excluded is 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 Medicine: Charges for herbal, holistic, and homeopathic medicine are excluded from coverage.
Claim Forms: The TWA Retiree Medical Plan will not pay the cost for anyone to complete your claim forms.

Cosmetic Treatment: Excluded are the following:

- Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction, and sclerotherapy for varicose veins or spider veins); and
- Cosmetic surgery, unless required as a result of accidental injury or surgical removal of diseased tissue.

Counseling: All forms of marriage counseling are excluded from coverage.

Custodial Care and Custodial Care Items: Excluded are 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 for routine dental care or treatment of dental disease or defect.

Developmental Therapy for Children: Excluded are charges for all types of developmental therapy.

Dietician Services: Excluded are charges for the services of a Dietician.

Drugs: The following are excluded from coverage:

- 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 which 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. (Even though they 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 which promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered);
- Drugs prescribed for cosmetic purposes (such as Minoxidil);
- Medications used primarily for the purpose of weight control;
- Infertility drugs;
- Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs not approved by the FDA, or experimental drugs, even though the individual is charged for such drugs; and
- Any and all medications not approved by the FDA as appropriate treatment for the specific diagnosis.

Ecological and Environmental Medicine: Excluded are diagnosis, testing, treatment, and care.

Educational Testing or Training: Testing or training that does not diagnose or treat a medical condition is not covered. For example, testing for learning disabilities is excluded.

Experimental Treatment: Medical treatment, procedures, drugs, devices, or supplies which are generally regarded as experimental or investigational services (see Experimental or Investigational Services in the glossary) for definition), including, but not limited to, treatment for:

- Premenstrual Syndrome, Chronic Fatigue Syndrome, and Epstein-Barr Syndrome;
- Hormone pellet insertion; and
- Plasmapheresis.

Eye Care: Eye exams, refractions, eye glasses or the fitting of eye glasses, radial keratotomy or surgeries to correct refractive errors, visual training, and vision therapy are not covered.

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: Excluded are care, treatment, services, or supplies for which payment is not legally required.

Government-Paid Care: Excluded are care, treatment, services, or supplies provided or paid for by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents; however, this exclusion does not apply to Medicare or Medicaid.

Infertility Treatment: Excluded are expenses or charges for infertility treatment or testing and charges for treatment or testing for hormonal imbalances which cause male or female infertility, regardless of the primary reason for hormonal therapy. This includes, but is not limited to, medical services, supplies, and procedures for or resulting in impregnation, including: in vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, and reversal of tubal ligations or vasectomies.

Drug therapy is also excluded, including treatment for ovarian dysfunction and infertility drugs such as Clomid or Pergonal.

Only the initial tests are covered to diagnose systemic conditions such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders is eligible for coverage.

Lenses: No lenses are covered except the first pair of medically necessary contact lenses following cataract surgery.

Massage Therapy: Excluded are all forms of massage and soft-tissue therapy, regardless of who performs the service.

Medical Necessity: Excluded are services and supplies considered not medically necessary.

Medical Records: Excluded are charges for requests of medical records.

Missed Appointments: If you incur a charge for missing an appointment, the plan will not pay any portion of the charge.

Nursing Care: Excluded are the following:

- Care, treatment, services, or supplies received from a nurse which do not require the skill and training of a nurse;
- Private duty nursing care which is not medically necessary, or if medical records establish that such care is within the scope of care normally furnished by hospital floor nurses; and
- Certified nurse's aides.

Organ Donation: Expenses incurred as an organ donor when the recipient is not covered under the TWA Retiree Medical Plan.

Pregnancy of Dependent Children: Prenatal care and delivery charges are excluded for covered dependent children, unless charges are due to certain complications. Examples of covered complications include: ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Relatives: You are not covered for treatment by a medical practitioner (including, but not limited to: a nurse, physician, physiotherapist, or speech therapist) who is a close relative (spouse, child, brother, sister, parent, or grandparent) of you or your spouse, including adopted and step relatives.

Sex Changes: Sex changes or transsexual and related operations are not covered.

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

dysfunction or other sexual dysfunction, or the for the purpose of producing, restoring, or enhancing sexual performance/experience.

Sleep Disorders: Treatment of sleep disorders is not covered unless considered medically necessary.

Speech Therapy: Expenses are not covered for losses or impairments caused by mental, psychoneurotic, or personality disorders or for 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 (TMJ): Except as described in Covered Expenses, diagnosis or treatment for temporomandibular joint (TMJ) disease or syndrome by a similar name, including adult orthodontia to treat TMJ, is not covered.

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 is not covered by the TWA Retiree Medical Plan.

War-Related: Services or supplies are excluded when received as a result of a declared or undeclared act of war.

Weight Reduction: Excluded are hospitalization, surgery, treatment, and medications for weight reduction other than for approved treatment of morbid obesity.

Wellness Items: Items which promote well-being and are not medical in nature, and are not specific for the illness or injury involved (such as massage therapy, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas, and health club memberships) are not covered.

Also excluded are:

- Services or equipment intended to affect high levels of performance (primarily in sports-related activities), including strengthening and physical conditioning; and
- Services related to vocation, including but not limited to: physical exams, performance testing, and work hardening programs.

Work-related: Medical services and supplies for treatment of any work-related injury or illness sustained by you or your covered eligible dependent, whether or not covered by Workers' Compensation, occupational disease law, or other similar law.

CheckFirst for Pre-Determination of Benefits

CheckFirst, administered by UnitedHealthcare, allows you to find out if:

- The recommended service or treatment is covered by the TWA Retiree Medical Plan; and
- Your physician's proposed charges fall within the plan's *usual and prevailing fee limits*.

If you are using a network provider, the provider's fees will always be within usual and prevailing fee limits; however, you may contact CheckFirst to determine if the proposed services are covered by the TWA Retiree Medical Plan.

You may either submit a CheckFirst Pre-determination Form to UnitedHealthcare before your proposed treatment, or you may contact CheckFirst to receive pre-determination over the phone. If you receive pre-determination over the phone, ask for written confirmation.

You may request a CheckFirst Pre-determination Form from UnitedHealthcare, or you may contact Employee Services by phone at 1-800-447-2000 to request the form. You will need the following information from your physician:

- Diagnosis;

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

UnitedHealthcare, the claims processor, reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different from the information you submitted for pre-determination.

For *hospital* stays, CheckFirst can pre-determine the amount payable by the TWA Retiree Medical Plan; however, if you are under age 65, you need to contact UnitedHealthcare to request a QuickReview pre-authorization. A CheckFirst pre-determination does not pre-authorize the length of a hospital stay or determine medical necessity.

For outpatient surgery only, UnitedHealthcare will determine the medical necessity of your proposed surgery before making a pre-determination of benefits. UnitedHealthcare will mail you a written response.

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 pre-determination 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 pre-determination procedure.

Multiple surgical procedures: If you are having multiple surgical procedures performed at the same time, the procedures that are not the primary reason for surgery are covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgery. You should contact CheckFirst to find out how the plan reimburses the costs for the additional procedures.

QuickReview for Hospital Pre-Authorization

QuickReview is the TWA Retiree Medical Plan's hospital pre-authorization program, administered by UnitedHealthcare. If you are:

- Age 65 or over, QuickReview does not apply to you; or
- Under age 65, you are required to contact UnitedHealthcare to request pre-authorization of any hospital admission or surgery, or within 48 hours (or the next business day) following emergency care. If you do not contact UnitedHealthcare, your expenses are still subject to review and will not be covered under the plan if they are not considered medically necessary.

UnitedHealthcare will tell you:

- Whether the proposed treatment is considered medically necessary and appropriate for your condition; and
- The number of approved days of hospitalization, if applicable.

QuickReview does not determine whether you are eligible for benefits under the plan or how much you will be reimbursed. For information on eligibility or coverage, contact CheckFirst.

Any portion of a stay that has not been approved is considered not medically necessary. The plan does not pay charges for any portion of a stay that is not medically necessary. For example, if UnitedHealthcare 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 are not covered.

You are required to contact UnitedHealthcare in 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; and

- During the first 16 weeks of pregnancy to participate in the prenatal program.

If your physician recommends surgery or hospitalization, ask your physician for the following information:

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

Contact UnitedHealthcare as soon as possible, with the information provided by your physician. In the event of an emergency hospital admission, call within 48 hours after the admission (or the next business day if you are admitted on a weekend).

- If your illness or injury prevents you from personally contacting SHIPS, any of the following may contact UnitedHealthcare for you:
  - A family member or friend;
  - Your physician; or
  - The hospital.
- UnitedHealthcare authorizes the medically necessary length of your hospital stay. In some cases, UnitedHealthcare may refer you for a consultation before surgery or hospitalization is authorized. To avoid any delays in surgery or hospitalization, notify UnitedHealthcare as far in advance as possible.
- Be sure to write down the reference number given to you when you call; you will need that number if you call UnitedHealthcare at a later time.
- If you receive pre-authorization of a hospital stay over the phone, ask for written confirmation of the pre-authorization.
  After you are admitted to the hospital, UnitedHealthcare provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, UnitedHealthcare consults with your physician and hospital to verify the need for any extension of your stay. Contact UnitedHealthcare again if you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness. If you are scheduled for outpatient surgery, you should also contact UnitedHealthcare. If you do not call, you may be asked to provide medical documentation to support the medical necessity of your surgery before any claim will be paid. UnitedHealthcare does not guarantee that benefits will be paid. UnitedHealthcare, the claims processor, reserves the right to make adjustments upon receipt of the final claim papers if the actual service differs from the pre-authorization information you submitted.

Prescription Drug Benefits

If you are enrolled in the TWA Retiree Medical Plan, prescription drugs may be purchased either at retail pharmacies or through the mail service program. For information on which drugs are covered, see Covered Medical Expenses. For excluded drugs, see Exclusions.

Retail Prescription Drug Program

As a participant in the TWA Retiree Medical Plan, you may have your prescriptions filled at any pharmacy in the PAID Prescriptions network, which is administered by Medco.

You will receive your ID card within a couple of weeks after enrolling in the TWA Retiree Medical Plan. If you need a prescription in the meantime, contact Employee Services at 1-800-447-2000 for assistance.

PAID Prescriptions has over 51,000 network pharmacies throughout the United States, Puerto Rico, and the U. S. Virgin Islands. The network includes 9 out of 10 retail pharmacies nationwide. To request a list of participating pharmacy chains, call Medco or visit their web site at http://www.medco.com/.

Retirees under age 65[1] will pay the following costs at the network pharmacy:

- $10.00 copayment for generic prescription drugs
- 30% of the cost of a brand name prescription drug when no generic is available, and

- $10.00 plus the difference in cost between brand name and generic, if a brand name is elected when a generic is available.

Prescriptions for short term or acute care illnesses, such as colds, flu, or allergies, may be filled at network pharmacies. Prescriptions for maintenance medications or for more than a 30-day supply must be filled using the mail service program.

Retirees age 65 and over will pay 20% of the cost of generic or brand name drugs after the deductible is satisfied.

Retirees age 65 and over should follow these steps:

(1) Present your PAID Prescriptions ID card to the pharmacy when you order your prescription from a network pharmacy;
(2) Pay the discounted price for the prescription drugs and obtain a receipt when you pick up your prescription;
(3) File a claim with PAID Prescriptions for reimbursement of your Covered expenses.

PAID Prescriptions reports the claim to UnitedHealthcare (the claims processor). UnitedHealthcare then mails you an explanation of benefits (EOB) advising you of the total charges you submitted, and the amounts eligible and paid under the TWA Retiree Medical Plan. PAID Prescriptions will explain any amounts not covered and the reason they are not covered. If you have questions concerning this program, call the Medco number on your PAID Prescriptions ID card.

Prior Authorization

To be eligible for benefits, certain prescriptions require prior authorization to determine medical necessity before you can obtain them at a participating pharmacy or through the mail service program. Medications requiring prior authorization for prescriptions include, but are not limited to:

- Growth hormones;
- Imitrex; and
- Contraceptives for medical conditions.

Contact Medco to find out whether your prescription requires prior authorization. When you submit your prescription, the pharmacist will receive a message from Medco instructing him or her to call Medco.

If Medco does not have a prior authorization on file for you, the pharmacist will then contact your physician to review the request for approval. Both you and your physician will be sent a letter about the authorization review. If authorization is approved, Medco will automatically allow refills for the original approved time. When your renewal date approaches, you will be sent a letter notifying you of the upcoming expiration with instructions on how to obtain a new authorization.

To request prior authorization, ask your physician to write a letter on his or her letterhead to Medco or have your physician call and provide the following information:

- The name of the drug, strength, and supply being prescribed;
- The medical condition for which the drug is being prescribed;
- The proposed treatment plan; and
- Any other pertinent information.

Member Services will advise you whether prior authorization is approved or denied. If it is denied, they will explain the reason for denial.

Mail Service Prescription Drug Program[1]

You and your covered eligible dependents are eligible for the mail service program through Medco. You may use the mail service program for 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. Injectable drugs that are FDA-approved for self-administration may also be purchased through the mail service program.

Under the mail service program, you may order up to a 90-day supply of your prescription drug (but no more than the number of days prescribed by your physician). You pay a copayment (with no annual deductible) for each prescription or refill. Your copayments are not eligible for reimbursement under the TWA Retiree Medical Plan. Copayments, which are subject to change, are currently:

- $10 for generic drugs; and
- $30 for brand name drugs if no generic is available
- $10 plus the difference between brand name and generic if the brand name is elected when a generic is available.

[1]Effective January 1, copayments for Mail Order prescription drugs will increase.§ Generic Drugs: You pay a $25 copayment per prescription (or the cost of the drug if the prescription cost is less than $25).§ Brand Name Drugs: You pay 25% of the cost of the drug up to a $150 maximum. (If a generic drug is available and you choose a brand name drug, you pay the generic copayment plus the cost difference between the brand and generic drug.)

You will pay a coinsurance amount of 100% of the discounted price for oral contraceptives instead of a copayment.

A registered pharmacist fills your prescription. Generally, your order is shipped within three working days of receipt. Please allow up to 14 days for delivery. All orders are sent by United Parcel Service (UPS) or first class mail. UPS delivers to rural route boxes but not to post office (P.O.) boxes. If you have only a P. O. Box address, your order is sent by first class mail.

You and your covered eligible dependents may purchase oral contraceptives through the mail service program, but since these are not covered by the TWA Retiree Medical Plan, you pay the full cost of the prescription drugs. However, the mail service program offers a significant discount compared to retail prices.

Generic Drugs

Many drugs are available in generic form. Your prescription will be substituted with a generic when available and your physician considers it appropriate. A-rated generic drugs are used because they generally cost less and have the same therapeutic effect and composition as their brand equivalents. By using A-rated generic drugs, you save money for yourself and the Company.

When your physician writes the prescription order, he or she either indicates that it must be filled with the brand name or that the pharmacist may substitute the generic equivalent. If substitution is allowed, your prescription will be filled with the generic drug.

Ordering Mail Service Prescriptions

Initial order: To place your first order for a prescription through the mail service program, follow these steps:

- To request a mail service order envelope, call Medco.
- Provide the information requested on the back of your mail service order envelope, and complete and enclose the patient profile. (The profile will not be necessary on refills or future orders unless your health changes significantly.)
- Insert the original written prescription signed by your physician.
- If the prescription is for an oral contraceptive, call Medco before placing your order to find out how much you must pay for the prescription.
- Indicate the desired method of payment on the mail service order envelope. You may charge your payment to a major credit card (MasterCard, VISA, or Discover) or pay by personal check or money order. If paying by check or money order, enclose your payment with the order. Do not send cash.
- Mail your order to the address on the envelope.

Refills

To order refills, follow these steps:

- Place your refill order at least two weeks before your current supply runs out.
- Contact Medco to request a refill. They will need your member ID number (retiree's Social Security number), current mailing address, and Medco prescription number.
- If you prefer to order by mail, complete a mail service order envelope and attach your Medco refill prescription label to the form or write the prescription refill number on the envelope.

Ordering On the Internet

The Internet gives you access to Medco 24 hours a day, seven days a week. Using Medco online, you can order prescription drug refills, check on the status of your order, and request additional forms and envelopes.

To access Medco:

- Go to http://www.medco.com, then
- Click on Member Services, then
- Select the service you would like to use:
    - refill your current prescription;
    - check the status of your recent order; or
    - request mail service envelopes and claim forms.

To refill a prescription online, you will simply need to supply your member number (Social Security number), and the Medco prescription numbers you want to refill. Verify your address on file and review your order. When you order online, you will receive a detailed summary of your order, including costs. Please allow up to 14 days for delivery of your prescription.

Medical Maximum Benefit

Medco sends you a statement with each prescription they fill. The statement advises you of your copayment and the amount the Company paid. The amount the Company paid is applied to your medical maximum benefit, as explained in Key Plan Provisions for retirees under age 65 and Key Plan Provisions for retirees age 65 and over.

Safe and Appropriate Use of Medications

You and your covered eligible dependents benefit from a comprehensive medication safety review. This program is coordinated by Optimal Health as part of your Medco prescription drug benefits.

When your prescriptions are filled through network retail pharmacies or the mail service pharmacy, they are reviewed for any potential drug interactions based on your personal medical profile. This is especially important if you take many different medications or see more than one physician. If there are questions about your prescription, your pharmacist will contact your physician before dispensing the medication. (This may delay the processing of your prescription.)

IMPORTANT NEWS FOR MEDICARE ELIGIBLE RETIREES/DEPENDENTS

Irrespective of whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, for those under age 65 retiree participants/dependents who are Medicare-eligible) ends, and your primary prescription drug coverage will be Medicare Part D. As such, it is very important that you enroll in Medicare Part D coverage immediately—as soon as you become eligible.

Your coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as noted above) will become your secondary coverage, and will coordinate benefits with Medicare Part D in the same manner that it coordinates with Medicare Parts A and B (or Medicare+Choice). Keep in mind that if you or your dependent(s) is(are) eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if you do not enroll in all or part of the Medicare program, your benefits under the TWA Retiree Health and Life Benefits Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

To file a prescription drug claim under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as explained above), you must have already filed with Medicare Part D and received your Medicare Part D Explanation of Benefits (EOB). Submit to UnitedHealthcare:

- Your prescription receipt from the pharmacy
- Your Medicare Part D EOB
- Your completed prescription claim form for Medicare Part D expenses (available on Jetnet).

Upon receipt of your complete claim, UnitedHealthcare will process your claim under your retiree medical coverage, coordinating benefits with Medicare Part D. For more information, refer to Coordination of Benefits.

If your selected Retiree Medical Benefit Option is the TriCare Supplement Insurance Option, follow the Medicare Part D claim instructions provided to you by Hartford/ASI.

MEDICARE COVERAGE

If Medicare covers you, knowing how your Medicare coverage works will help you understand how benefits apply under the TWA Retiree Medical Plan. You are eligible for Medicare on the first of the month that you reach age 65, if you or your spouse worked at least ten (10) years in Medicare-covered employment and you are either a US citizen or a permanent resident. You might also qualify if you are under age 65 and are disabled or have chronic kidney disease.

You may choose to be covered under Original Medicare, or under a Medicare+Choice Health Plan. Original Medicare includes Part A (hospital coverage) and Part B (medical coverage). Effective January 1, 2006, Medicare Part D (prescription drug coverage) becomes effective for those who have enrolled in the coverage.

This summary provides some general information about Medicare Parts A and B, Medicare+Choice, and Medicare Part D, but does not explain all of the program's benefits and features. If you have specific questions, contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available at www.medicare.gov.

Medicare Part A - Medicare Part A helps pay for:

- Hospital care;
- Skilled nursing facilities following a hospital stay;
- Home health care; and
- Hospice care.

Part A requires you to meet an annual deductible. Most people qualify for Part A without paying any premium. Both the deductible and the premium (if applicable) that you pay are subject to change each year. Medicare rates, including the annual deductible, for the following year are available each November on the Internet at http://www.medicare.gov.

Medicare Part B - Medicare Part B helps pay for:

- Medical expenses such as doctor's charges, inpatient and outpatient medical and surgical services and supplies, physical, occupational, and speech therapy, diagnostic tests, and durable medical equipment;
- Clinical laboratory and x-ray services;
- Home health care;
- Outpatient hospital services for diagnosis and treatment of an illness or injury;
- Blood; and
- Certain preventive services (effective January 1, 1999).

Part B requires you to meet an annual deductible. After the deductible, Medicare pays 80% of the Medicare approved amount for most services. The premium for coverage is based on a per month rate. Both the deductible and the monthly premium you pay are subject to change each year. Medicare rates, including the annual deductible, for the following year are available each November on the Internet at http://www.medicare.gov.

Medicare Assignment

Always ask your doctors if they accept Medicare assignment of benefits, because assignment can save you money. If they do, they will accept the Medicare approved charge for a particular service or supply, and will not charge you more than the deductible and 20% coinsurance.

Physicians who do not accept Medicare assignment may not charge you more than 115% of the Medicare approved amount for a particular service. (This is known as the "limiting charge.") In this case, you are responsible for paying 20% of the Medicare approved amount, after meeting your deductible, plus the additional 15%.

Beginning in 1998, physician can choose not to participate or accept Medicare payments. Medicare will not pay for any services provided by a physician who has chosen to opt out. Physicians who opt out of Medicare must notify patients before treating them. If you have been notified and choose to continue receiving services from a physician who has opted out of Medicare, you must pay the full cost for that physician's services.

Medicare+Choice

When you choose a Medicare+Choice Health Plan, your health care is 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+Choice Health Plans also include private Fee-for-Service plans and Medical Savings Accounts.

Medicare+Choice Health Plans provide 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; and
- Health education and wellness programs.

You usually pay a small copayment when you receive medical care covered under a Medicare+Choice Health Plan. Also, you pay the Part B premium plus any additional premium charged by the Medicare+Choice Health Plan. Both the Part B premium charged by Medicare and the premium charged by the Medicare+Choice Health Plan are subject to change each year.

Medicare Part D Prescription Drug Coverage

This summary provides some general information about Medicare Part D, but does not explain all of the program's benefits and features. If you have specific questions, contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available at www.medicare.gov (see Important Contacts).

Medicare Part D, which becomes effective for enrollees on January 1, 2006, helps pay for both brand name and generic drugs at participating pharmacies in your area. You pay a monthly premium for this coverage, just like you do for Medicare Part B. For 2006, Medicare Part D will have a $250 deductible that you must satisfy before Medicare will pay benefits for your prescription expenses. After this deductible is met, you will still pay a portion of your prescription costs, by paying a copayment or coinsurance. Depending on the Medicare Part D plan you choose, you may a lesser copayment or coinsurance for generic drugs than for brand name drugs. Some Medicare Part D plans may offer mail-order purchase of your medications. www.medicare.gov (see Important Contacts) provides more complete information about Medicare Part D, and you should carefully review this information, along with the information you receive from Medicare Part D prescription drug providers, to choose the plan that best meets your needs.

IMPORTANT NEWS FOR MEDICARE ELIGIBLE RETIREES/DEPENDENTS: Effective January 1, 2006, irrespective of whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, for those under age 65 retiree participants/dependents who are Medicare-eligible) ends, and your primary prescription drug coverage will be Medicare Part D. As such, it is very important that you enroll in Medicare Part D coverage immediately—as soon as you become eligible.

Your coverage under the TWA Retiree Medical Age 65 and Over Plan (or the TWA Retiree Medical Under Age 65 Plan, as noted above) will become your secondary coverage, and will coordinate benefits with Medicare Part D in the same manner that it coordinates with Medicare Parts A and B (or Medicare+Choice). Keep in mind that if you or your dependent(s) is(are) eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if you do not enroll in all or part of the Medicare program, your benefits under the TWA Retiree Health and Life Benefits Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

IF YOU HAVE OTHER COVERAGE

Coordination of Benefits

If you or any covered eligible dependents are covered under any other group medical plan, the TWA Retiree Medical Plan will coordinate benefits to avoid duplication of payment for the same expenses. The TWA Retiree Medical Plan will take into account all payments you have received under any other plan and will only supplement those payments up to the amount you would have received if the TWA Retiree Medical Plan was your only coverage.

The TWA Retiree Medical Plan does not coordinate benefits with any medical plan sponsored by any participating AMR subsidiary. If you or a covered eligible dependent is covered by a Company-sponsored plan, the TWA Retiree Medical Plan will not pay any benefits. While you are covered as your spouse's eligible dependent under a Company-sponsored medical plan, you must suspend participation in the TWA Retiree Medical Plan. If you or a covered eligible dependent is hospitalized when coverage begins, your prior coverage is responsible for medical services until you are released. If you have no prior coverage, this plan will only pay benefits for the portion of your stay occurring after you became eligible under this plan.

Other Plans

"Other group medical plan" includes:

- Employer-sponsored 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+Choice, and Medicare Part D) and Medicaid;
- Property or homeowner's insurance, or no-fault motor vehicle coverage, except if you have purchased this coverage.

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. If the TWA Retiree Medical Plan is the primary plan, it pays normal benefits without consideration of amounts payable under any other plan.

The following general rules determine which plan is primary:

- If you are covered by Medicare (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.
- 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.
- The TWA Retiree Medical Plan is primary to CHAMPUS.
- 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 primary and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless the divorce decree specifies otherwise (see QMCSO in the eligible dependents section of this guide).
    - 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 are divorced, the plan of the parent with custody is primary unless the divorce decree specifies otherwise (see QMCSO in the Eligible Dependents section of this guide).

- If your retiree medical coverage is the TriCare Supplement Insurance Option, TriCare is your primary coverage, and TriCare Supplement Insurance is your secondary coverage. If your Retiree Medical Benefit is the TriCare Supplement Insurance Option, the coordination of benefits is determined by the terms and provisions of this insurance. Consult the summary plan description provided by ASI for further information on coordination of benefits.

If you or your spouse is eligible for Medicare (including Parts A, B, Medicare+Choice, and/or Part D), even if 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 receiving Medicare benefits.

When the TWA Retiree Medical Plan is Secondary

Here is how to calculate benefits under the TWA Retiree Medical Plan when it is the secondary plan, and the primary plan is not Medicare:

- First, the normal benefits are calculated as though the TWA Retiree Medical Plan is the primary plan.
- Next, the amount paid by the primary plan is subtracted from normal benefits under the TWA Retiree Medical Plan.
- Finally, the TWA Retiree Medical Plan pays the difference, if any.

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 TWA Retiree Health and Life Benefits Plan coordinates benefits with Original Medicare (Parts A, B, and D) if you are eligible for such coverage. Coordination applies regardless of whether you are actually enrolled in Medicare coverage, and regardless of whether you select Original Medicare or a Medicare+Choice Health Plan.

Coordination with Medicare+Choice 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 TWA Retiree Medical Plan 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 TWA Retiree Medical Plan, the TWA Retiree Medical Plan pays its normal benefit amount.

TriCare Supplement Insurance Option Coordination of Benefits

If your Retiree Medical Benefit is the TriCare Supplement Insurance Option, your TriCare coverage is your primary coverage, and your TriCare Supplement Insurance Option is your secondary coverage. Consult the coordination of benefits information in your TriCare Supplement Insurance summary plan description (this document is available from ASI, the administrator of the TriCare Supplement Insurance Option).

FILING MEDICAL CLAIMS

This section explains the procedures for filing claims under the TWA Retiree Medical Plan (including the Retail Prescription Drug Program).

Whenever you file a claim, be sure to keep a copy of the claim and any other information (such as itemized bills) that you include with the claim. For information on requesting a second review or appealing a denied claim see Requesting A Second Review.

TWA Retiree Medical Plan Claims

UnitedHealthcare is the claims processor for the TWA Retiree Medical Plan. They provide claim services, but they do not insure these health benefits.

The following is a summary of how to file claims under the TWA Retiree Medical Plan.

- Complete a Medical Claim Form each time you receive medical services, and follow the instructions that accompany the form. If you are not eligible for Medicare and received services from a PPO provider, your provider will file the claim for you. For prescriptions, see Retail Prescription Drug Program.
- Submit all itemized receipts from your physician or other health care provider. A cancelled check is not acceptable.
- Submit the Explanation of Benefits (EOB) showing any amounts paid by other coverage you have that pays benefits as your primary coverage before the TWA Retiree Medical Plan. It is especially important that you include any Explanations of Medicare Benefits (EOMBs) if you are eligible for Medicare. (However, if Medicare is your primary plan, see Medicare Crossover for more information about how you should file claims.)
- Mail the completed claim form with the original itemized bills, receipts, and EOBs to UnitedHealthcare at the address on the claim form.

You must submit the original itemized bill or receipt provided by your physician, hospital, or other medical service provider, so you should make copies for your own records. Photocopies are not accepted. In addition, each bill or receipt must include 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 charges for the treatment or service; and
- Name of provider, address, and tax ID number.

All medical claims payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid. Payments may, however, be sent directly to your physician, hospital or other medical provider if your provider accepts assignments of benefits. In this case, the EOB will be mailed to you and the payment mailed to your provider. To request claim forms, call UnitedHealthcare and leave your request on the automated forms voicemail option. Requests are processed daily on weekdays.

It is extremely important that you fully complete the sections of the form dealing with other possible coverage. Examples of other possible coverage include a spouse's group health plan, Workers' Compensation, Medicare, CHAMPUS, and no-fault motor vehicle insurance. If you have questions about your coverage or your claim under the TWA Retiree Medical Plan, call the claims processor.

Hospital Bill Audit

If you are hospitalized and your hospital expenses exceed $10,000, the claims processor will compare your bill with hospital records to verify the expenses shown for your stay are correct. If any errors are discovered, the claims processor will make the necessary adjustments. You should not be affected by this procedure.

Retail Prescription Drug Program

Retirees under age 65 will pay the copayment amount at the PAID Prescriptions network pharmacies, administered by Medco.

Retirees age 65 and over:

- Pay the discounted price for your prescription when you fill it.
- Complete a PAID Prescriptions claim form and mail it to the address on the form. To request a claim form, call the Member Services number on your PAID Prescriptions ID card.
- PAID Prescriptions will process your claim and send the information to UnitedHealthcare for payment under the terms of your medical plan.

Claim Filing Deadline

You must submit all health claims within two years of the date the expenses were initially incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment.

Medicare Crossover

When you are covered by both Medicare and the TWA Retiree Medical Plan, you can avoid having to file claims twice by

using Medicare Crossover. With Medicare Crossover, when you file your Medicare claim, the information is sent electronically to the TWA Retiree Medical Plan for processing - so you don't need to file a separate claim form for each plan.

Using Medicare Crossover will make reimbursement faster. However, delays can occur in transmitting the information from Medicare to the TWA Retiree Medical Plan if your Medicare claim form is incomplete or inaccurate.

- For questions about Medicare Crossover, contact UnitedHealthcare.
- Call your state's Medicare claims processor with address changes or questions about Medicare.

Who Is Eligible

Medicare Crossover is available only if Medicare is your primary coverage. Medicare Crossover is available to retirees and Medicare-covered eligible dependents.

If your spouse has coverage under a group medical plan offered by another employer, he or she will not be eligible for Medicare Crossover under the TWA Retiree Medical Plan. However, your spouse should check to see if his or her employer offers a similar program for its employees and retirees.

How To Enroll

To take advantage of Medicare Crossover, you must complete and return an enrollment form available from UnitedHealthcare. There is no cost for participating in the program. Using Medicare Crossover won't change the amount of your benefits under Medicare or the TWA Retiree Medical Plan.

Medicare Crossover is available in all 50 states. If you live in a different state for part of the year, the enrollment form provides space for you to indicate the states in which you expect to have medical expenses. Your Medicare Crossover automatic filing will be set up with the Medicare administrator for the residences you indicate on your enrollment form. You may change your address or add addresses in additional states by contacting your Medicare claims processor.

Eligible Expenses

Medicare Crossover applies to:

- Medicare Part B - Physician-related expenses and durable medical equipment expenses; and
- Medicare Part A - Inpatient hospital expenses are not eligible for Medicare Crossover (The hospital files claims for inpatient hospital expenses directly with Medicare and UnitedHealthcare).

IMPORTANT: When you receive your Explanation of Medicare Benefits (EOMB), it will include a message telling you that your claim has been sent to the secondary plan (the TWA Retiree Medical Plan). If it does not indicate that your claim was forwarded, you must submit a claim to the TWA Retiree Medical Plan.

You will continue to receive a separate Explanation of Benefits (EOB) from the TWA Retiree Medical Plan. You can use your EOMB and your EOB to calculate any amounts you owe your medical service provider.

CONTINUATION OF COVERAGE

COBRA (Consolidated Omnibus Budget Reconciliation Act) Continuation Coverage

You and your covered eligible dependents have the right to elect to continue group health coverage if it would terminate for certain specified reasons. This continuation right is in accordance with the requirements of Federal Law (PL 99-272), as amended, and is available in the event your or your covered eligible dependents' coverage would terminate due to any of the following qualifying events:

1. Your termination of employment for any reason, except gross misconduct;
2. Loss of eligibility due to reduced work hours (i.e., personal leave of absence, military leave of absence) (If you take a Family Medical Leave Act (FMLA) leave of absence and do not return to active employment, the termination of employment occurs at the earlier of the end of the leave or the date that you give notice to the company that you will not be returning to your job, unless the company eliminates coverage before your last day

of FMLA leave for the class of employees to which you belong and continues to employ such class of employees.);
3. Your death;
4. Your divorce or legal separation from your lawful spouse;
5. Your entitlement to Medicare benefits under Title XVIII of the Social Security Act;
6. A dependent child ceasing to meet the plan's definition of an eligible dependent; or
7. In certain instances, the bankruptcy of the Company.

If one of your covered eligible dependents would lose coverage due to one of the reasons shown in 4 or 6 above, you or your covered eligible dependents must notify Employee Services @ 1-800-447-2000 within 60 days of the later of the event or the loss of coverage so that appropriate notice of continuation rights and the terms which apply to the continuation can be provided.

The Company has the responsibility to notify CONEXIS of your death, termination of employment or reduction in hours, or Medicare eligibility. Notice must be given to CONEXIS within 30 days of the event. When CONEXIS is notified that one of these events has happened, CONEXIS will in turn notify you that you have the right to choose continuation coverage. Under the law, you have until the later of 60 days from 1) the date you would lose coverage because of one of the events described above; or 2) your receipt of election notice from CONEXIS, to inform CONEXIS that you want to elect continuation coverage.

If you or your covered eligible dependents do not choose continuation coverage within the time period described above, the group health coverage will end. If you or your covered eligible dependents choose continuation coverage, the Company is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated TWA retirees or their family members. This means that if the coverage for similarly situated TWA retirees, or their family members is modified, your coverage will be modified. ("Similarly situated" refers to current TWA retirees or their dependents who have not had a qualifying event.)

If there is a choice among types of coverage under the plan, you and your covered eligible dependents are entitled to make a separate election among the types of coverage. Thus, a spouse or other eligible dependents is entitled to elect continuation of coverage even if the covered retiree does not make that election. Similarly, a spouse or other eligible dependent may elect a different coverage from the coverage that the retiree elects.

If the group health plan maintained by the Company under which you have coverage is limited to a specific geographical service area and you move away from the plan's service area, you will be given the opportunity to elect coverage under any other plan maintained by the Company that provides coverage in the area for similarly situated persons.

The law permits the company to charge any person who elects to continue coverage 102% of the full cost the plan pays for group health coverage.

Coverage cannot be continued beyond the earliest to occur of:

- The last date for which any required premium with respect to the qualified beneficiary was paid;
- Any date following your or your covered eligible dependent's election to continue coverage in which the person whose coverage is being continued becomes covered under another group health plan or entitled to Medicare benefits, unless a pre-existing condition provision excludes coverage;
- The date which the Company ceases to provide any group health plan (including successor plans) to any retirees or employees; or
- A date which is:
    - 18 months from the qualifying event, if coverage is being continued because you terminated employment or lost eligibility due to reduced hours;
    - 36 months from the qualifying event, if coverage is being continued because your covered eligible dependent lost coverage due to your entitlement to Medicare; however, if you also experience a termination of employment or a reduction of hours, your covered eligible dependents will be entitled to coverage for the later of 18 months (or 29 months of coverage if there is a disability extension, or 36 months after the date you become entitled to Medicare) if this will provide a longer period of coverage); or
    - 36 months from the qualifying event, if coverage is being continued for any other reason, unless you retired from the Company and experience a qualifying event that is the bankruptcy of the Company, in which case, you and your covered eligible dependents may be entitled to extended coverage.

If you or your qualified beneficiary were disabled at the time of termination or reduction in hours and continue to be disabled at the time of the qualifying event (determined by Social Security) or if you become disabled (as determined by Social Security) within the first 60 days of the qualifying event, you and your covered eligible dependents are entitled to the later of either 1) 29 months of continuation coverage; 2) coverage until the first of the month that is more than 30 days after you or the qualified beneficiary whose disability resulted in the extension from 18 months to 29 months are determined, pursuant to Title II or XVI of the Social Security Act, as no longer being disabled; or 3) the coverage period applicable to you or your covered eligible dependents.

In certain cases, the Company is permitted to charge you up to 150% of the applicable premium periods beyond which you or your covered eligible dependents receive continuation coverage beyond the applicable maximum period due to a disability. To maintain the coverage, it is necessary to pay the full cost of continuation of coverage on time, including any additional expenses permitted by law. If continuation of coverage is elected, monthly statements will be sent from CONEXIS indicating when each payment is due.

Refund of Premium Payments

If your covered eligible dependent elects continuation of coverage and later discovers that he or she does not meet the eligibility requirements for coverage (for example, if he or she becomes covered under any other group medical plan or becomes entitled to enroll in Medicare), he or she must contact CONEXIS within three months 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 of the amounts paid. If the amount of premium payments for continuation of coverage is less than the amount of these claims, no premium payment will be refunded and the participant will be responsible for the balance due. However, if the plan receives reimbursement for the claims, the plan will refund the premiums. This time limit for refunds also applies if the Company discovers that continuation of coverage has been provided to your eligible dependent in error.

TriCare Supplement Continuation

You have the ability to continue coverage under the TriCare Supplement Medical Option, as this coverage provides portability. Contact ASI/TriCare for more information.

RETIREE DENTAL INSURANCE PLAN BENEFITS

The Retiree Dental Insurance Plan was offered to TWA Retiree Health and Life Benefits Plan participants and their eligible dependents in November, 2001 -- this was a one-time offer of enrollment, and if you did not enroll in this plan during the "one-time only" enrollment period, you do not participate in this coverage. If you, at any time since the January 1 2002 effective date of the Retiree Dental Insurance Plan, allowed the coverage to terminate for any reason (including failure to timely pay the required ongoing monthly premiums to maintain this coverage), you are not eligible to re-enter/re-enroll in the plan.

The Retiree Dental Insurance Plan provides dental coverage for you and your eligible dependents. This dental coverage pays benefits for routine dental care and treatments for disease, defect, and injury.

You have the option to select any dentist. The Plan provides both in-network and out-of-network benefits. However, you can increase your out-of-pocket savings when you choose to visit an in-network participating Preferred Dentist Program (PDP) dentist. The MetLife PDP provides dental coverage at affordable group rates. As a member of this Plan, you will have access to over 47,000 highly qualified participating dentists who agree to accept negotiated fees.

Retiree Dental Insurance Benefits

Under the Retiree Dental Insurance Plan, services for most preventive and routine care are covered at 100%. Services such as fillings, simple extractions, labs and other tests are covered at 60%, while major restorative services are covered at 35%, once a $50 individual or $100 family annual deductible has been met.

Benefits Summary		
Type of Service	**In-Network[1]**	**Out-of-Network[2]**
Type A - Preventive	100% when performed by a PDP	100% Reasonable and Customary Fees
Type B - Basic Restorative	60% when performed by a PDP	60% Reasonable and Customary Fees

Type C - Major Restorative	35% when performed by a PDP	35% Reasonable and Customary Fees
Annual Deductible[3] (Applies to Type B and C Services)		
	In-Network	**Out-of-Network**
Individual	$ 50	$ 50
Family	$100	$100
Annual Maximum Benefit[3]		
	In-Network	**Out-of-Network**
Per Person	$1,000	$1,000

[1] **"In-Network Benefits": When you or your eligible dependent visit a participating Preferred Dentist Program (PDP) dentist, plan benefits are based on a negotiated fee schedule. You are responsible for the difference between the negotiated PDP fee for a given service and the percentage of the PDP fee that your Plan covers for that service, subject to your deductible.**

[2] **"Out-of-Network Benefits": When you or your eligible dependents visit a non-participating dentist, plan benefits are based on the Reasonable and Customary charges of dentists in your area, as determined by MetLife for your plan. You are responsible for the difference between your dentist's charge for a given service and the percentage of Reasonable and Customary fee that your plan covers, subject to your deductible.**

[3] **The annual deductible applies to both in-network and out-of-network benefits. You do not have to satisfy a separate deductible for each. In addition, the annual maximum applies to in-network and out-of-network coverage. There is not a separate maximum for each. In order to meet a family deductible, two members of the family have to completely satisfy the individual deductible.**

How the Retiree Dental Insurance Plan Works

You can take advantage of savings under this Plan for services that are not covered by the Retiree Dental Insurance Plan. When you participate in the Preferred Dentist Program (PDP) and visit a network dentist, savings are passed on to you and your family through discounted fees on certain services that are not covered under the Plan. Your cost for these non-covered services will be less due to the reduced fees the participating dentist has agreed to charge.

Take a look at a hypothetical example that shows how visiting a PDP dentist can save you money. This example assumes you have met your annual deductible.

Example of Savings When You Visit a Participating PDP Dentist			
Take a look at a hypothetical example[1] that shows how visiting a PDP dentist can save you money:			
Type B Service: (Filling)		**Amount**	
PDP Fee Schedule Amount:		$65	
Dentist's Usual Charge:		$80	
Reasonable and Customary Allowable Amount:		$75	
When you visit a participating dentist (In-Network)		**When you visit a non-participating dentist (Out-of-Network)**	
PDP Fee Schedule Amount:	$65	**Dentist's Usual & Prevailing Fee:**	$80

Amount the plan pays (60% of the $65 PDP Fee Schedule):	-$39	**Amount the Plan pays (60% of the $75 Reasonable and Customary Amount):**	-$45
Your Out-of-Network Cost:	**$26**	**Your Out-of-Pocket Cost:**	**$35**

[1]This example assumes that you have met your annual deductible. In this example, you would $9.00 ($35.00 minus $26.00) — or 26% — by using a participating PDP dentist.

Terms You Should Know

The following is information you need to know about Retiree Dental coverage and circumstances that determine how benefits are paid:

Dentally necessary: Only dental services that are dentally necessary are covered by the Retiree Dental Insurance Plan. Cosmetic services are not covered. See the Glossary on page Error! Bookmark not defined. for the definition of "dentally necessary."

Predetermination of benefits: If your dentist estimates that charges for a procedure will be substantial, you should request predetermination of benefits before you receive treatment. However, it is recommended that you obtain predetermination for any proposed procedure. To request predetermination from MetLife, your dentist may complete the standard Dental Claim Form, indicating that it is for predetermination of benefits.

Alternative treatment: If you undergo a more expensive treatment or procedure when a less expensive alternative is available, the Retiree Dental Insurance Plan pays benefits based on the less expensive procedure that is consistent with generally accepted standards of appropriate dental care.

When expenses are incurred: For purposes of determining Retiree Dental Insurance Plan coverage and benefits, the dental expense is deemed to be incurred at the time of the initial treatment or preparation of the tooth.

The Preferred Dentist Program (PDP): The Retiree Dental Insurance Plan offers a network of over 70,000 participating dentists nationwide (general dentists and specialists) who provide fee discounts to Retiree Dental Insurance Plan participants. You are not required to use PDP network dentists, but will benefit from cost savings when you do. You can request a customized directory of participating dentists in your area by calling MetLife (see Contact Information on page Error! Bookmark not defined.).

Injury by others: If you are injured by someone else and the Retiree Dental Insurance Plan pays a benefit, the insurance company has the right to recover payment from the third party (see Subrogation).

Coordination of benefits: If you or a covered dependent has coverage under any other group dental plan, the Retiree Dental Insurance Plan coordinates benefits with the other plan. (See Coordination of Benefits in this Retiree Dental Insurance Plan section.)

Covered Dental Expenses

To be covered by the Retiree Dental Insurance Plan, a dental expense must be dentally necessary and provided by a duly qualified and licensed dentist or physician (unless specifically excluded). Charges for covered items must be within the reasonable and customary fee limits. The following dental services and supplies are covered by the Retiree Dental Plan:

What's Covered:	How Often/Limitations:
Type A - Preventive	
Cleanings	One cleaning per six-month period, not to exceed two cleanings per calendar year
Exams	One exam per six-month period, not to exceed two exams per calendar year
Fluoride Treatments	One fluoride treatment per calendar year for covered dependent children under

	age 19
X-rays	**Full mouth X-rays:** one per 60 months. **Bitewing X-rays:** one set per calendar year for covered adults; one set per six-month period for covered children — not to exceed two sets of x-rays per calendar year
Type B - Basic Restorative	
Crown, Denture and Bridge Repair	When dentally necessary: no limitations
Fillings	When dentally necessary; no limitations
Denture Relines and Rebases	Relines and rebases to dentures, limited to 36 months (covered only after six months following the initial installation)
Labs and Other Tests	When dentally necessary: no limitations
Simple Extractions	When dentally necessary: no limitations
Space Maintainers	Space maintainers for dependent children under age 19
Type C - Major Restorative Services	
Bridges and Dentures	Initial placement to replace one or more natural teeth that are lost while covered by the Retiree Dental Insurance Plan Dentures and bridgework replacement — one every five (5) years Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed.
Crowns/Inlays/Onlays	Crowns/Inlays/Onlays replacement: once every five (5) years
Endodontics	Root canal treatment limited to once per tooth per 24 months
General Anesthesia	When dentally necessary in connection with oral surgery, extractions, or other covered dental services
Oral Surgery	When dentally necessary; no limitations
Periodontics	Periodontic scaling and root planing, once per quadrant, per 24 months; Periodontic surgery, once per quadrant, per 36 months
Periodontic Maintenance	Total number of periodontal maintenance treatments and prophylaxis cannot exceed four (4) treatments per calendar year
Surgical Extractions	When dentally necessary; no limitations

Dentures and bridgework: Full and partial dentures and fixed bridgework, including:

- Installation of the initial appliance to replace natural teeth extracted, including adjustments within six months of installation
- Replacement if the appliance is more than five years old and cannot be repaired (Appliances that are over five years old but can be made serviceable will be repaired, not replaced)
- Installation of the appliance for teeth missing as a result of a congenital anomaly. (Charges are limited to the allowance for a standard prosthetic device.)

The total allowance for both a temporary and permanent denture or bridge is limited to the maximum benefit for a permanent denture or bridge. Charges are determined from the date the first impression is taken.

Extractions, necessary surgery, and related anesthetics: These services are considered covered dental treatments. However, fractures and dislocations of the jaw is included under the Retiree Medical Benefit Options.

Fillings and crowns: Silver (amalgam) or porcelain fillings and plastic restorations subject to the following:

- Porcelain crowns are covered only for the 10 front upper and 10 front lower teeth
- Porcelain or plastic facings on crowns posterior to the second bicuspid are not covered
- Gold fillings and crowns are covered only when the tooth cannot be restored with other materials
- Crowns may only be replaced if the existing crown is more than five years old, regardless of the reason for the replacement.

Oral examinations, x-rays, and laboratory tests: The following are covered if necessary to determine dental treatment:

- Full mouth x-ray once in any 60-month period
- Routine x-rays not more than once per six-month period, not to exceed two sets of x-rays per calendar year
- Other x-rays necessary to propose diagnosis or examine progress of treatment.

Periodontal treatment: Necessary periodontal treatment of the gums and supporting structures of the teeth and related anesthetics are covered.

Preventive treatment:

- Exams – once per six-month period, not to exceed two exams per calendar year
- Routine x-rays – once per six-month period, not to exceed two sets of x-rays per calendar year
- Teeth cleaning – once per six-month period, not to exceed two cleanings per calendar year
- Fluoride treatments once a year for children under age 19 (not covered on or after the child’s 19th birthday)
- Space maintainers for dependent children under age 19.

Root canals: Root canals and other Endodontics treatments are covered. The charge for root canal therapy is considered to have been incurred on the date the tooth is opened.

Benefits Limitations

The fact that a dentist recommends a dental service does not mean that dental expense benefits will be paid under the American Airlines Retiree Dental Insurance Plan. Dental expense benefits will be based on the most cost-effective materials and methods of treatment that meet generally accepted dental standards. MetLife's dental consultants may review dental services to determine whether the dental service is necessary in terms of generally accepted dental standards for the purpose of determining the extent to which dental expense benefits are payable under the American Airlines Retiree Dental Insurance Plan.

Dental Plan Exclusions (Excluded Expenses)

The following expenses are not eligible for reimbursement under the Retiree Dental Insurance Plan:

- Diagnosis, evaluation, or treatment of Temporomandibular joint disorders (TMJ)
- Services, treatments, and supplies received before Retiree Dental Insurance Plan coverage began
- Services and treatments not performed by a dentist, except cleaning and scaling of teeth and fluoride treatments performed by a licensed dental hygienist that is supervised and billed by a licensed dentist
- Cosmetic services, surgery, or supplies
- Treatments, services, and supplies covered by any workers' compensation laws, occupational disease laws, or employer's liability laws, or which an employer is required by law to furnish in whole or in part
- Services, treatment, and supplies received through a medical department or similar facility maintained by your employer
- Home health aids used to prevent decay, such as toothpaste and fluoride gels

- Appliances or treatment for bruxism (grinding teeth), including, but not limited to, occlusal guards and night guards
- Duplicate appliances or duplicate prosthetic devices
- Services, treatment, and supplies received where no charge would have been made in the absence of dental expense benefits, or which are not required to be paid
- Materials or services that are experimental under generally accepted dental standards
- Services, treatments, and supplies received as a result of dental disease defect or injury due to an act of war, or a warlike act in time of peace, which occurs while coverage is in effect
- Instruction for oral care such as hygiene or diet
- Periodontal splinting
- Benefits otherwise provided under your employer's plan or any other plan that your employer or an affiliate contributes to or sponsors
- Implants
- Charges for broken appointments or for completing dental forms
- Sterilization supplies
- Services, treatments, and supplies furnished by a family member
- For Type C Expenses:
    - Replacement of a lost, missing or stolen crown, bridge or denture;
    - Initial installation of a denture or bridgework to replace one or more natural teeth lost before the dental expense benefits started;
    - Replacement of an existing crown, removable denture or fixed bridgework unless it is needed because the existing crown, denture or bridgework can no longer be used and was installed at least 5 years prior to its replacement; and
    - Replacement of existing immediate temporary full denture by a new permanent full denture unless: (a) the existing denture cannot be made permanent, and (b) the permanent denture is installed within 12 months after the existing denture was installed
- Orthodontia
- Sealants
- Myofunctional therapy or correction of harmful habits
- Fluoride treatments over the age of 19.

Filing Dental Claims

MetLife is both the insurer and claims processor for the Retiree Dental Insurance Plan. Do not file claims with Ceridian. Ceridian's only function, with respect to the Retiree Dental Insurance Plan is to perform the direct billing services for payment of premiums.

Completing the Dental Claim Form

The following is a summary of how to file claims for dental expense benefits:

- Complete the top portion of the Dental Expense Claim form available on Jetnet. Follow the instructions that accompany the form and then present the form to your dentist, who completes the remaining portion.
- Mail the completed claim form to MetLife at the address on the form.
- All dental claim payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid. Payments may, however, be sent directly to your dentist or other dental provider if you provider accepts Assignment of Benefits. If you assign benefits to the service provider, the EOB will be mailed to you and the payment mailed to your provider.

Claim Filing Deadline

You must submit all dental claims **within two years** of the date the expenses were incurred. Claims submitted more than 24 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 under the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Cancellation/Termination of Retiree Dental Insurance Plan

Coverage under the Retiree Dental Insurance Plan is provided under a group insurance policy (Policy Form G2130-S) issued by MetLife. Coverage terminates when your dental contributions cease or upon termination of the Group Contract

by the Policyholder upon prior written notice to MetLife. MetLife may discontinue the group policy for non-payment of premium or if eligibility requirements are not met. There is a 31-day limit for the following services that are in progress:

- Completion of a prosthetic device
- Crown or root canal therapy after individual termination of coverage.

Coordination of Retiree Dental Insurance Plan Benefits

When You Have Other Coverage

Your Retiree Dental Insurance Plan includes a coordination of benefits (COB) provision that determines which plan is primary and how benefits will be paid when you or your dependent(s) are covered by more than one plan.

"Plan" means a plan that provides benefits or service for dental and is either a:

- Group insurance plan
- Group blanket plan but not including a school accident type of plan
- Group practice plan
- Group service plan
- Group prepayment plan
- Governmental program required by law, excluding Medicaid but including any No-Fault coverage required by law, OR
- Any other plan that covers people as a group.

Each policy or contract will be treated as a separate contract.

Which Plan Is Primary

When more than one plan covers a person, one plan is primary and another is considered secondary. The two plans will coordinate benefits with each other so the amount reimbursed is not more than 100% of the actual expenses. The order of benefit determination will be based on the following:

- Any plan that does not include a coordination of benefits provision is automatically considered as the primary plan
- As a Retiree, this Plan will determine your benefits first, unless benefits are payable under Medicare
- Any dependent who is still employed will have his or her plan considered as primary
- Any dependent child who is covered under more than one plan by his or her parents will have his or her primary plan determined by the parent whose birthday is earlier in the year. These parents must be married, or if not married, a court decree awards joint custody, without specifying that one party is not responsible for providing health care coverage

  Example: If one parent's birthday is January 8, and the other parent's birthday is March 3, then the plan covering the parent with the January 8 birthday will be considered primary

- If both parents have the same birthday (regardless of the year of birth), the plan that has covered the parent for the longer period of time will be considered primary
- If terms of a court decree specify one parent is responsible for health care and the plan is aware of those terms, that plan will be primary
- If none of the above rules determine the order of benefits, the plan that has covered the person for the longer period of time will be considered primary

When your Retiree Dental Insurance Plan is primary, it means that this Plan's benefits are determined first, and any other plan is considered secondary.

Additional Rules

The following sections apply to the Retiree Dental Insurance Plan.

- Eligibility Under Qualified Medical Child Support Order

- Coordination with Medicare
- Continuation of Coverage

TWA RETIREE LIFE INSURANCE BENEFITS

Retiree life insurance is term life insurance that pays a benefit to your designated beneficiary at the time of your death. The amount of your Retiree Life Insurance coverage depends on your workgroup at the time of your retirement, your age at retirement and, in some cases, the number of years you've been retired. Only employer paid life insurance, as described below, will be extended to eligible retirees.

"Term life insurance" is coverage that pays a death benefit but has no cash value. The TWA Retiree Life Insurance Plan is insured by MetLife.

Benefits

The following term life insurance benefits are extended only to retired TWA Pilots:
If you worked for Trans World Airlines, Inc. and/or TWA Airlines LLC for less than 10 years, all of your Life Insurance will cease on your retirement date.

If you worked for Trans World Airlines, Inc. and/or TWA Airlines LLC for 10 or more years and retired on early official or normal, or disability retire with at least five years of service, life insurance in the amount of $50,000 will be continued for the first year after you retire. Then, on each anniversary of your retirement, this amount will be reduced by $5,000 until $20,000 is reached.

If you continued to work beyond age 60, then at your actual retirement, the life insurance was converted, subject to additional reductions as discussed above, to the amount shown below:

Age of Actual Retirement	Amount of Basic Life Insurance
60	$50,000
61	$45,000
62	$40,000
63	$35,000
64	$30,000
65	$25,000
66 and Over	$20,000

The following term life insurance benefits are extended only to retired TWA Mechanics and Related Employees, TWA Passenger Service Employees and TWA Flight Attendants:
If you are a retired Mechanic and Related Employee or Passenger Service Employee and you retired from Trans World Airlines, Inc. or TWA Airlines LLC on or after August 1, 1999, term life insurance in the amount of $20,000 is provided for one year after your retirement. Thereafter, your life insurance is reduced by $2,000 per year until $10,000 is reached. In order to be eligible for the retiree life insurance, you must have worked for Trans World Airlines, Inc. and/or TWA Airlines LLC for 10 or more years and retired on or before age sixty-five (65).

If you are a retired Mechanic and Related Employee or Passenger Service Employee and you retired from Trans World Airlines, Inc. before August 1, 1999, life insurance in the amount of $10,000 is provided for one year after your retirement. Thereafter, your life insurance is reduced $1,000 per year until $5,000 is reached. The eligibility requirements are the same as above.

If you are a retired Flight Attendant and you retired from Trans World Airlines, Inc. or TWA Airlines LLC on or after August 1, 1999, life insurance in the amount of $20,000 is provided for one year after your retirement. Thereafter, your life insurance is reduced by $2,000 per year until $10,000 is reached. In order to be eligible for retiree life insurance, you must have worked for Trans World Airlines, Inc. and/or TWA Airlines LLC for 10 or more years and retired after age fifty (50). If you are a retired Flight Attendant and you retired from Trans World Airlines, Inc. before August 1, 1999, life insurance in the amount of $10,000 is provided for one year after your retirement. Thereafter your life insurance is reduced $1,000 per year until $5,000 is reached.

The following term life insurance benefits are extended only to retired TWA Flight Dispatch Officers:
If you worked for Trans World Airlines, Inc. and/or TWA Airlines LLC less than 10 years, all of your life insurance will cease when you retire.

If you are age 65 or younger and retired after working for Trans World Airlines, Inc. and/or TWA Airlines LLC for 10 or more years or "Officially Retired," your life insurance, in the amount of $25,000, will be continued for the first year after your retirement. On each anniversary of your retirement, this amount will be reduced by $2,000 until the percentage shown in the following schedule is reached:

Years of Trans World Airlines, Inc., and/or TWA Airlines LLC Service	Insurance Continued: Percentage of the greater, $25,000 or your annual Basic Earnings
10 but less than 15	20%
15 but less than 20	25%
20 or longer	30%

The amount of your life insurance produced by this schedule will be rounded to the nearer $1,000 and will be based on your annual basic earnings immediately prior to your retirement. If you continue to work beyond age 65, then upon your actual retirement, your retiree life insurance will be continued at the amount you would have had, had you retired at age 65. In no event will the amount of your retiree life insurance continued at your retirement be an amount greater than the amount in force on your last day of active service.

The following term life insurance benefits are extended only to retired TWA Non-Contract, Non-Management Employees:

If you worked for Trans World Airlines, Inc. and/or TWA Airlines LLC for less than 10 years, all of your life insurance will cancel on the date your employment terminates.

If you are age 65 or younger and retired under the Noncontract Retirement Plan after working for Trans World Airlines, Inc and/or TWA Airlines LLC for 10 or more years or "Officially Retire," as defined by TWA Airlines LLC policy:

- as a Part-time Employee, $5,000 of life insurance will be continued during the first year of your retirement. On each anniversary of your retirement this amount will be reduced by $500 until $2,500 is reached.
- as a Full-time Employee, $10,000 of life insurance will be continued during the first year of your retirement. On each anniversary of your retirement, this amount will be reduced by $1,000 until $5,000 is reached.

If you continued to work beyond age 65, then at your actual retirement, your life insurance was converted, subject to further reductions as discussed above, to the amount shown below:

Age at Actual Retirement	Amount of Life Insurance for Part-time Employees	Amount of Life Insurance for Full-time Employees
65	$5,000	$10,000
66	4,500	9,000
67	4,000	8,000
68	3,500	7,000
69	3,000	6,000
70	2,500	5,000

The following term life insurance benefits are extended only to retired TWA Management Employees:

If you worked for Trans World Airlines, Inc. and/or TWA Airlines LLC less than 10 years, all of your life insurance will cease when you retire.

If you are age 65 or younger and retired after working for Trans World Airlines, Inc. and/or TWA Airlines LLC for 10 or more years or "Officially Retired," your life insurance will be continued in accordance with the following schedule:

Years of Trans World Airlines, Inc., and/or TWA Airlines LLC Service	Insurance Continued: Percentage of the greater, $25,000 or your annual Basic Earnings
10 but less than 15	20%
15 but less than 20	25%
20 or longer	30%

The amount of life insurance produced by this schedule will be rounded to the nearer $1,000 and will be based on your annual basic earnings immediately prior to your retirement.

However, if the schedule produces an amount less than $10,000, your life insurance will continue in the amount of $10,000 for one year after your retirement. Each year thereafter, your life insurance amount will be reduced by $1,000 until the greater of the amount produced by the schedule or $5,000 is reached. Should the schedule produce an amount of life insurance greater than $10,000, the amount will not be reduced.

If you continue to work beyond age 65, then upon your actual retirement, your retiree life insurance will be continued at the amount you would have had, had you retired at age 65. In no event will the amount of your retiree life insurance continued at your retirement be an amount greater than the amount in force on your last day of active service.

Beneficiary Designation

For retiree life insurance coverage, benefits are paid to the named beneficiaries on file at MetLife in the event of your death. You may change your beneficiary designation at any time by filing a new form with MetLife. Beneficiary information cannot be given out or changed over the telephone. For your protection, it must be requested or changed in writing.

Unless prohibited by law, your life insurance benefits are distributed as indicated on your Beneficiary Designation Form. For this reason, you should review your beneficiary form periodically, especially if you get married, divorced, or your spouse dies.

When a beneficiary is a minor (under the legal age defined by the beneficiary's state of residence), a guardian must be appointed in order for the life insurance benefits to be paid. MetLife requires a certified court document appointing the guardian of the minor's estate or property. If the beneficiary does not have a guardian, the life insurance benefits will be retained by MetLife and interest compounded daily until the minor child reaches the legal age.

To avoid complications in paying beneficiaries, an organization or endowment should not be named unless it is a legal entity (has a legal existence, such as a corporation or trust). If you designate a trust, MetLife assumes that the designated trustee is acting in a proper fiduciary capacity unless written notice to the contrary is received at the home office of MetLife.

MetLife and the Company are not liable for any payment made to a trustee before receiving such written notice. If the full amount of your insurance is not payable to the trustee or if a testamentary trustee is named, write to MetLife for assistance in proper documentation.

If your beneficiary is not living at the time of your death, the benefits under your coverage are paid to the first class of surviving family members in the order outlined below:

- Spouse;
- Children or stepchildren;

- Parents;
- Brothers and sisters; then
- Estate.

Conversion Rights
If coverage reduces after you retire, and you wish to keep it at the higher level, you can convert the amount of the reduction in coverage to a personal policy (other than term life insurance) offered by MetLife, without providing proof of good health.

To convert to a personal policy, a Conversion Notice and first payment must be received by MetLife within 31 days of the date coverage was reduced. You may request a Conversion Notice by contacting MetLife. If you apply within this 31-day period, MetLife will not require you to provide proof of good health.

If you should die during the 31-day period, whether or not the conversion policy has been applied for, MetLife will pay the appropriate beneficiary a death benefit equal to the amount of life insurance you had on the date coverage was reduced.

Verbal Representations
Nothing you say regarding this insurance is binding on anyone unless you or your beneficiary has something in writing from the Company or the claims processor confirming your coverage.

Claims Payment
In order to process this benefit, the Company must have an original certified death certificate. The original death certificate will not be returned because MetLife will need to retain it for their records.

The life insurance claim will be paid approximately three to four weeks after MetLife receives all necessary documentation.

ADMINISTRATIVE INFORMATION
Information About Claims
Confidentiality of Claims
The Company and its agents (including the claims processors) 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 properly administer coverage. The Company treats your medical information as confidential and discloses it only as may be required for the administration of the plan (as described in this paragraph) or as may be required by law.

Payment of Benefits
Benefits will be paid to you unless you have assigned payment to your provider (as explained in this section). They will be paid as soon as satisfactory written proof of a claim is received by the claims processor. 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 claims processor 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.

Assignment of Benefits
You may request that the claims processor pay your service provider directly by assigning your benefits. You may assign

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.

Right to Recovery

If claims payments are more than the amount payable under this plan, the claims processor may recover the overpayment. The claims processor may seek recovery from one or more of the following:

- Any plan participant to whom the payment was made;
- Any other self-funded plans or insurers;
- Any institution, physician, or other service provider; and
- Any other organization.

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

Reimbursement

If you recover damages for an injury or illness (for example, if you receive a settlement from the person that caused the injury or illness or that person's insurance carrier), the plan has a right to be reimbursed for the amount of benefits it has paid on your behalf for treatment of the injury or illness.

As a condition for receiving benefits under this plan, you:

- Grant the plan a first lien against any settlement, verdict, or other amounts you receive;
- Assign to the plan any medical benefits you are eligible to receive under an automobile policy or other coverage, up to the amount this plan has paid in benefits;
- Agree to sign and deliver any documents necessary to help the plan protect its rights (refusal to sign these documents does not diminish the plan's reimbursement rights); and
- Assist the plan by complying with any reasonable request to help the plan recover any benefits it has paid, without taking any action that may prejudice the plan's right to reimbursement.

Subrogation

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

If someone else caused your injury or illness, this plan has the right to collect payment from the third party (or their insurance carrier) for the medical treatment of your injury or illness. The plan subrogates (substitutes) its own rights for your rights.

This means the plan will be paid first from any settlement or judgment you receive. The plan may assert this right independently of you.

As a condition for receiving benefits under this plan, you agree to:

- Cooperate with the plan to protect the plan's subrogation rights;
- Provide the plan with any relevant information it requests;
- Obtain consent of the plan before releasing any party from liability for payment of medical expenses; and
- Sign and deliver documents regarding the plan's subrogation claim, if requested. (Refusal to sign these documents does not diminish the plan's subrogation rights.)

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 plan. The plan will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs.

Requesting a Second Review

The claims processor will process your completed claim promptly. If your claim is denied in whole or in part, the claims processor will give you a written notice of denial within 90 days of receipt of your completed claim. (Under special

circumstances, the claims processor may be allowed an additional 90 days.) This notice will include a specific reason for the denial. The claims processor may request additional information necessary for further consideration of your claim. If you feel that your claim should not have been denied (in whole or part) you or your authorized representative has the right to request that the claims processor conduct a second review of claim denial within 90 days of the denial.

Under the TWA Retiree Medical Plan, you must complete a Request for Second Review of Claim Denial form. You may request this form by calling UnitedHealthcare. The form advises you of the information you must include with your request for a second review to ensure a complete and fair review based upon the provisions and guidelines of this plan. Send the completed form, along with a copy of all supporting documentation, to the claims processor within 90 days of receipt of the claim denial. If you don't file it within 90 days, you lose your right to request a second review and to later file an appeal.

The claims processor will provide a written response regarding re-evaluation of your claim within 90 days of receipt of the completed Request for Second Review of Claim Denial form.

Filing an Appeal

If, after re-evaluating your claim, the claims processor determines that you are still not entitled to the claimed benefit, you may then file an appeal with the Company. You must complete and file an Application for Appeal within 90 days of receiving notice that the second review of your claim was denied. You may obtain the form by calling Employee Services at 1-800-447-2000.

The Application for Appeal advises you of the information to include. You must complete the form and provide all requested information or your appeal will not be considered. You must file your appeal within 90 days after you receive the claims processor's second review or your right to appeal is waived. Be sure to include a copy of the claims processor's second review denial letter. A copy of the Explanation of Benefits (EOB) alone is not sufficient.

Send the Application for Appeal and any additional evidence or documentation in support of your claim to the Pension Benefits Administration Committee (PBAC).

After your appeal information is received, your case will be reviewed under the guidelines of the PBAC. Appointed officers of the Company are on the committee. In some cases, the officers designate another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the claims processor (if appropriate), will be reviewed by the PBAC or its designees. A written decision regarding your case will be sent to you within 60 days after the PBAC has received all information pertinent to your appeal. Under special circumstances, the PBAC may be allowed an additional 60 days. The decision of the PBAC is final. If you still feel that your claim has been improperly denied, refer to the section of this guide entitled "Your Rights" for a description of your legal rights.

Administrative Information

Your Rights

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result

of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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

New: You may also request a certificate of creditable coverage within 24 months after your coverage has ended. To request a certificate of creditable coverage, contact HR Employee Services (see Contact Information below), either by phone, by e-mail, or by mail, and ask for a HIPAA certificate of creditable coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the 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 which 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 or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Where To Receive Help

For information on your claims, contact the claims processor at the addresses and phone numbers located in the Important Contacts section of this guide.

Plan Administrator:

American Airlines, Inc.
Mailing address:
Mail Drop 5134-HDQ
P. O. Box 619616
DFW Airport, Texas 75261-9616

Street address: (Do not mail to this address.)
4333 Amon Carter Blvd., MD5134
Fort Worth, Texas 76155

Claims Processor:
The claims processors for each plan are listed in the Important Contacts section of this guide.

Trustee:
State Street Bank & Trust
200 Newport Avenue
North Quincy, Massachusetts 02171

Employer ID Number:
13-1502798

Agent for the Legal Process:
Managing Director, Total Rewards
American Airlines, Inc.

Mailing address:
Mail Drop 5134-HDQ
P. O. Box 619616
DFW Airport, Texas 75261-9616

Street address: (Do not mail to this address)
4333 Amon Carter Blvd., MD5134
Fort Worth, Texas 76155

Service of legal process may also be made on the plan administrator.

Plan Name:
The TWA Retiree Health and Life Benefits Plan

This plan includes:

- TWA Retiree Medical Plan Under Age 65 and TWA Medicare Supplement Plan
- TWA Retiree Life Insurance
- TriCare Supplement Insurance Option

Plan Number:
511

Plan Year:
January 1 through December 31

About this Guide
This TWA Health and Life Benefits Guide ("guide") is the Summary Plan Description (SPD) for the TWA Retiree Health and Life Benefits Plan ("the plan") as it pertains to TWA retiree medical and life insurance coverage. The provisions of this guide apply to eligible retirees and eligible dependents, including spouses, who are covered under the TWA Retiree Medical and Life Insurance Plans.

The Company reserves the right to alter, amend, modify, or terminate this plan, any program described in this guide, or any part thereof at its discretion. Changes will not affect claims for services or supplies received before the change. Only the Pension Benefits Administration Committee (PBAC) is authorized to change this plan. From time to time, you may receive updated information concerning plan changes. Neither this guide nor updated materials are contracts or assurances of compensation or benefits of any kind. In the event of a conflict between the provisions of this guide and the provisions contained in any insurance policies for fully-insured programs, the policy shall govern in all cases with respect to retirees covered by such policy.

PLAN AMENDMENTS

The Benefits Strategy Committee ("BSC"), as appointed by the Chief Executive Officer, has the sole authority to adopt new employee benefit plans ("Plans") and terminate existing plans. The Pension Benefits Administration Committee (PBAC), as appointed by the Chief Executive Officer, has the sole authority to interpret, construe, and determine claims under the Plans. The PBAC also has the authority to amend the Plan or make recommendations to the BSC for material amendments to the Plans.

PLAN ADMINISTRATION

The plan is administered by American Airlines. The hospitals, physicians, and other service providers in the PPO network are completely independent of the Company. Neither the Company nor the network administrators are responsible for the medical services provided.

The coverage for the TWA Retiree Medical Plan Under Age 65 for 2002 is self-funded by Company contributions; a combination of Company contributions and contributions from the under age 65 retirees for 2003; and self-funded through retiree contributions for the TWA Medicare Supplement Plan. Retiree contributions as plan assets are held in a Voluntary Employee Benefit Association (VEBA) trust established under Section 501(c)(9) of the Internal Revenue Code. Self-funded benefits are paid from trust assets. The claims processors are independent companies that provide claim payment services. They do not insure these benefits. TWA Retiree Life Insurance is fully insured and premiums are paid by the Company. The TriCare Supplement Insurance Option is fully insured and underwritten by the Hartford Life and Accident Insurance Company and administered by the Association and Society Insurance Corporation (ASI). Premiums for this insurance are paid by retiree and Company contributions.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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 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 Protected Health Information 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 501), including the Employee Assistance Program (EAP),
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries(Plan 503),
- Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 510),
- Trans World Airlines, Inc. Retiree Health and Life Benefits Plan (Plan 511)
- American Airlines, Inc. Retiree Dental Plan(Plan 512), and
- 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, dental, vision, prescription drug, mental health, and health care flexible spending account benefits, are subject to the limitations described in this section.

The EAP is included only to the extent it is involved in the provision and 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:

- Disability plans (short-term and long-term disability)
- Life insurance plans, including accidental death & dismemberment (AD&D) *
- 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.

***This is the formal name of the benefit plan. Only the Health plan components of this benefit plan are covered by this section. Life insurance and other non-Health benefits are not subject to this section**

The Plans will disclose Protected Health Information 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 Protected Health Information 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 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 employee benefit plan of the Plan Sponsor employer, unless that use or disclosure is permitted or required by law (for example, for Workers Compensation programs);
- 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 individuals' 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;
- 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 Protected Health Information:

- 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;
- PBAC Appeals group personnel involved in receiving, researching, and responding to health plan member appeals filed with the PBAC;
- Employee 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 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 personnel, and thus have access to the call center systems;
- HR Records Room personnel responsible for managing benefit plan record storage;
- Certain Management Advisory Services (MAS) 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 paralegal and administrative assistants, and Legal Records Room personnel who manage record storage;
- 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;
- 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 protected health information, 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 Protected Health Information 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 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 Protected Health Information 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 noncompliance 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 noncompliance.

Other Related Information:

HIPAA Authorization Form and Instructions
HIPAA Authorization Form and Instructions
HIPAA Privacy Notice

(These forms are available on the forms menu of *Jetnet.*)

CLAIMS FILING AND APPEALS INFORMATION

Administrative Changes for Filing Claims and Appeals

The following section outlines revised federal regulations for claim and appeal procedures for ERISA-governed employee benefit plans (this includes American Airlines, Inc. sponsored health and welfare benefit plans). These revised regulations apply to claims or appeals submitted under the group health plans on or after January 1, 2003.

Definitions Used in the Procedures

The following terms have specialized definitions (required by the federal regulations); therefore, it is necessary to understand their meanings within the context of the revised procedures.

Claims Involving Urgent Care

- Claim for medical care or treatment for which the time periods for making non-urgent claim determinations:
    - Could seriously jeopardize claimant life or health or ability to regain maximum function, or
    - Physician with knowledge of claimant's condition determines that such time would subject claimant to severe pain that cannot be managed without the care/treatment that is the subject of the claim.

Determination of "claim involving urgent care" is made by an individual acting on behalf of the plan, applying judgment of prudent layperson with average health/medical knowledge, or

Physician with knowledge of claimant's medical condition can determine "claim involving urgent care" and agents of the plan must accept physician's determination.

Concurrent Care Claim

A claim for which benefits or an ongoing course of treatment have been approved for a period of time or number of treatments.

Pre-service Claim

Any claim that, under the terms of the plan, requires approval in advance of obtaining medical care in order to receive benefit.

Post-service Claim

Any claim that, under the terms of the plan, does not require approval in advance of obtaining medical care in order to receive benefit.

Adverse Benefit Determination

- Denial, reduction, termination of, or failure to provide/pay a benefit under the plan; and/or
- Denial, reduction, termination of, or failure to provide/pay a benefit based on a claimant's eligibility to participate in the plan; AND/OR
- Denial, reduction, termination of, or failure to provide/pay a benefit based on application of utilization review; and/or

- Denial, reduction, termination of, or failure to provide/pay a benefit based on plan provisions involving experimental/investigational treatment or medical necessity.

Notice, Notification

Delivery in a manner that ensures actual receipt of the information by plan participants and beneficiaries (e.g., in-hand delivery to employee at his/her worksite; insert in a periodical distributed to employees; distribution via first class mail (or be second or third-class mail with return and forwarding postage guaranteed and address correction requested).

Group Health Plan

- An employee welfare benefit plan (maintained by an employer or employee organization) providing, through insurance or otherwise:
    - medical, surgical, or hospital care or benefits; dental care benefits; and/or
    - benefits in event of sickness, accident, death, or unemployment.

Health Care Professional

State-licensed physician or other health care professional (licensed to perform specified health services consistent with state law).

Relevant

Document, record, or other information that:

- Was relied upon in making the benefit determination; and/or
- Was submitted, considered, or generated in the course of benefit determination, whether or not it was relied upon in making the benefit determination; and/or
- Is in compliance with administrative processes and safeguards designed to ensure and verify that benefit determinations have been made in accordance with plan provisions and that those provisions have been applied consistently and uniformly;
- With regard to a group health plan, statements of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, whether or not it was relied upon in making the benefit determination.

Claims Processing Requirements

- If a claimant (or his representative) submits a claim for benefits that does not comply with the plan's claim procedures, the plan must provide the claimant (or his representative) with oral or written notice of deficiency in the claim and the steps necessary to cure the deficiency within 5 calendar days of discovery of the deficiency.
- If a claimant (or his representative) submits a claim involving urgent care that does not comply with the plan's claim procedures, the plan must provide the claimant (or his representative) with oral or written notice of deficiency in the claim and the steps necessary to cure the deficiency with 24 hours of discovery of the deficiency. The claimant then has at least 48 hours to provide the specified information. Upon receipt of the specified information, or at the end of the additional period of time provided for the claimant to supply specified information, the plan administrator must render a decision on the claim not later than 48 hours after receipt.
- With respect to an urgent care claim submitted to the plan (provided the claim is complete and is not lacking any information necessary for determination), the plan administrator must render a decision on the claim ASAP, but no more than 72 hours after receiving the claim.
- Requests by the claimant for an extension of treatment involving urgent care beyond the period of time or number of treatments authorized must be decided as soon as possible-considering the medical urgency-and the plan administrator must notify the claimant of the benefit determination (either favorable or unfavorable) within 24 hours after receipt of the claim, provided that the claimant's extension request was made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
- For pre-service claims, the plan administrator must make a benefits determination within 15 days of receiving the claim. This 15 day period may be extended for one additional 15 day period in cases where the extension is necessary due to matters beyond the plan's control and the plan administrator notifies the claimant (notification must occur before the expiration of the initial 15 day period) of the circumstances requiring the extension. If extension is necessary because the claimant has failed to submit the information necessary to decide the claim,

the notice of extension must specify what information is lacking and allow the claimant at least 45 days to provide the missing information.

- For post-service claims, the plan administrator must notify the claimant of an initial adverse benefit determination within a reasonable time, but not more than 30 days after receipt of the claim. This 30 day period may be extended for one additional 15 day period in cases where extension is necessary due to matters beyond the plan's control, and the plan administrator notifies the claimant (notification must occur before the expiration of the initial 30 day period) of the circumstances requiring the extension. If extension is necessary because the claimant has filed to submit the information necessary to decide the claim, the notice of extension must specify what information is lacking and allow the claimant at least 45 days to provide the missing information.

Appeals Processing Requirements

- A group health plan may not require a claimant to file more than 2 levels of appeal.
- To meet the requirement of reasonable claim procedures, a group health plan must meet the following requirements for appeal review of adverse benefit determinations:
- Give claimant at least 180 days to request a review of an adverse benefit decision under the plan's internal review processes;
- Provide for a review that accords no particular deference to the initial adverse benefit determination (referred to as de novo review, meaning "to look anew");
- For adverse benefit determinations involving medical judgment, issues of experimental or investigational treatment, and issues of medical necessity or appropriateness, the plan must have the review conducted through consultation with a health care professional who is independent of any health care professional involved with the initial denial determination and who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Inform the claimant of the identity of any medical or vocational entities consulted by the plan in connection with the claim at issue;
- In the case of a request for urgent care, provide expedited claim review process.
- Where claimant has requested review of a denied claim for urgent care, the plan administrator must render a review decision within 72 hours after receiving the request for review of the denial.
- If a group health plan has approved an ongoing course of treatment (concurrent care claim) to be provided over a period of time or for a specific number of treatments, any premature reduction or termination by the plan of such treatment is considered an adverse benefit determination. The plan administrator must notify the claimant of the adverse benefit determination far enough ahead of the reduction/termination to allow the claimant to lodge an appeal and obtain a review decision before the benefit can be reduced or terminated.
- For adverse benefit determinations made on pre-service claims, the plan administrator must decide the appeal of such determination within 30 days after receiving the claimant's appeal request. If the plan provides for 2 levels of review of an adverse determination, both appeals must be decided and decisions rendered within this same 30-day period.
- For adverse benefit determinations made on post-service claims under plans having only one appeal level, the plan administrator must render a review decision within 60 days of the claimant's appeal request. If the plan has 2 levels of appeals for adverse determinations, both appeal processes must be completed and decisions rendered within the same 60-day period.

IMPORTANT CONTACTS

For Information About:	Contact:	Phone/Web Site:
General Information		
General questions, information updates, and request forms)	**HR Employee Services** AMR Corporation MD 5141-HDQ P.O. Box 619616 DFW Airport, TX 75261-9616	**(800) 447-2000** **Web site:** jetnet.aa.com
Medical Plan		
TWA Retiree medical Plan Claims Processor	**UntiedHealthcare** AMR Medical Claim Unit P. O. Box 30551 Salt Lake City, UT 84130-0551	**(800) 638-9599** **www.myuhc.com**
Network Provider Listing	**UnitedHealthcare**	**(800) 638-9599** **www.myuhc.com**
Retiree Medical Plan Billing & Eligibility	**Ceridian** P. O. Box 544011 St. Petersburg, FL. 33747-4011	**(800) 995-9935**
QuickReview (For pre-authorization of hospitalization and surgery)	**UnitedHealthcare**	**(800) 638-9599**
CheckFirst	**UnitedHealthcare** 1600 West Plano Parkway Suite 100 Plano, TX 75075	**(800) 638-9599**
Continue Coverage for Incapacitated Child	**UnitedHealthcare** Statement of Health Underwriting 184 Shuman Blvd., Suite 400 Naperville, IL 60563-8493	**(800) 865-6098**
Nurse Advocate Program *For all self-funded TWA Retiree Plan medical coverage (not for HMO or TriCare Supplement)*	**UnitedHealthcare**	**(800) 638-9599**
Cancer Resource Network *For all self-funded TWA Retiree Plan medical coverage (not for HMO or TriCare Supplement)*	**UnitedHealthcare**	**(800) 638-9599**
NurseLine *For all self-funded TWA Retiree Plan medical coverage (not for HMO or TriCare Supplement)*	**UnitedHealthcare**	**(800) 638-9599**
TriCare Supplement Insurance Option		
• **Enrollment, member services, inquiries**	**ASI** 2301 Research Blvd., Ste 300 Rockville, MD 20850-6265	**(800) 638-2610, Ext. 255** **(800) 311-3124 (Fax)** **www.asicorptricaresupp.com** **E-mail:** **custsvc@asicorporation.com**

• **Claim Inquiries**	**ASI** P. O. Box 2510 Rockville, MD 20847	**(800) 638-2610, Ext 255** **(800) 310-5514 (Fax)**
• **DEERS**	**Defense Manpower Data Center Support Office (DMDC)** Attn: COA 400 Gigling Road Seaside, CA 8385506771	**(800) 538-9552** **(800) 866-363-2883 (for TTY/TTD)** **(831-655-8317 (Attn: CSO) (Fax)** **E-mail:** addrinfo@osd.pentagon.mil **Web site:** https://www.dmdc.osd
Prescription Drugs		
• **Retail**	**PAID Prescriptions** P. O. Box 1015 Parsippany, NJ 07054-5415	**(800) 988-4125** www.medcohealth.com
• **Mail Order**	**Medco** P. O. Box 98830 Las Vegas, NV 89195-0049	**(800) 988-4125** www.medcohealth.com
• **Prior Authorizations**	**Merck-Medco Managed Care** 8111 Royal Ridge Parkway Suite 101 Irving, TX 75063	**(800) 841-5345** www.medco.com
Medicare		
Medicare (For eligibility, enrollment premiums, and lost Medicare cards; for Medicare publications, policies, and Medicare+Choice Health Plans in your area)	**Social Security Admin:** **Medicare:**	**(800) 772-1213** **(800)440-6081** www.medicare.gov
Continuation of Coverage (COBRA)		
COBRA Continuation of Coverage	**CONEXIS**	**(877) 902-9207** www.conexis.org
Term Life Insurance		
Term Life Insurance	**MetLife**	**(800) 440-6081**
TWA Retiree Dental Insurance Plan		
• Plan Design or coverage questions	**MetLife** AMR Dental Claim Unit P. O. Box 6086 Utica, NY 13504-6086	**(800) 438-6388** www.metlife.com/dental
• Enrollment, Billing, or Eligibility Questions	**Ceridian** P. O. Box 534011 St. Petersburg, FL 33747-4011	**(800) 995-9935** www.ceridian-benefits.com

GLOSSARY OF TERMS

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, to diagnose or treat a patient. Examples include fees for x-rays, lab tests, medicines, operating rooms, and medical supplies.

Assignment of Benefits: You may authorize the claims processor to directly reimburse your medical service provider for your *eligible medical expenses* by requesting that the provider accept 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.

Basic Earnings: The term basic earnings means the employee's base pay, excluding foreign increment and living allowances, incentive compensation, bonus or any other additional compensation. The amount of earnings which American Airlines, Inc. or TWA Airlines LLC reports to insurers for any *retiree* will be considered conclusive.

Child: See Eligibility and Enrollment (Dependents)

Chiropractic Care: Diagnosis, treatment, or care for an *injury* or illness when provided by a licensed chiropractor.

Coinsurance: You pay a percentage of *eligible medical expenses* and the TWA Retiree Medical Plan pays the remaining percentage. For example, after you satisfy your deductible under the TWA Medicare Supplement Plan, you pay 20% coinsurance for most *covered expenses* and the TWA Retiree Medical Plan pays 80%.

Company: American Airlines or a participating AMR Corporation subsidiary.

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; and
- Is not an institution for rest, education, or *custodial care*.

Copayments: The specific dollar amount you pay for certain services such as mail order service for *prescription drugs*, or an office visit if you are in the Under Age 65 plan.

Covered Expenses: The term *covered expenses* means the usual and prevailing fee charge incurred, but only those incurred after you and your covered *eligible dependents* become covered, for services and supplies that are recommended by a *physician* and are *medically necessary* for the care and treatment of the *injury*, sickness or pregnancy.

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 medical expenses* a person or family must pay before a plan will begin reimbursing *eligible medical expenses*.

Dentist: The term dentist means an individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition a *physician* will be considered to be a dentist when he or she performs any of the dental services under the terms of the comprehensive dental plan and is operating within the scope of his or her license.

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 Dependent: See Eligibility and Enrollment (Dependents)

Eligible Medical Expenses: The TWA Retiree Medical 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.

Employee: The term *employee* means a regular full-time employee or a regular part-time employee of the *Company*.

Employer: The term *employer* means American Airlines, Inc. or TWA Airlines LLC, which contributes to the coverage described in this guide.

Expenses Incurred: An expense will be considered to be incurred at the time the service or the supply is actually provided.

Experimental or Investigational Service: A service or supply is experimental or investigational if it meets all 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, or medical treatment is the subject of ongoing phase I, II or III clinical trials or under study (or that the consensus 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, device, or medical treatment 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 or opinion among medical experts.

Explanation of Benefits (EOB): A statement provided by the claims processor that shows how a service was covered by the plan, how much is being reimbursed, and what portion (if any) is not covered.

Free Standing 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; and

- Responsible for maintaining facilities on the premises for surgical procedures and treatment; and 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.

Hospital: An institution, which is primarily engaged in medical care or treatment at the patient's expense and is either:

- Accredited as a hospital by the Joint Commission on the Accreditation of Health Care Organizations;
- Recognized under *Medicare* as a hospital or psychiatric or tuberculosis hospital and is eligible to receive *Medicare* payments; or
- Supervised by a staff of physicians, has 24-hour nursing services, maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment, and operates continuously.

Hospitalization or Hospital Stay: See the term *Inpatient*.

Incapacitated Child: A *child* who is incapable of self-support because of a physical or mental condition and who legally lives with the employee or retiree and depends on the employee or retiree for support.

Injury: The term *injury* means an accidental bodily injury and will include all injuries received by an individual in any one accident.

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

Long Term Disability: Long Term Disability means long term disability income protection insurance for the totally disabled employee.

Medical Maximum Benefit: The most the plan will pay for eligible expenses during the entire time a person is covered by the plan.

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 TWA Retiree Medical Plan determines medical necessity based on and consistent with standards approved by the 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; and
- Either:
    - Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications; or
    - Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institute 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 or experimental in nature.

In the case of confinement in a hospital, the length of confinement and *hospital* services and supplies are considered medically necessary to the extent the claims processor or QuickReview determines them to be:

- Appropriate for the treatment of the illness or *injury*;
- Not for the patient's scholastic education, vocation, or training; and
- 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.

Medicare: The term *Medicare* means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

Mental Health Disorder: A neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disease or disorder of any kind.

Network: A group of *physicians*, *hospitals*, pharmacies, and other medical service providers who have agreed to provide discounted fees for their services.

Nurse: 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. This term includes all of the following professional designations:

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

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: 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, but is not limited to, the following licensed individuals, listed alphabetically:

- Audiologist;
- Certified social worker or advanced clinical practitioner;
- Chiropractor;
- Clinical psychologist;
- Doctor of osteopathy (D.O.);
- Medical doctor (M.D.);
- Nurse anesthetist;
- Nurse practitioner;
- Physical or occupational therapist; and
- Speech pathologist or speech language pathologist.

Preferred Provider Organization (PPO): A group of *physicians*, *hospitals*, and other health care providers who have agreed to provide medical services at negotiated rates. The medical coverage for under age 65 TWA retirees is a "Preferred Provider Organization (PPO)" style plan.

Pre-existing Condition (or Pre-existing Condition Limitation): A pre-existing condition includes any physical or mental condition that was diagnosed or treated before the participant's original coverage effective date (the date first enrolled in coverage) in the health plan and which will not be covered under that plan for a specified period after enrollment.

Prescription Drugs: Drugs and medicines that must be accompanied by a *physician's* written order and dispensed only by a licensed pharmacist. Prescription drugs also include injectable insulin and prenatal vitamins while pregnant.

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* criterion as defined in this section.

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; and
- 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*; and
- 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*; or
- Educational care.

Reliable Evidence: Reliable evidence includes:

- Published reports and articles in the authoritative medical and scientific literature (including, but not limited to: AMA Drug Evaluation, American Hospital Formulary Service Drug Information, U. S. Pharmacopedia Dispensing Information, and National Institutes of Health);

- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment, or procedure; and

- Written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

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.

Restorative and Rehabilitative Care: Care that is expected to result in an improvement in the patient's condition and restore reasonable function. After improvement ceases, care is considered to be maintenance and is no longer covered.

Retiree: The term Retiree means those employees who retired from Trans World Airlines, Inc., TWA Airlines LLC (provided he or she did not elect to participate in the American Airlines, Inc. retiree benefits program); Ozark Air Lines, Inc. or Trans World Express.

School: Regular attendance at an educational institution, including a vocational or technical school, if the student is enrolled:

- In a program leading to a degree or certificate; and

- On a full-time basis (generally 12 credit hours at colleges and universities).

Special Dependent: A foster child or *child* for whom you are the legal guardian.
Spouse: Your lawful spouse.

Urgent 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, and sprains.

Usual and Prevailing Fee Limits: The maximum amount the plan will consider as an *eligible medical expense* for medical services and supplies. The following factors are considered when determining if a charge is within the *usual and prevailing fee limits*:

- The range and complexity of the services provided; and
- The typical charges in the geographic area where the provider is located and other geographic areas with similar medical cost experience.

The claims processors for the medical and dental plans use computerized databases of claims activity by procedure code, zip code area, and date of service to determine the *usual and prevailing fee limit*. If the database does not contain a statistically significant number of claims for a particular procedure, the *usual and prevailing fee limit* is determined according to the relative unit value method.

Under the relative unit value method, every procedure is assigned a specific unit value based on a standard professional reference. These unit values are assigned according to the complexity of a procedure. The unit value is then multiplied by a dollar value per unit. (This dollar value is referred to as the "area conversion factor" and is determined by statistical calculations that take into account all charges from a particular zip code area.) The fee determined as a result of this multiplication is the maximum charge allowed under the plan.

Under the medical plans, when the claims processor reviews a claim for usual and prevailing fees, it 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. In such cases, the plan will pay for the services as a group and not individually. Coding individual services and procedures (called "coding fragmentation" or "unbundling") usually results in higher *physician* charges than if coded and billed on a more appropriate combined basis.

For example, the appendix is often removed by the surgeon during a hysterectomy. The appropriate code for the hysterectomy procedure includes removal of the appendix. However, some *physicians* will bill separately for a hysterectomy and an appendectomy. The plan pays benefits up to the *usual and prevailing fee limit* of the more appropriate combined code rather than for the separate procedures if they are performed at the same time.