TWU Rep. Employees Benefits Guide

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

To help you make the most of those benefits, this Guide describes the major provisions of the plans and explains how you can use them effectively.

The benefits described in this Guide include:

- Health Care Benefits
  - Medical Options, specifically
    - Standard Medical options
    - Value Plus Option
    - Value Option
    - HMOs
  - Supplemental Medical Plan (terminated coverage for active employees effective December 31, 2010)
  - Dental Coverage
  - Vision Coverage
  - Employee Assistance Program
- Life Insurance & Accident Insurance;
- Disability Benefits;
- Flexible Spending Accounts
  - The Health Care Flexible Spending Account
  - The Dependent Day Care Flexible Spending Account
- Long Term Care Insurance and
- Retiree Benefits.

Additional Important Information

In addition to the descriptions of the benefits provided and how each plan works, this Summary Plan Description also provides general and plan specific information in the:

- About this Guide section
- General Eligibility section
- General Enrollment section
- Life Events section
- Additional Health Benefit Rules section
- Plan Administration section
- Reference Information section, including a Contacts list, the Glossary, and the Archives of older versions of the Guide.

Start a Chat

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Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

About This Guide

This Employee Benefits Guide for Employees Represented by the Transport Workers Union of America, AFL-CIO ("TWU employees");("Guide") contains the legal plan documents and the summary plan descriptions (SPDs) for the following plans of the Flexible Benefits Program: the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (the "Group Life and Health Plan"), and the Long-Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (collectively the "Plans").

The provisions of this Guide apply to eligible employees of the participating subsidiaries of AMR Corporation, including employees on the United States payroll, spouses, dependents and surviving spouses who elect coverage under the benefits program.

The Company reserves the right to modify, amend or terminate any of the Plans, any program described in this Guide, or any part thereof, at its sole discretion. Changes to the Plans generally will not affect claims for services or supplies received before the change.

Only the Pension Benefits Administration Committee (PBAC) is authorized to change the Plans. From time to time, you may receive updated information concerning changes to the Plans. Neither this Guide nor updated materials are contracts or assurances of compensation, continued employment or benefits of any kind.

In the event of a conflict between the Plans' provisions contained in this Guide and the provisions contained in any applicable collective bargaining agreement (and/or insurance policies for fully-insured programs), the collective bargaining agreement (and/or insurance policy for fully-insured programs) shall govern in all cases with respect to employees covered by such agreement.

American Airlines, Inc., sponsor and administrator of the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries, believes that the some of the medical coverages in this plan meet the requirements to be deemed "grandfathered health plan(s)", while others do not under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your medical coverage may not include certain consumer protections of PPACA that apply to other plans — for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA — for example, the elimination of lifetime limits on benefits. The following chart specifies which medical benefit options in this plan are grandfathered, and which are not:

Medical Option	Grandfathered or Non-Grandfathered
Standard Medical Option 1	Grandfathered
Standard Medical Option 3	Grandfathered
Value Medical Option	Non-Grandfathered
Value Plus Medical Option	Non-Grandfathered
HMO Medical Options	May be either, depending upon the HMO; contact your specific HMO for this information

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Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

American Airlines, Inc.
PO Box 619616
Mail Drop 5141, HDQ1
Dallas-Fort Worth Airport, TX 75261-9616

You may also contact the Employee Benefits Security Administration, US Department of Labor, at 1-866-444-3272. This Employee Benefits Security Administration, US Department of Labor website has a table summarizing which protections do and do not apply to grandfathered health plans.

General Eligibility

You are eligible for coverage for yourself and your eligible dependents after you fulfill a one-month waiting period of active employment.

- You must provide proof of eligibility for dependent coverages.
- Spouses, common law spouses, Company-recognized Domestic Partners and dependent children are eligible for coverage under certain benefits.
- Some employees may be ineligible for coverage under the Flexible Benefits Program.

Determination of Eligibility

You are eligible for the **Value Plus Option, Value Option or an HMO** only if you reside where your network/claims administrator or HMO offers a network. Your eligibility is determined by the ZIP code of your Jetnet alternate address on record. Jetnet allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence). Since many employees maintain more than one residence, you may list both addresses in Jetnet; however, your alternate address determines your eligibility. If you do not have an alternate address listed in Jetnet, your eligibility is based on your permanent address.

This does not apply to the Standard Options.

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Employee Eligibility

You are eligible for coverage for yourself and your eligible dependents after you fulfill a one-month waiting period.

If you are not at work on the date coverage would otherwise begin, coverage is effective on the date you are actively at work, unless you are not actively at work due to a health condition; then coverage is effective on the date coverage would otherwise begin. If you do not enroll for coverage when you are first solicited for benefits, you will receive "default coverage."

After you receive your enrollment information, you may enroll on the Benefits Service Center.

You are ineligible to participate in the Flexible Benefits Program if your employment relationship with the Company is defined under "Ineligibility."

Proof of Eligibility

AMR Corporation and its subsidiaries reserve the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct and may result in termination of employment, benefit or plan coverage termination, and efforts to recover any overpaid benefits.

Whether you:

- Request to enroll dependents when you are first eligible to enroll in benefits, or
- Request to enroll new dependents during annual enrollment, or
- Request to enroll new dependents as the result of a Life Event,

you must submit proof of the dependents' eligibility to HR Services within 60 days of the date you request their enrollment. Examples of proof that dependents you want to enroll qualify include: official government-issued birth certificates, adoption papers, marriage licenses, etc., as detailed in the Proof of Eligibility Requirements.

Important: Your dependents' coverage and enrollment will be effective only after you have timely requested their enrollment and timely provided satisfactory proof of eligibility.

Coverage Requiring Proof of Good Health

The following coverage requires proof of good health:

- **As a new employee:** Employee Voluntary Term Life Insurance (in amounts greater than the 1× basic coverage)
- **As an existing employee:** Employee Voluntary Term Life Insurance (if you waived coverage when first eligible or wish to increase coverage)
- **As a new or existing employee:** Spouse Term Life Insurance (all levels of coverage)

Proof of good health is determined based on the information you supply in the Statement of Health. For coverage requiring proof of good health, coverage becomes effective only after MetLife approves your Statement of Health and your first contribution is paid, either by you or through payroll deductions.

Eligibility During Leaves of Absence and Disability

You may be eligible to continue benefits for yourself and your eligible dependents for a period of time during a leave, subject to the specific rules governing leaves of absence. The type of leave you take determines the cost of your benefits (i.e., whether you and the Company share the cost of the benefits or you pay the full cost of benefits). In order to continue your benefits during a leave of absence, you must timely pay the required contributions for your benefits during your leave.

Your leave of absence begins when your payroll transaction record is changed to reflect that you are on a leave of absence.

- HR Services will send you a letter acknowledging your leave, instructing you to access Jetnet to register your leave of absence Life Event, and asking you to decide if you will or will not continue your benefits while on leave.
- Once you record your Life Event and benefit elections on the Benefits Service Center, it will display a confirmation statement showing your choices, the monthly cost of benefits, covered dependents, etc.
- If you have not received the HR Services' letter within 10 days of being placed on a leave, immediately contact HR Services by clicking on the "Start a Chat" button at the top of this page to be sure you can continue coverage during the leave.

If you elect not to continue your benefits during your leave of absence or if you fail to timely pay the required monthly contributions for coverage, your benefits will terminate for the duration of your leave of absence. When you return to active employee status, you may reactivate most of your benefits. However, some benefits will require you to supply proof of good health in order to reactivate (i.e., Voluntary Term Life Insurance Benefit).

Family Medical Leave of Absence (FMLA) or Military Leave

If your leave is an FMLA or military leave, special rules govern your rights to continue or resume your benefits, which are based on federal law.

While you are:

- Receiving accrued sick pay
- During the first year of an unpaid sick or injury-on-duty leave of absence

you may keep the same health and welfare benefits you had by continuing to pay your share of the cost. If your disability continues beyond 12 months, you must pay 100% of contributions. Should your disability continue until your retirement at age 65, your active health and welfare benefits terminate at age 65, and you are then eligible for Retiree Medical and Life Benefits. (See the Retiree Medical Benefit Guide for more information about Retiree Medical and Life Benefits.)

When you are on a military leave of 30 days or more, you may continue health coverage for your eligible dependents (and resume your coverage upon ending your military leave) under the Uniformed Services Employment and Reemployment Rights Act (USERRA). For more information see "Continuation of Coverage for Employees in the Uniformed Services" under "Continuation of Coverage – COBRA Continuation" in the *Additional Health Benefit Rules* section.

You may review a detailed description of each leave of absence or consult with your supervisor/manager.

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Eligibility After Age 65

As an active employee, your medical coverage continues for you and your covered dependents as long as you remain an active employee. When you reach age 65 (or your spouse reaches age 65), you (or your spouse) must notify the Company in writing that you want Medicare to be your only coverage.

If you elect Medicare as your only coverage, your Company-sponsored active medical coverage will terminate, including coverage for your dependents. If your spouse elects Medicare as his or her only coverage, only your spouse's Company-sponsored active coverage will terminate.

Note: This section does not refer to Retiree Medical coverage.

Dependent Eligibility by Benefit

Dependent eligibility requirements are different depending on the benefit coverage you elect.

Medical Coverage

An eligible dependent is an individual (other than the employee covered by the Flexible Benefits Program) who lives in the United States, Puerto Rico or the U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse, Company-recognized Domestic Partner or common law spouse. Company-recognized Domestic Partners and their children may be eligible for coverage under your HMO. Contact your HMO directly for eligibility criteria. Company-recognized Domestic Partners and their children are not eligible to participate in Flexible Spending Accounts.
- Child under age 26 who is not eligible for his or her own medical coverage through his or her employer. (This applies to grandfathered Medical Benefit Options.)
- Incapacitated child age 26 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Dental and Vision Coverage

An eligible dependent is an individual (other than the employee covered by the Flexible Benefits Program) who lives in the United States, Puerto Rico or the U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse, Company-recognized Domestic Partner or common law spouse.
- Unmarried child under age 23 who maintains legal residence with you.
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Child Life Insurance and Child Accidental Death and Dismemberment (AD&D) Insurance

An eligible dependent is an individual (other than the employee covered by the Flexible Benefits Program) who lives in the United States, Puerto Rico or the U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. Child means the following:

- Incapacitated child age 19 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.
- Your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild (including the child of a Company-recognized Domestic Partner) who is:
  - Under age 19 unmarried and supported by you; or
  - Under age 23 and who is:
    - A full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
    - Unmarried;
    - Supported by you; and
    - Not employed on a full-time basis.
- The term does not include any person who:
  - Is in the military of any country or subdivision of any country; or
  - Is insured under the Group Policy as an employee.
- For Texas residents “child” means the following for Life Insurance:
  - Your natural child, adopted child or stepchild (including the child of a Company-recognized Domestic Partner) who is under age 25 and unmarried. The term also includes your grandchild who is under age 25, unmarried and who was able to be claimed by you as a dependent for Federal Income Tax purposes at the time you applied for Life Insurance.
  - A child will be considered your adopted child during the period you are party to a suit in which you are seeking the adoption of the child.
- The term does not include any person who:
  - Is in the military of any country or subdivision of any country; or
  - Is insured under the Group Policy as an employee.

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Spouse Life Insurance and Spouse Accidental Death and Dismemberment (AD&D) Insurance

An eligible dependent is an individual (other than the employee covered by the Flexible Benefits Program) who lives in the United States, Puerto Rico or the U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways: spouse, Company-recognized Domestic Partner or common law spouse not employed by the Company.

Dependent Eligibility Requirements

Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Company-recognized Domestic Partner as defined by the Plan
- For Medical coverage: Stepchild
- For Medical and Dental coverage: Stepchild, if the child lives with you, and you (the employee) either jointly or individually claim the stepchild as a dependent on your federal income tax return
- Special Dependent, if you meet all of the following requirements:
  - You must have legal custody and legal guardianship of the child.
  - The child must maintain legal residence with you and be wholly dependent on you for maintenance and support.
  - You must submit a Statement of Dependent Eligibility for Special Dependent Form to HR Services and HR Services must approve the form. (Complete and return the form to HR Services, along with copies of the official court documents awarding you custodianship or guardianship of the child.)You must receive confirmation from HR Services notifying you of its determination.
  - HR Services will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 60 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by HR Services. If you submit the request after the 60-day time frame, the child will not be added to your coverage.
- You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a National Medical Support Notice issued by a state agency (see "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" under "Qualified Medical Child Support Orders (QMCSO) Procedures" in the *Additional Health Benefit Rules* section.

Coverage for an Incapacitated Child — Medical Coverage Only

An "incapacitated child" age 26 or older is eligible for continuation of coverage if all of the following criteria are met:

- The child was already continuously covered as your dependent under this Plan before reaching age 26.
- The child is mentally or physically incapable of self-support.
- You file a Statement of Dependent Eligibility for Incapacitated Child within:
  - **For UnitedHealthcare:** Within 60 days of the date coverage would otherwise end
  - **For Blue Cross and Blue Shield of Texas:** Within 45 days of the date coverage would otherwise end
  - **For Aetna:** Within 90 days of the date coverage would otherwise end
  - **For HMOs:** Contact your HMO for the time limit
- And your network/claims administrator then approves the application.
- The child continues to meet the criteria for dependent coverage under this Plan.
- You provide additional medical proof of incapacity as may be required by your network/claims administrator from time-to-time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your network/claims administrator determines the child is no longer incapacitated. If you elect to drop coverage for your child, you may not later reinstate it.
- Either the child maintains legal residence with you and is wholly dependent on you for maintenance and support, or you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Dependents of Deceased Employees

If you have elected medical coverage for your spouse and children and you die as an active employee, your dependents' medical coverage will continue for 90 days at no contribution cost. Your covered dependents are also eligible to continue medical coverage and certain other benefit options for up to 36 months under COBRA Continuation Coverage at the full COBRA rate (see "Continuation of Coverage – COBRA Continuation" in the *Additional Health Benefit Rules* section. The 90 days of coverage are part of the 36 months of COBRA coverage.

If you are over age 55 but not yet 65 and working as an active employee, your surviving spouse is eligible for Retiree Medical Benefits if you die and were otherwise eligible for this coverage. This applies regardless of your spouse's age at the time of your death.

Your covered dependents can elect to continue dental and vision insurance benefits under COBRA at the full COBRA rate if they had dental and/or vision benefits at the time of your death. To continue dental and/or vision coverage, your dependents must pay contributions effective from the date of your death.

Common Law Spouses and Company-recognized Domestic Partners

Quick Tip

Common law spouse criteria vary by state, so check with your state's requirements for common law marriage.

Common Law Spouses

Common law spouses are eligible for enrollment in Plan benefits only if your common law marriage is recognized and deemed (certified) legal by the individual state where the employee resides, and only if the employee and spouse have fulfilled the state's requirements for common law marriage.

To enroll your common law spouse for benefits, you must complete and return a Common Law Marriage Recognition Request Form. Along with the form, you must provide proof of common law marriage, as specified on the form.

Applicants for common law recognition may not be married to other persons; additionally, applicants may not be of the same gender.

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

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

Company-recognized Domestic Partners

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

- Are the same gender
- Reside together in the same permanent residence and have lived in a spouse-like relationship for at least six consecutive months
- Are both at least 18 years of age and are not related by blood in a degree that would bar marriage
- Are not legally married or the common law spouse or Company-recognized Domestic Partner of any other person and cannot enter into a marriage recognized as legal in all 50 states and under the laws of the United States
- Submit a complete and valid "Declaration of Company-recognized Domestic Partnership" from the Company-recognized Domestic Partner Enrollment Kit

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

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

- Standard, Value and Value Plus Medical Options
- Dental Benefit (for active employees, their spouse or Company-recognized Domestic Partner, and eligible dependents)
- Vision Insurance Benefits
- Spouse and Child Life Insurance Benefits
- Retiree Medical Benefits
- Accident Insurance Benefits

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

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

Company-recognized Domestic Partners may be eligible to participate in:

- Health Maintenance Organizations (HMOs). Contact your HMO directly for eligibility criteria.

If your Company-recognized Domestic Partner is covered under the Retiree Medical Benefits at the time of your death, coverage will continue for the 90 days immediately following your death. At the end of the 90-day period, your Company-recognized Domestic Partner may elect COBRA Continuation Coverage for up to 36 months.

Employees Married to Other Employees

Married employees have the option of being covered under one employee's medical, dental and/or vision benefits, if they choose. Married employees may elect to be covered under one employee's benefits during annual enrollment or at the time of a Life Event.

During annual enrollment, the employee who is electing to cover both employees for medical, dental and/or vision benefits must indicate that he or she is covering the spouse (and any other eligible dependents) in the "Dependents" area of the online Benefits Service Center. The employee who will be covered as the spouse must choose "AA-Married" on the Benefits Service Center.

The following benefits, plans and voluntary benefits must still be maintained independently:

- Accident Insurance Benefits
- Employee Term Life Insurance Benefits
- Retiree Medical Benefits (when available)

Employees married to other employees in other workgroups or other subsidiaries should carefully consider available options and costs before making any decisions. If you have any questions regarding your benefits under this situation, please contact HR Services (see "Contact Information" in the *Reference Information* section).

Change in spouse's employment: If employees choose to maintain separate benefits and one spouse ends his or her employment with the Company or moves to a subsidiary that does not offer the:

- Flexible Benefits Program,
- benefit program for Pilots, or
- benefit program for Flight Attendants,

the spouse who changes his or her employment is eligible for coverage as a dependent (if he or she waives coverage under the subsidiary's health plan). However, if an employee is discharged for gross misconduct not related to any existing health condition for which treatment was provided for under the Plans, benefits or options, he or she cannot be covered as a dependent of the active employee.

Spouse not eligible for full benefits: During the one-month waiting period required for some workgroups to be eligible for benefits, the new employee may be covered as the spouse of the active employee who already has benefits. If your spouse or Company-recognized Domestic Partner is working as a Part-Time Extendable, Part-Time Non-Extendable, Home-Based Reservations, Reduced Workweek Reservations and Premiums Service Guest Relations Representative employee, he or she may waive medical, dental and/or vision coverage and be covered as a dependent under your coverage.

Retirees married to active employees: Retirees married to active employees are eligible for coverage as dependents of active employees. The benefits available and benefit limits, if any, are defined by the active employee's coverage unless the retiree has opted for a lesser medical maximum plan. When the actively working spouse retires, each retiree is covered under his or her own retiree health benefit, if applicable. Please refer to the Retiree Medical Benefit Guide for information specific to each workgroup.

Spouse on leave of absence: For leaves of absence, when Company-provided benefits terminate, a spouse on a leave of absence may continue to purchase coverage as an employee on leave or elect to be covered as the dependent of the actively working spouse, but not both.

The actively working spouse's health coverage determines the health benefit coverage for all dependents. Because a leave of absence is a Life Event (see the Life Events section), the actively working spouse may make changes to his or her other coverages.

The actively working spouse may elect to:

- Add the spouse on leave as a dependent
- Cover only eligible dependent children
- Cover both the spouse and children
- Enroll himself or herself, and the spouse and children as dependents

If an employee elects to be covered as a dependent during a leave of absence, the following conditions apply:

- Optional coverages the person elected as an active employee end, unless payment for these coverages is continued while on leave.
- Proof of good health may be required to re-enroll or increase optional coverages upon the employee's return to work.

Provided the employee on leave makes timely payments for benefits, Company-provided coverage (where the Company pays its share of the cost and the employee on leave pays his/her share) will continue for a period of time for employees on family, sick, injury-on-duty or maternity leaves. These employees cannot be covered as dependents. For other types of leaves, the employee must timely pay the full cost of his/her coverage while on leave.

Other Information

Eligible dependent children: If both spouses are covered under the Flexible Benefits Program, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year, unless the parents elect otherwise. Contact HR Services (see "Contact Information" in the *Reference Information* section) to change this requirement. If one spouse is covered under the Flexible Benefits, the children are covered under the parent with Flexible Benefits, unless the parents elect otherwise through HR Services. Children cannot be covered under both parents' health benefits. See "Dependent Eligibility Requirements" on page 12 for additional information.

- **Contributions:** Both you and your spouse may elect to be covered independently under the benefits plans or options for which you are each eligible. If married employees choose to be covered under one employee, the contributions for the employee covering both will reflect either Employee plus One or Employee plus Two or more, whichever is applicable. This applies to contributions for the Medical, Dental and Vision Benefits. Contributions for benefits that still must be maintained independently, such as Life Insurance (see the Life Insurance section), will be applied appropriately and payroll-deducted from each employee's paycheck.
- **Family deductibles:** If the parents choose different options, the family deductible applies to the employee covering the children and the individual deductible applies separately to the other parent.
- **HMO participation:** Company-recognized Domestic Partners may be eligible for coverage under your HMO, subject to the HMO's eligibility rules. If your Company-recognized Domestic Partner can be covered under your HMO, you will be able to choose coverage for him or her when you enroll. The decision to offer coverage to Company-recognized Domestic Partners is made by individual HMO plan provisions, not by American Airlines.
- **Accident coverage:** Both you and your spouse or Company-recognized Domestic Partner must enroll for yourselves (for married employees without children) — you cannot be covered both as an employee and as a dependent. For married employees with dependents, you cannot be covered as an employee and as a dependent; therefore, only the parent who elects medical coverage for the dependent children may elect family accident coverage, and the spouse or Company-recognized Domestic Partner must waive coverage. If your spouse or Company-recognized Domestic Partner works for an AMR subsidiary that does not offer accident coverage, you may elect Voluntary Personal Accident Insurance Benefit for him or her (see the Accident Insurance Benefits section).
- **Flexible Spending Accounts:** Contributions to the Health Care Flexible Spending Account and/or the Limited Health Care Spending Account (see the Health Care Flexible Spending Account section) and Dependent Day Care Flexible Spending Account (see the Dependent Day Care Flexible Spending Account section) may be made by one or both spouses. Either of you may submit claims to the account. However, if only one spouse is making contributions to the account, claims must be submitted under that person's Social Security number. If you both make contributions to the Dependent Day Care Flexible Spending Account, you may only contribute the maximum amount the law permits for a couple filing a joint tax return. For the Health Care Flexible Spending Account or Limited Health Care Spending Account, you may both make contributions up the maximum allowed by American Airlines. You may not file claims for expenses incurred by a Company-recognized Domestic Partner who is an employee of AA (or his or her dependents) under your Flexible Spending Accounts according to federal law. Company-recognized Domestic Partners who are both AA employees may each have his or her own Flexible Spending Account.
- **Retiree Medical Benefits:** If you are both eligible for benefits, you must each maintain (or prefund, if your workgroup requires that you prefund for Retiree Medical Benefits) your Retiree Medical Benefits as individuals. By maintaining (or prefunding, if applicable) your Retiree Medical Benefits separately, the death of your spouse or a divorce would not jeopardize your eligibility for Retiree Medical Benefits.

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Ineligibility

The following individuals are not eligible to participate in this benefits program:

- A leased employee, as defined in section 414(n) of the Internal Revenue Code. This includes any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service, or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker; this term includes any of the following former classifications:
  - Temporary employee
  - If a temporary worker becomes a regular employee, and meets all of the other requirements to participate in the Flexible Benefits Program without a break in service, the time worked as a full-time temporary worker will be credited solely toward the eligibility requirement for life and health coverage. Under no circumstances will time worked as a temporary worker entitle the individual to retroactive group health and welfare benefits.
  - Provisional employee
  - Associate employee
- An independent contractor
- Any person:
  - Who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion)
  - Who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate
  - Whose compensation is reported to the Internal Revenue Service on a form other than a Form W-2, regardless of whether such person was treated as an employee for federal income tax purposes
- Parents or grandchildren. Neither your parents nor grandchildren are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchild's legal guardian).

  You may be eligible for reimbursement of their eligible expenses under the Health Care Flexible Spending Account (see the Health Care Flexible Spending Account section) and Dependent Day Care Flexible Spending Account (see the Dependent Day Care Flexible Spending Account section) if you claim your parent or grandchild as a dependent on your federal income tax return.

General Enrollment

You have the opportunity to select benefits tailored to your individual needs and preferences each year during annual enrollment. The annual enrollment period is October 1 through October 31. Employees enroll online using the Benefits Service Center.

- The Plan year is January 1 through December 31.
- If you do not enroll for benefits during the annual enrollment period, you will automatically default to your current selections (if available) for the following year, at the applicable rates for the following year (Note: this does not apply to Flexible Spending Accounts).
- If one or more of your current selections are no longer available and you do not make another selection, you will be enrolled in the applicable benefit or plan designated as the default coverage for your workgroup.
- After annual enrollment is completed and the new benefit year has begun, you will only be able to make changes to your elections if you experience a Life Event.
- If you are adding new dependents to your benefits, you must submit to HR Services proof that these dependents qualify as your eligible dependents within 60 days of the date you request enrollment.
- Life Event changes must be made within 60 days of the Life Event.

The Benefits Service Center

The Benefits Service Center (the online enrollment tool) on Jetnet reflects the current benefits coverages available to you and the rates for those coverages. The Benefits Service Center is updated by October 1 with your benefits options and the new rates for the upcoming Plan year – January 1 through December 31.

In This Section

Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

Annual Enrollment

Each year eligible employees have the opportunity to select benefits for the upcoming Plan year — January 1 through December 31. During annual enrollment you can:

- Enroll for coverage,
- Add or remove a dependent to coverage,
- Make changes to your prior elections, or
- Continue your previous elections at the applicable new rates.

New rates are shown on the Benefits Service Center when you enroll. With the exception of Life Events, annual enrollment is the only time you can change your coverage elections.

Any elections you make during annual enrollment are generally effective the following January 1. If proof of good health is required, the effective date for coverage, if approved, may be delayed to allow for review of your proof of good health, (e.g., to add or increase life insurance coverage).

Once annual enrollment ends on October 31, your benefit elections for the upcoming plan year are recorded and "locked in", and you are not allowed to make changes to these elections unless you experience a Life Event that would enable you to make such changes. However, between the close of annual enrollment (beginning November 1) and the start of the new plan year (January 1 following annual enrollment), you may be permitted to CORRECT any erroneous elections you made during annual enrollment, as long as you make those corrections before the start of the new plan year.

For example, during annual enrollment for the upcoming plan year, you elected to establish a Dependent Day Care Flexible Spending Account (DDFSA), even though you do not have any dependents. When you are reviewing your benefit elections a month later (end-November), you discover your mistake. If you request correction of your mistake before the beginning of the upcoming plan year, your election correction is permitted. However, if you fail to discover your mistake and fail to request correction until after the new plan year begins (such as on January 12), you will not be permitted to make any correction of your enrollment mistake unless you experience a Life Event. This rule is set down by the federal government, and American Airlines cannot override this rule; to do so would jeopardize the tax-exempt status of the benefit plan for all employees.

Remember, these post-annual enrollment changes to your benefit elections are permitted to allow you to correct elections errors ONLY. Any other changes (such as: you have changed your mind about enrolling in a particular benefit, you want to change the network/claims administrator you elected, etc.) are not permitted.

How to Enroll

All employees enroll using the online enrollment tool — the Benefits Service Center. See the Enrollment Planning Page on the Benefits page of Jetnet for information on enrolling.

Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

New Employee Enrollment

As a new employee, you will receive enrollment information shortly after you begin working. You may elect coverage for yourself and your eligible dependents (see the General Eligibility section) and have a one-time opportunity to enroll in the Employee Voluntary Term Life Insurance Benefit without having to provide proof of good health (coverage levels in excess of 1 times your salary require a Statement of Health).

Proof of good health is required if you wish to enroll in the Voluntary Term Life Insurance benefit at any level, at any time after you were first eligible, or to increase life insurance coverage levels. You must mail a completed, dated and signed Statement of Health form to MetLife, postmarked within 30 days after your enrollment deadline. If your Statement of Health is not postmarked within 30 days after the close of your new employee enrollment window, your application for this coverage will not be considered, and you must wait until the next annual enrollment (or your next Life Event) to apply for this benefit.

FAQ: When can I enroll for benefits?

As a new employee, you can enroll shortly after you begin working. As an existing employee, you can enroll during the annual enrollment period or if you experience a Life Event during the year.

When Coverage Begins as a Newly Hired Employee

If you enroll by the enrollment deadline, your selected coverage (if different from default coverage) begins after you have been employed for one month.

When Coverage Begins as a Current Employee

When you enroll during the annual enrollment period, your selected coverage (if different from default coverage) begins on January 1 and continues through December 31 (the Plan year).

If you want to add new dependents to your benefits, you must submit to HR Services proof that these dependents qualify as your eligible dependents within 60 days of the date you request their enrollment. Proof that the dependents you enroll qualify as your dependents includes documents such as: official government-issued birth certificates, adoption papers, marriage licenses, etc., as detailed in the Proof of Eligibility Requirements.

Waiving Coverage

You may only waive medical coverage if you have other medical coverage (for example, through your spouse's employer). You may choose to waive other coverages if you wish. Your dependents will not receive this coverage unless you are also covered under this same benefit. If you waive coverage, you can enroll in coverage later in the year only if you experience a Life Event, such as marriage, divorce or the birth or adoption of a child.

Default Coverage

As a new employee, if you do not enroll for benefits when you are first eligible, or you are not eligible for the options you elect, you will default to the following coverages:

Benefit	Default	Comments
Medical Benefit Option	Standard Option 1/ $150 deductible	If your current option is not available in your location, you and your eligible dependents will be enrolled in the Standard/$150 Deductible Option 1
Dental Benefit Option	Plan 1	N/A
Vision Insurance Benefit	No coverage	N/A

Benefit	Default	Comments
LTD Plan	Union plan	Contact your union for information about this coverage
Basic Term Life Insurance Benefit	2 times pay	Up to a maximum of $70,000
Voluntary Term Life Insurance Benefit	No coverage	N/A
AD&D Insurance Benefit	No coverage	N/A
Spouse Life Insurance	No coverage	N/A
Child Life Insurance	No coverage	N/A
Flexible Spending Accounts (FSAs) (Health Care FSA and Dependent Day Care FSA)	No coverage	Your FSA accounts will default to $0.00 unless you take action to establish the accounts and enter a dollar amount for the accounts

If you are a current employee and during annual enrollment you do not make selections for the upcoming benefit year, you will default to the same benefit selections (at the applicable new rates) as you are enrolled in for the current year with the following exceptions:

- **Flexible Spending Accounts (FSAs):** If you do not elect an FSA, you will not have FSA accounts for the following year. Per IRS rules, you must actively elect an FSA each year you wish to participate.
- **Current Benefit Not Offered or Employee Not Eligible:** If your current benefit is no longer offered in your area, or if you no longer qualify for the current year's benefit, you must select a replacement benefit or option or you must waive coverage. If you do not either elect coverage or waive coverage, you will default to the coverages listed in the Default Coverage Table above.

HIPAA Special Enrollment Rights – Medical Benefit Option

If you declined coverage for you or your dependents under the Medical Benefit Option because you or they have medical coverage elsewhere and one of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your dependents in the Medical Benefit Option:

- You and/or your dependents lose the other medical coverage because eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
- The employer contributions to the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.

- You and/or one of your dependents exhaust a lifetime maximum in another employer's health plan or other health insurance coverage.
- You and/or one of your dependents' employers cease to offer benefits to the class of employees through which you (or one of your dependents) had coverage.
- You and/or one of your dependents were enrolled under an HMO or other group or individual plan or arrangement that will no longer cover you (and/or one of your dependents) because you and/or one or your dependents no longer reside, live or work in its service area.
- You have a new dependent as a result of your marriage, your child's birth, adoption or placement for adoption with you. Coverage is retroactive to the date of birth, adoption or placement for adoption.

As an employee, you may enroll yourself and request enrollment for your new spouse and any new dependents within 60 days of your marriage. You may request enrollment for a new child within 60 days of his or her birth, adoption or placement for adoption. If you miss the 60-day deadline, the enrollment will not be processed. You will have to wait until the next annual enrollment period to enroll your dependent.

In addition, if you are not enrolled in these employee benefits as an employee, you also must enroll in the benefits when you request enrollment for any of these dependents. If your spouse is not enrolled in the benefits, you may enroll yourself and request enrollment for your spouse in the employee benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage, coverage will begin on the first day of the first calendar month after the completed enrollment request is received and proof of eligibility is timely provided. To request special enrollment or obtain more information, contact HR Services (see "Contact Information" in the *Reference Information* section).

If you are adding new dependents to your benefits during the special enrollment rights period, keep in mind that you must submit to HR Services proof that these dependents qualify as your eligible dependents. Proof that the dependents you want to enroll qualify as your dependents includes official government-issued birth certificates, adoption papers, marriage licenses, etc., as detailed in the Proof of Eligibility Requirements.

When Coverage Ends

Coverage for you and your dependents ends when you terminate employment, cancel coverage, stop paying for coverage or if you become ineligible for coverage (for example, due to a change in your job classification). See "Continuation of Coverage – COBRA Continuation" in the *Additional Health Benefit Rules* section. In addition, your dependent's coverage ends if the dependent no longer meets the eligibility requirements, as explained in the "Dependent Eligibility Requirements" in the *General Eligibility* section.

If you die as an active employee, your covered dependents continue to receive the same medical coverage they had before you died. COBRA Continuation Coverage continues for 90 days at no cost. At the end of 90 days, your eligible dependents can continue medical coverage for up to 36 months under the full COBRA rate. The 90 days of coverage immediately following your death is included in the 36 months. Dental coverage is available for purchase through COBRA Continuation Coverage. All other coverages end at the time of your death.

If you are over age 50 and working as an active employee, your surviving spouse is eligible for the Retiree Medical Benefit if you die and were otherwise eligible for this coverage. This applies regardless of your spouse's age at the time of your death.

While you are:

- Receiving accrued sick pay,
- or while you are receiving paid sick time;
- and during the first year (12 months) of an unpaid sick or injury-on-duty leave of absence or while you are receiving paid sick time

you may keep the same benefits you elected for the current plan year. You cannot have more than 12 months of Company-subsidized health benefits while you are on an unpaid sick or injury-on-duty leave of absence. You are responsible for paying your share of the cost for coverage. When you begin a leave of absence (when your payroll transaction record is changed to reflect that you're on a leave of absence), HR Services sends you a letter acknowledging your leave and instructing you to access Jetnet to register your Leave of Absence Life Event and decide whether or not to continue your benefits while on your leave. When you register your Life Event and benefit elections on Jetnet, it will display a confirmation statement showing your choices, the monthly cost of benefits, etc. If you have not received the HR Services letter within 10 days of being placed on leave, contact HR Services immediately so you may continue your benefits while on leave (see "Contact Information" in the *Reference Information* section). Also, refer to the Policies and Procedures section on Jetnet for more information and/or contact your manager.

Important: If you elect not to continue payment for your benefits during your leave of absence, your benefits will terminate while you are on leave. When you return to active status, you may reactivate most of your benefits; however, the Voluntary Term Life Insurance Benefit. OSTD Insurance Benefit will require you to supply proof of good health in order to reactivate.

Life Events: Making Changes During the Year

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

Life Event changes must be made within the 60-day time frame. If you miss the 60-day deadline, your Life Event change will not be processed. You will have to wait until the next annual enrollment period to make changes to your benefits.

In This Section **See Page**

Life Events

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

When you experience a Life Event, remember these guidelines:

- Most Life Events are processed online through the Benefits Service Center. Visit the Life Events Planning page from the Benefits page on Jetnet for a complete list of all Life Events and the correct procedures for processing your changes.
- If you process your Life Event within 60 days of the event, your changes are retroactive to the date the Life Event occurred (or the date proof of good health is approved, as applicable).
- AMR Corporation and its affiliates reserve the right to request documented proof of dependent eligibility criteria for benefits at any time. If you do not provide proof of eligibility when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct and may result in termination of employment and termination of benefits coverage.
- You must timely provide acceptable proof of eligibility to HR Services before your dependent(s) can be enrolled in benefits.

Glossary Term: Life Event

A circumstance or change that happens during the year that allows you and/or your dependents to make changes to your coverage options outside the annual enrollment period.

If you are adding new dependents to your benefits as a result of a Life Event, keep in mind that you must submit to HR Services proof that these dependents qualify as your eligible dependents within 60 days of the date you request their enrollment. Proof that the dependents you want to enroll qualify as your dependents includes documents, such as: official government-issued birth certificates or hospital records, adoption papers, marriage licenses, etc., as detailed in the Proof of Eligibility Requirements.

- Any change in your cost for coverage applies on the date the change is effective. Retroactive contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.
- You may only stop or waive medical benefits for yourself if you have other medical coverage.
- You cannot enroll your dependents in coverage if you are not covered under the same benefits.
- You may start or increase a Flexible Spending Account only if you have enrolled a dependent who was not previously covered.
- Starting or increasing either Life, Accident or Disability Benefits may require proof of good health and coverage will only be effective after the applicant is approved. If death occurs before a Life Event is processed, the amount of coverage payable is your current amount of Life and/or Accident Insurance.

When you add Life or Accident Insurance Benefits, you must designate a beneficiary. Periodically thereafter, you may want to update your beneficiary designations. You can make beneficiary changes on the Benefits Service Center. Once you complete and submit the online beneficiary designation form, it supersedes all previous designations.

- If a death or accident occurs before your first-time enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Benefits that will be paid is your first time enrollment announcement. If you have coverage and you are requesting an increase, the amount payable is your current amount of coverage.
- You may only increase your Life Insurance Benefit by one level per year, with proof of good health.
- If you elect to enroll in any coverage requiring proof of good health, you must submit a completed, dated and signed Life Insurance, Statement of Health Form to MetLife postmarked within 30 days after your enrollment/election date. If your Statement of Health is not postmarked within 30 days after your enrollment/election date, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next Life Event) to apply for any of these coverages.
- Losing Medicaid or CHIP coverage enables you to enroll in medical, dental and/or vision benefits.
- Becoming eligible for a state premium subsidy program enables you to enroll in medical, dental and/or vision benefits.
- Also see birth or adoption for other information regarding Life Events that may trigger allowable changes in coverage.

If You Experience the Following Life Event…	Then, You Can…
You become first eligible for Company-provided benefits	Enroll online through the Benefits Service Center.
You get married or declare a Company-recognized Domestic Partner	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for your eligible spouse/Company-recognized domestic partner and stop coverage for an eligible dependent or yourself. Although you can add or drop coverage for dependents or yourself, you cannot change benefit options at this time. Company-recognized Domestic Partners and their dependents may be eligible for HMOs. Contact your HMO for eligibility – eligibility is determined by the HMO. You may add or drop dental coverage but you may not switch between Dental Option 1 and Dental Option 2 or vice versa. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your eligible spouse/Company-recognized domestic partner and/or child, or increase or decrease existing employee coverage. ▪ **Spouse Term Life Insurance Benefit:** Start coverage. ▪ **Child Term Life Insurance Benefit:** Start coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts.

If You Experience the Following Life Event…	Then, You Can…
You divorce or legally separate **OR** **Your Company-recognized Domestic Partner relationship ends**	▪ **Medical and Dental Options and Vision Insurance:** Stop coverage for your eligible spouse or Company-recognized Domestic Partner. Add coverage for yourself and/or your eligible dependents (dependent coverage may be subject to QMCSO). You cannot change benefit options at this time. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Contact your union to determine if changes are permitted for your LTD coverage. ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your eligible spouse/Company-recognized domestic partner and/or child, or increase or decrease existing employee coverage. ▪ **Spouse Term Life Insurance Benefit:** Stop coverage. ▪ **Child Term Life Insurance Benefit:** Stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for yourself; stop coverage for your eligible spouse/Company-recognized domestic partner or child; increase or decrease existing employee coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts.
You or your spouse/Company-recognized Domestic Partner becomes pregnant and you are covered under the following medical benefit option	▪ **Standard Medical Options:** Contact your network/claims administrator and the Health*matters* MaternityMatters program. ▪ **Value Plus Option:** Contact your network/claims administrator and the Health*matters* MaternityMatters program. ▪ **Value Option:** Contact your network/claims administrator and the Health*matters* MaternityMatters program. ▪ **HMO:** Contact your HMO. ▪ This does not permit you to make any changes to your benefit elections until the baby is born.

If You Experience the Following Life Event…	Then, You Can…
You or your spouse/Company-recognized Domestic Partner gives birth or adopts a child or has a child placed with you for adoption or you add eligible dependent(s) to your household or your dependent regains eligibility for coverage under the Plan	▪ **Medical and Dental Options and Vision Insurance:** Start or add coverage for the eligible dependent(s) and yourself and/or your spouse/Company-recognized domestic partner. You cannot change benefit options at this time. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Contact your union to determine if changes are permitted for your LTD coverage. ▪ **Voluntary Term Life Insurance Benefit:** Add coverage for your child; increase or decrease existing coverage for you with proof of good health. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse or Company-recognized Domestic Partner or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.

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If You Experience the Following Life Event…	Then, You Can…
Your covered dependent no longer meets the Plan's eligibility requirement	▪ **Medical and Dental Options and Vision Insurance:** Stop coverage for your eligible dependent. You cannot change benefit options at this time. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Contact your union to determine if changes are permitted for your LTD coverage. ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your eligible dependent; increase or decrease existing coverage for you with proof of good health. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your eligible dependent or yourself; increase or decrease existing coverage. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs. ▪ **Additionally:** Contact HR Services to advise that a COBRA packet should be sent to the dependent's address.
Your dependent child attains age 13 or he or she or no longer requires dependent day care **OR** **Your elderly parent no longer requires dependent day care**	▪ **Dependent Day Care Flexible Spending Account:** Stop or reduce Dependent Day Care Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.

If You Experience the Following Life Event…	Then, You Can…
Your spouse, Company-recognized Domestic Partner or dependent dies	▪ **Medical and Dental Options and Vision Insurance:** Stop coverage for your eligible spouse/Company-recognized Domestic Partner or dependent. You cannot change benefit options at this time. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Contact your union to determine if changes are permitted for your LTD coverage. ▪ **Voluntary Term Life Insurance Benefit:** Stop coverage for your eligible dependent; increase or decrease existing coverage for you with proof of good health. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Stop coverage for your eligible spouse/Company-recognized Domestic Partner or dependent or start or stop coverage for yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.

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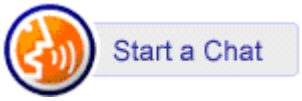
If You Experience the Following Life Event…	Then, You Can…
Change in spouse's/Company-recognized Domestic Partner's employment or other health coverage **OR** **Your spouse's/Company-recognized Domestic Partner's employer no longer contributes toward health coverage** **OR** **Your spouse's/Company-recognized Domestic Partner's employer no longer covers employees in your spouse's position**	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for your eligible spouse/Company-recognized domestic partner, your eligible dependent or yourself; stop coverage for your eligible spouse, eligible dependent or yourself. You cannot change benefit plans at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your eligible spouse/Company-recognized Domestic Partner or eligible dependent in the applicable benefit option. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Contact your union to determine if changes are permitted for your LTD coverage. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.

If You Experience the Following Life Event…	Then, You Can…
You or your dependent(s) exhausts a maximum benefit limit: **In another medical plan** **OR** **You or your dependents were enrolled in an HMO or another arrangement that will no longer cover you due to your failure to live, work, or reside in the arrangement's service area**	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for your eligible spouse, your eligible dependent or yourself; Stop coverage for your eligible spouse/Company-recognized Domestic Partner, your dependent, or yourself. You cannot change benefit plans at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your eligible spouse/Company-recognized Domestic Partner or eligible dependent in applicable benefit options. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partners, your eligible dependent or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.
Your benefit coverages are significantly improved, lowered or lessened by the Company **(Plan Administrator/Sponsor will determine whether or not a change is "significant")** **OR** **Your contribution amount is significantly increased or decreased by the Company** **(Plan Administrator/Sponsor will determine whether or not a change is "significant")**	**Make changes to the applicable benefit coverages:** The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMCSO) that requires you to provide health care coverage for a child	**Medical and Dental Option and Vision Insurance:** Start or add coverage for the eligible dependent(s) and yourself. You cannot change benefit options at this time (unless your existing option cannot cover the child).



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If You Experience the Following Life Event…	Then, You Can…
You, your spouse/Company-recognized Domestic Partner or your dependent(s) enroll in Medicare or Medicaid	**Medical and Dental Options and Vision Insurance:** Stop coverage for the applicable eligible person. You cannot change benefit options at this time.
You or your dependent(s) lose Medicaid or CHIP coverage	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for yourself and your eligible dependents. If you are already enrolled in Medical, Dental and Vision Options, you cannot change medical, dental or vision options at this time.
You or your dependent(s) become eligible for a state premium assistance program	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for yourself and your eligible dependents. If you are already enrolled in Medical, Dental and Vision Options, you cannot change Medical, Dental or Vision Options at this time.
You move to a new home address: **Update both your permanent AND alternate addresses (or your permanent address if you do not have an alternate address) online through www.jetnet.aa.com.** **Submit a revised form for payroll tax purposes. The form is available online through Jetnet.aa.com.** **Contact other organizations such as the American Airlines Credit Union and C. R. Smith Museum directly to update your contact information.** **Provide your new address and current emergency contact numbers to your manager/supervisor, as well.**	▪ **Medical Option:** May select from medical options available in new location if you are covered under the Value or Value Plus Option or an HMO and you moved out of the service area or to any area with different options available. For example, you may change from a Standard Option to the Value or Value Plus or an HMO; or from the Value or Value Plus or an HMO to a Standard Option, but you may not change between Standard Options or between Standard Options. Contact HR Services for more information. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Contact your union to determine if changes are permitted for your LTD coverage. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your eligible spouse and/or dependent; increase or decrease existing coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your eligible dependent or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in Flexible Spending Accounts. ▪ **If you move or relocate to a new location within the last two months of the year, contact HR Services so they can ensure your elections are filed for this current year and for next year.**

If You Experience the Following Life Event…	Then, You Can…
You become disabled	▪ **Notify:** Your manager/supervisor and download a Disability Claim Form. ▪ **Long-Term Disability:** Contact your union for information about the claim process. ▪ **Complete and submit:** Your claim for disability benefits.
You take a leave of absence	▪ **You will receive:** A letter from HR Services acknowledging your leave and instructing you to access Jetnet to register your Leave of Absence Life Event and decide whether or not to continue your benefits while on your leave. Register your Life Event and your benefit elections on Jetnet, and it will display for you a confirmation statement showing your choices, the monthly cost of benefits, etc. ▪ **Your cost depends on:** The type of leave you are taking.
You return from a leave of absence; register your Jetnet Life Event and make selections or changes to your benefits	▪ If you did not continue payment of your benefits during your leave and wish to reactivate your benefits upon your return to work, you may do so; however, you will be required to provide proof of good health for certain benefits (i.e., Basic Term Life Insurance).
You return from an unpaid leave of absence	▪ **Medical and Dental Options and Vision Insurance:** Resume coverage. You cannot change benefit options at this time. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Contact your union to determine if changes are permitted to your LTD coverage. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage; increase or decrease existing employee coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.

If You Experience the Following Life Event…	Then, You Can…
You change from part-time to full-time employment or full-time to part-time employment	▪ **Medical and Dental Options and Vision Insurance:** Add coverage for your eligible spouse/Company-recognized Domestic Partner and eligible dependent or yourself; stop coverage for your eligible spouse, eligible dependent, or yourself. You cannot change benefit options at this time, unless you have elected a reduced schedule (flex time, if applicable for your workgroup). Company-recognized Domestic Partners and their dependents may be eligible for HMOs. Contact your HMO for eligibility – eligibility is determined by the HMO. ▪ **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. ▪ **Long-Term Disability Plan:** Contact your union to determine if changes are permitted for your LTD coverage. ▪ **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your eligible spouse and/or dependent, or increase or decrease existing coverage. ▪ **Spouse Term Life Insurance Benefit:** Start or stop coverage. ▪ **Child Term Life Insurance Benefit:** Start or stop coverage. ▪ **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your dependent, or yourself; increase or decrease existing coverage. ▪ **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.
You die	▪ **Continuation of Coverage:** Your eligible dependents or spouse/Company-recognized Domestic Partner should contact your manager/supervisor, who will coordinate with a Survivor Support representative in HR Services to assist with all benefits and privileges, including the election of Continuation of Coverage, if applicable.

If You Experience the Following Life Event…	Then, You Can…
Your spouse or Company-recognized Domestic Partner dies	▪ **Continuation of Coverage:** You will receive information about Continuation of Coverage Overview through COBRA for the eligible surviving children of your spouse or Company-recognized Domestic Partner, if you contact HR Services as required below. ▪ **Contact:** HR Services within 60 days of your eligible spouse or Company-recognized Domestic Partner's death to update your records and make the appropriate changes, if applicable, to your benefits coverage. Click on the "Start a Chat" button on the top of this page.
You end your employment with the Company or you are eligible to retire	▪ **Review: "**When Coverage Ends" in the *General Enrollment* section ▪ **Review:** The information you receive regarding Continuation of Coverage through COBRA. ▪ **Contact:** HR Services for information on retirement. Click on the "Start a Chat" button on the top of this page.
You transfer to another workgroup or subsidiary of AMR corporation	▪ **Contact:** Your manager/supervisor, HR Services or the new subsidiary to determine benefits available to you and to make new benefit elections.
You and/or your eligible dependent(s) declined AA medical coverage because you or they had coverage elsewhere (external to AA), and any of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your eligible dependents in a Medical Benefits Option: ▪ Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) ▪ Employer contributions for the other coverage stopped ▪ Other coverage was COBRA and the maximum COBRA coverage period ended ▪ Exhaustion of the other coverage's lifetime maximum benefit ▪ Other employer-sponsored coverage is no longer offered ▪ Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your eligible dependents no longer reside, live, or work in its service area ▪ You have a new dependent via your marriage, your child's birth/adoption/placement for adoption with you	You have 60 days from the date of the event to enroll yourself and/or your eligible dependents in one of the Medical Benefit Options offered to you. You cannot change Medical Benefit Options at this time, if you are already enrolled. **This event allows you to add medical coverage only.**

If Your Dependent(s) Lose Eligibility Under the Plan

If your dependent(s) lose eligibility under the Plan, you must file a Life Event or contact HR Services to remove the ineligible dependent(s) from your coverage — even if you have missed the 60-day deadline.

- If you contact HR Services after the 60-day deadline you will be able to remove your dependent(s) from coverage, but the effective date of the removal will be the date you notified HR Services, and your resulting contribution rate changes, if any, will be effective as of the date you notified HR Services.
- You will not receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified HR Services of their ineligibility.
- **Important:** If you do not file a Life Event, notify HR Services of your dependent(s) losing eligibility and request your dependent(s) be solicited for COBRA within the 60-day time frame, the dependent(s) will lose their right to continue coverage under COBRA, so it is important that you are timely in registering your dependent(s)' removal from coverage within the 60-day time frame.

If You Process Your Life Event after the Deadline

If you miss the 60-day deadline and the event occurred in the current year, you must wait until the next annual enrollment period to add or delete your dependents.

If you miss the 60-day deadline and the event occurred in the previous year, you may add dependents to your file but you may not cover them under your benefits, make any changes to existing dependents or make any benefit plan changes. (Adding the dependent to your file lists the dependent as eligible to be enrolled at the next annual enrollment, but does not enroll him or her in benefits currently.)

Special Life Event Considerations

The following section explains special circumstances that may happen in your life and how these changes affect your benefits. You must take all of the steps described below for your Life Event within 60 days of the date it occurs.

- **Birth or adoption of a child:** To add a natural child to your coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth. You should not wait to receive the baby's Social Security number or official birth certificate. These documents may take more than 60 days to arrive and prevent you from starting coverage effective on the baby's birth date.

To add an adopted child to your benefit coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective the date the child is placed with you for adoption and is not retroactive to the child's date of birth.

- **Relocation:** If you are enrolled in the Value Plus Option and you move to a location where Value Plus is available, you will stay enrolled in Value Plus and your *network/claims administrator* will stay the same, or you may elect coverage that was not available in your prior location, such as an HMO.

If Value Plus is not available, you must choose another medical option, or you may waive coverage if you have other coverage (such as your spouse's employer-sponsored plan).

- If you are enrolled in the Value Option and you move to a location where Value is available, you will stay enrolled in Value and your *network/claims administrator* will stay the same, or you may elect coverage that was not available in your prior location, such as an HMO.

If the Value Option is not available, you must choose another medical option, or you may waive coverage if you have other coverage (such as your spouse's employer-sponsored plan).

- If you are enrolled in an HMO and you move out of that HMO's service area, you must choose another medical option.

If you are enrolled in a Standard Medical Option and you move to a location where your network/claims administrator is not the preferred network/claims administrator, you will keep your same network/claims administrator, at the preferred rate.

Contact HR Services and a representative will assist you with your election. Click on the "Start a Chat" button on the top of this page. If you are enrolled in an HMO or in the Value or Value Plus Option and you do not process your relocation Life Event within 60 days of your move, you will stay in your selected plan. If your selected plan is not available, you will automatically be enrolled in the default Medical Benefit Option for your workgroup.

Change in Medical Benefit Option: If you change medical options, your deductibles and out-of-pocket maximums may not transfer to the new option. For a detailed explanation of how this works, see "Mid-Year Medical Benefit Option Change: Impact on Deductibles and Out-of-Pocket Maximums" in the *Medical Benefit Options Overview* section.

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

Stepchild: Stepchild, if the child lives with you, and you the employee either jointly or individually claim the stepchild as a dependent on your federal income tax return. See Dependent Eligibility Requirements" in the *General Eligibility* section.

Benefit Coverages Affected by Life Events

Flexible Spending Accounts Benefit: If you change the amount of your contributions during the year, claims from your Health Care Flexible Spending Account for eligible health care expenses incurred before the change are payable up to the original amount you elected to contribute. Claims for expenses incurred after the change are payable up to your newly elected contribution amount. You forfeit part of your balance when the contributions before your change are greater than your claims before the change and you reduce the amount you elect to contribute. Your Dependent Day Care Flexible Spending Account reimburses based on the contributions in your account at the time of the claim.

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Fast Fact

You may change your medical option only if you move during the year and your current medical option is not available in your new location.

When you process a Life Event change, the change to your Flexible Spending Accounts is only valid for the remainder of the calendar year. If you process a Life Event change within the last two months of the year, there will not be time to process changes to your Flexible Spending Accounts for that year.

- **Voluntary Term Life Insurance Benefit:** You may only increase this coverage by one level per year with approved proof of good health.
- **Move/Relocation:** If you want to process a Relocation or Move Life Event within the last two months of the year, you must contact HR Services so they can help you ensure that you make appropriate changes for the remainder of this current year and for next year.

Benefit Coverages Not Affected by Life Events

The following benefits are not affected by Life Event changes, except as noted:

- **Medical Benefit Options:** You may change medical options only if you relocate and your current medical benefit option is not available in your new location.
- **Dental Option:** You may change dental options only during the annual enrollment period.
- **Vision Insurance Benefit:** You may add or delete vision coverage only during the annual enrollment period.

HIPAA Special Enrollment Rights – Medical Benefit Option

If you declined coverage for you or your dependents under the Medical Benefit Option because you or they have medical coverage elsewhere and one of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your dependents in the Medical Benefit Option:

- You and/or your dependents lose the other medical coverage because eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
- The employer contributions to the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.
- You and/or one of your dependents exhaust a lifetime maximum in another employer's health plan or other health insurance coverage.
- You and/or one of your dependents' employers cease to offer benefits to the class of employees through which you (or one of your dependents) had coverage.
- You and/or one of your dependents were enrolled under an HMO or other group or individual plan or arrangement that will no longer cover you (and/or one of your dependents) because you and/or one of your dependents no longer reside, live or work in its service area.
- You have a new dependent as a result of your marriage, your child's birth, adoption or placement for adoption with you. Coverage is retroactive to the date of birth, adoption or placement for adoption.

As an employee, you may enroll yourself and request enrollment for your new spouse and any new dependents within 60 days of your marriage. You may request to enroll a new child within 60 days of his or her birth, adoption or placement for adoption. If you miss the 60-day deadline, the enrollment will not be processed. You will have to wait until the next annual enrollment period to enroll your dependent.

In addition, if you are not enrolled in these employee benefits as an employee, you also must enroll in the benefits when you enroll any of these dependents. If your spouse is not enrolled in the benefits, you may enroll yourself and request enrollment for your spouse in the employee benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage, coverage will begin on the first day of the first calendar month after the completed enrollment form request and timely proof of eligibility are received. To request special enrollment or obtain more information, contact HR Services (see "Contact Information" in the *Reference Information* section).

If you are adding new dependents to your benefits during the special enrollment rights period, keep in mind that you must submit to HR Services proof that these dependents qualify as your eligible dependents. Proof that the dependents you want to enroll qualify as your dependents includes official government-issued birth certificates, adoption papers, marriage licenses, etc., as detailed in the Proof of Eligibility Requirements.

Medical Benefit Options Overview

The Company offers you the opportunity to enroll in medical coverage for you and your eligible dependent(s) that provides protection in the event of illness or injury. You may choose from several Medical Options or you may waive coverage completely if you have other coverage.

These are the available Medical Benefit Options:

- Standard Medical Options
- Value Option
- Value Plus Option, and
- an HMO (if available in your area).

You can only waive medical coverage if you have coverage under another medical plan (such as through your spouse/Company-recognized Domestic Partner's employer).

HR Services

If you have a question about your Medical Benefit Options, contact HR Services. You can chat with a Service Center Representative by selecting the "Start a Chat" button on the top of this page.

In This Section

Medical Benefit Options

You may choose one of the following Plan options:

- **Value Plus Option.** The Value Plus Option is self-funded by the Company. UnitedHealthcare (UHC), Aetna, and Blue Cross and Blue Shield of Texas administer these options; however, reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- **The Value Option.** The Value Option is self-funded by the Company. UnitedHealthcare (UHC), Aetna and Blue Cross and Blue Shield of Texas administer this option; however, reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- **One of the two Standard Medical Options.** The Standard Medical Options are self-funded by the Company. UnitedHealthcare (UHC), Aetna, and Blue Cross and Blue Shield of Texas administer these options; however, reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- **Health Maintenance Organization (HMO) Option.** HMOs are insured options whose covered services are paid by the HMO. The Company pays a flat monthly premium and the HMO pays for all covered services. HMOs are offered in many locations, but their coverage and features vary by location. If you live in a location where an HMO is offered, it will be indicated as an option in the Benefits Service Center when you enroll online.

Some Medical Benefit Options are not offered in all locations. During annual enrollment or as a new employee when you are first eligible and enroll for benefits, or if you experience a Life Event, the Benefits Service Center will reflect the options that are available to you.

You may choose from the following coverage levels:

- Employee
- Employee + one
- Employee + two or more

If you are married to an AMR employee, see "Employees Married to Other Employees" in the *General Eligibility* section for more information.

You can waive medical coverage if you are covered under another plan (such as your spouse/Company-recognized Domestic Partner's employer-sponsored plan). You may periodically be asked to provide proof of your other coverage.

You will not be able to file claims under a Medical Option of any AMR subsidiary if you waive coverage.

Your dependents must be enrolled in the same medical option that you are enrolled in. You cannot enroll your dependents in a different medical option. Your dependents cannot have medical coverage if you are not covered under the same medical option. See the General Eligibility section for additional rules.

You can only enroll in a medical option during annual enrollment or if you experience a qualifying Life Event during the year (see the Life Events section).

Network/Claims Administrators

The Standard Medical Options, the Value Plus Option and the Value Option — the Plan's self-funded Medical Options — **are administered by three network/claims administrators:**

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

A network/claims administrator is the health plan administrator that processes health care claims and manages a network of health care providers and care facilities. Medical necessity is determined by your network/claims administrator.

Each state has a designated preferred network/claims administrator. Your state is determined by the ZIP code of your Jetnet alternate address on record. Jetnet allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence). Since many employees maintain more than one residence, you may list both addresses in Jetnet; however, your alternate address determines your network/claims administrator. If you do not have an alternate address listed in Jetnet, your network/claims administrator is based on your permanent address.

See the sections Standard Medical Options and Value Option and Value Plus Option for more information on network/claims administrators and your medical option.

Administrator's Discretion

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

Medical Benefit Options Comparison

The table in this section provides a summary of features under the Standard, Value Plus and Value Medical Options. Benefits are available for eligible expenses that are medically necessary and within the usual and prevailing (U&P) fee limits for the Standard Medical Options. See the Glossary section for a definition of U&P. If you are covered under one of the Standard Medical Options, you must satisfy any individual annual deductibles before the option pays benefits for eligible expenses.

For the Value and Value Plus Options, other limitations apply depending on if you use in-network or out-of-network providers and facilities. Additionally, the Value and Value Plus Options determine eligible expenses by the use of Maximum Non-Network Reimbursement Program (MNRP) fee limits on out-of-network claims. See the Glossary section for the definition of MNRP. If you use out-of-network services or in-network hospital-based services under the Value Plus or Value Options, you must satisfy any individual annual deductibles before the option pays benefits for eligible expenses.

The table shows the amount or percentage you pay for eligible expenses. You also pay any amounts not covered by the options.

As you review the benefit comparison tables, keep the following in mind:

- The Maximum Medical Benefit for all Medical Benefit Options has been eliminated effective January 1, 2011.
- The annual out-of-pocket maximum applies to co-insurance amounts you pay under the Value Option and to network services subject to co-insurance under the Value Plus Option (i.e., for hospital services, including inpatient and outpatient care and surgery). The out-of-pocket maximum does not include deductibles, co-payments amounts, amounts not covered or amounts exceeding the MNRP fee.
- The annual out-of-pocket maximum applies to co-insurance amounts you pay under the Standard Medical Options. The out-of-pocket maximum does not include deductibles, amounts not covered, amounts exceeding the usual and prevailing fee limits or services covered at 50% (such as, convalescent and skilled nursing facilities following hospitalization).
- Under the Standard Medical Options, the retail prescription drug charges apply to the medical deductible, co-insurance and annual out-of-pocket amounts.
- Mail order prescription drug co-pays/co-insurance amounts do not apply to the out-of-pocket maximum for all Medical Benefit Options.
- Your eligibility for the Value Plus option is determined by your five-digit ZIP code. Employees living outside the access area are not eligible for the Value Plus Option and must select a different self-funded Medical Benefit Option or an HMO, if available.

For information regarding eligible medical expenses and expenses that are excluded from coverage, refer to "Covered Expenses" on page 58 and "Excluded Expenses" on page 66.

Preventive care coverage is determined by the type of Medical Benefit Option you select. Due the Patient Protection and Affordable Care Act (PPACA), with amendments made by the Health Care and Education Reconciliation Act (HCERA), signed into law March 23, 2010, the government has published recommendations of what services should be covered as preventive care. However, some of these services may not be covered by your option. Contact your network/claims administrator for more information about covered services.

All services must be medically necessary. Medical necessity is determined by the network/claims administrator.

New![*]

Features	What You Pay Under the Standard Medical Options	What You Pay Under the Value Option		What You Pay Under the Value Plus Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Deductibles and Maximum Medical Benefit					
Individual annual deductible For most covered services with a co-insurance component, the deductible must be met before benefits are payable. Co-pays are not subject to the deductible.	Option 1 – $150 Option 3 – $1,000	$500	$1,500	$100	$750
Family annual deductible For most covered services with a co-insurance component, the deductible must be met before benefits are payable. Covered expenses from any and all covered persons can be used to meet the family annual deductible. Co-pays are not subject to the deductible.	Option 1 – $400 Option 3 – $3,000	N/A	N/A	N/A	N/A

[*] *The provisions marked by the box that says "New!" have changed since the last Employee Benefits Guide was produced. To review the previous version of the Guide, see the Archives section.*

Features	What You Pay Under the Standard Medical Options	What You Pay Under the Value Option		What You Pay Under the Value Plus Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Individual annual out-of-pocket maximum* Only each individual's portion of covered expenses can be used to meet the individual annual out-of-pocket maximum. Co-pays and deductibles cannot be used to meet the individual annual out-of-pocket maximum.	Option 1 – $1,000 Option 3 – $2,500	$2,750 per person for expenses that require you to pay 20% co-insurance	N/A	$1,750 per person for services that require you to pay 15% co-insurance	N/A
Maximum Medical Benefit	Unlimited				
Preventive Care					
Annual routine physical exams	Not covered	No cost	Not covered	No cost	You pay the full cost (not covered out-of-network)
Well-child care	20% co-insurance for initial hospitalization at birth, immunizations and up to 7 well-child care visits for children up to age 2	No cost	Not covered	No cost	35% co-insurance for initial hospitalization at birth, immunizations and up to 7 well-child care visits for children up to age 2
Medical Care					
Physician's office visit (including X-ray and lab work)	20% co-insurance	$25 per visit	40% co-insurance	$20 per visit	35% co-insurance
Specialist's office (including X-ray and lab work)	20% co-insurance	$45 per visit	40% co-insurance	$40 per visit	35% co-insurance
Urgent care clinic	20% co-insurance	$45 per visit	40% co-insurance	$40 per visit	35% co-insurance
Gynecological care	20% co-insurance; preventive care not covered (except for mammograms, as listed below)	$25 per visit	40% co-insurance	$20 per visit to an OB/GYN (same as a visit to a PCP, whether the OB/GYN is treating you in the capacity of a specialist or a PCP) (OB/GYN visits related to care during pregnancy are subject to the $150 maternity co-pay)	35% co-insurance if medically necessary; preventive care not covered (except for mammograms, as listed below)
▪ Pap tests	20% co-insurance if medically necessary; routine pap tests are not covered	No cost, if part of an office visit 20% co-insurance if hospital outpatient	40% co-insurance	No cost if part of office visit	35% co-insurance if medically necessary; routine pap tests are not covered

Features	What You Pay Under the Standard Medical Options	What You Pay Under the Value Option		What You Pay Under the Value Plus Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network
▪ Mammograms — routine screening	20% co-insurance for routine screening mammograms are covered according to age-specific guidelines — refer to Mammograms in Covered Expenses	No cost, based on age guidelines, regardless of facility	40% co-insurance if medically necessary	No cost, based on age guidelines, regardless of facility	35% co-insurance
▪ Mammograms — diagnostic	20% co-insurance if medically necessary	No cost if part of office visit or at an independent facility. 20% co-insurance if hospital outpatient	40% co-insurance if medically necessary	No cost if part of office visit or at an independent facility 15% co-insurance if hospital outpatient	35% co-insurance if medically necessary
▪ Pregnancy	20% co-insurance	$150 copay per pregnancy includes pre- and post-natal visits and delivery (this includes physician's charges only; hospital charges are the same as for any hospitalization)	40% co-insurance	$150 maternity co-pay per pregnancy includes pre- and postnatal visits and delivery. (This includes physician's charges only; hospital charges are the same as for any hospitalization.)	35% co-insurance
▪ ***Second surgical opinions*** ▪ ***(No cost if ordered by the Plan or claim administrator)***	20% co-insurance if elected by participant	$45 per visit, if elected by participant	40% co-insurance if elected by participant	$40 per visit if elected by participant	35% co-insurance if elected by participant
Chiropractic care	20% co-insurance if medically necessary	$45 per visit Maximum 20 chiropractic visits per calendar year per covered family member combined in-network and out-of-network for medically necessary chiropractic care	40% co-insurance if medically necessary Maximum 20 chiropractic visits per calendar year per covered family member combined in-network and out-of-network for medically necessary chiropractic care	$40 per visit Maximum 20 chiropractic visits per calendar year per covered family member combined in-network and out-of-network for medically necessary chiropractic care	35% co-insurance Maximum 20 chiropractic visits per calendar year per covered family member combined in-network and out-of-network for medically necessary chiropractic care
Speech, physical, occupational, restorative and rehabilitative therapy, if medically necessary	20% co-insurance	$45 per visit	40% co-insurance if medically necessary	$40 per visit	35% co-insurance

Features	What You Pay Under the Standard Medical Options	What You Pay Under the Value Option		What You Pay Under the Value Plus Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Allergy care					
Physician's office visit	20% co-insurance	PCP – $25 per visit Specialist – $45 per visit	40% co-insurance	PCP – $20 per visit Specialist – $40 per visit	35% co-insurance
Allergy testing, shots or serum	20% co-insurance	No cost if administered in physician's office $25 copayment, if PCP office visit is charged; $45 for specialist visit	40% co-insurance	No cost if administered in physician's office $20 co-pay if PCP office visit is charged; $40 for specialist visit	35% co-insurance
Outpatient Services					
Diagnostic X-ray and lab	20% co-insurance	20% co-insurance at hospital; No cost if received at an independent network lab or in a doctor's office	40% co-insurance	15% co-insurance at hospital No cost if received at an independent in-network facility or in a physician's office	35% co-insurance
Outpatient surgery in physician's office (Pre-authorization is recommended to ensure medical necessity; see "CheckFirst (Predetermination of Benefits)" on page 70)	20% co-insurance	PCP – $25 per visit Specialist – $45 per visit	40% co-insurance	PCP – $20 per visit Specialist – $40 per visit	35% co-insurance
Outpatient surgery in a hospital or freestanding surgical facility (Pre-authorization is recommended to ensure medical necessity; see CheckFirst (Predetermination of Benefits)" on page 70)	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Pre-admission testing	20% co-insurance	20% if performed at hospital No cost if performed at an independent lab	40% co-insurance	15% co-insurance if performed at hospital No cost if performed at an independent lab	35% co-insurance
Hospital Services					
Inpatient room and board	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Intensive care unit and special care unit	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Ancillary services, including radiology, pathology, operating room and supplies	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance

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Features	What You Pay Under the Standard Medical Options	What You Pay Under the Value Option		What You Pay Under the Value Plus Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Newborn nursery care This care is considered under the baby's coverage, not the mother's. Within 60 days of the birth, you must process a Life Event change online through Jetnet to enroll your baby in your health coverage. If you do not, you must wait until the next annual enrollment period to enroll your baby. Payment of maternity claims does not automatically enroll your baby.	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Surgery and related expenses (such as anesthesia and medically necessary assistant surgeon)	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Blood transfusions	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance No cost if received at physician's office	35% co-insurance
Organ transplants	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Emergency ambulance	20% co-insurance	20% co-insurance	40% co-insurance	No cost	
Emergency room	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Out-of-Hospital Care					
Convalescent and skilled nursing facilities following hospitalization	50% co-insurance Maximum of 60 days per illness	20% co-insurance Maximum of 60 days per illness for in-network and out-of-network combined	40% co-insurance Maximum of 60 days per illness for in-network and out-of-network combined	15% co-insurance Maximum of 60 days per illness for in-network and out-of-network combined	35% co-insurance Maximum of 60 days per illness for in-network and out-of-network combined
Home health care	20% co-insurance	20% co-insurance	40% co-insurance	No cost when approved by your network/claims administrator	35% co-insurance
Hospice care	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Other Services					
Tubal ligation or vasectomy (Reversals are not covered)	20% co-insurance	20% co-insurance	40% co-insurance	$40 co-pay if performed in a physician's office 15% co-insurance in hospital	35% co-insurance
IUD insertion and removal (covered if performed as outpatient surgery in a physician's office)	Not covered	$25 co-pay	Not covered	$20 co-pay	Not covered
Infertility treatment, including in-vitro fertilization	Not covered				

Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

Features	What You Pay Under the Standard Medical Options	What You Pay Under the Value Option		What You Pay Under the Value Plus Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Radiation therapy and chemotherapy	20% co-insurance	20% co-insurance No cost in physician's office	40% co-insurance	15% co-insurance No cost in physician's office	35% co-insurance
Kidney dialysis (If the dialysis continues more than 12 months, participant must apply for Medicare)	20% co-insurance	20% co-insurance No cost in physician's office	40% co-insurance	15% co-insurance No cost in physician's office	35% co-insurance
Supplies, equipment and durable medical equipment (DME)	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Mental Health Benefits - No Treatment Limits					
Inpatient mental health care	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Alternative mental health care center — residential treatment	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Alternative mental health care center – intensive outpatient and partial hospitalization	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Outpatient mental health care	20% co-insurance	20% co-insurance, if at an outpatient facility If at a doctor's office: $25 PCP co-pay $45specialist co-pay	40% co-insurance	15% co-insurance, if at an outpatient facility If at a doctor's office: $20 PCP co-pay $40 specialist co-pay	35% co-insurance
Marriage/relationship/family counseling	Not covered				
Chemical Dependency Benefits - No Treatment Limits and No EAP Approval is Required**					
Detoxification	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Inpatient chemical dependency rehabilitation	20% co-insurance	20% co-insurance	40% co-insurance	15% co-insurance	35% co-insurance
Outpatient chemical dependency rehabilitation	20% co-insurance	20% co-insurance, if at an outpatient facility If at a doctor's office: $25 PCP co-pay $45 specialist co-pay	40% co-insurance	15% co-insurance, if at an outpatient facility If at a doctor's office: $20 PCP co-pay $40 specialist co-pay	35% co-insurance

Features	What You Pay Under the Standard Medical Options	What You Pay Under the Value Option		What You Pay Under the Value Plus Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Gender Reassignment Benefit (Cumulative benefit for surgery is $75,000. The cumulative benefit for travel is $10,000)					
Surgery ▪ One bilateral mastectomy or bilateral augmentation mammoplasty ▪ One genital revision surgery	Not covered	20% co-insurance	Not covered	15% co-insurance	Not covered
Travel Expenses	Not covered	Up to $10,000	Not covered	Up to $10,000	Not covered
Non-Surgical Treatments ▪ Physician's visits ▪ Specialist visits ▪ Outpatient mental health care ▪ X-rays and lab work ▪ Retail prescription drugs ▪ Mail order prescription drugs	Not covered	Covered as any other illness or injury under the Plan	Not covered	Covered as any other illness or injury under the Plan	Not covered
Prescription Medication					
Retail pharmacies Typically up to a 30-day supply — see "Excluded Expenses" on page 66	20% co-insurance for most prescription drugs; co-insurance applies to out-of-pocket maximum Medco network pharmacies offer discounts on prescriptions. You must show your Medco ID card when purchasing, in order to receive the discounted rates Reimbursement is based on Medco's discounted rates	Generic Drugs: 20% co-insurance ($20 min/$40 max) Formulary Drugs: 30% co-insurance ($30 min/$100 max)*** Non-Formulary Drugs: 50% ($45 min/$150 max)*** **Co-insurance amounts do not apply to deductible or out-of-pocket maximum.** **Limits apply for Long-Term Medications refills. See "Retail Refill Allowance — Long-Term Medications" under "Prescription Drug Benefits" in the *Value Option* section.**		Generic Drugs: 20% co-insurance ($10 min/$20 max) Formulary Drugs: 30% co-insurance ($30 min/$100 max)*** Non-Formulary Drugs: 50% co-insurance ($45 min/$150 max)*** **Co-insurance amounts do not apply to deductible or out-of-pocket maximum.** **Limits apply for Long-Term Medications refills. See "Retail Refill Allowance — Long-Term Medications" under "Prescription Drug Benefits" in the *Value Plus Option* section.**	
Mail Order (Medco) Purchase up to a 90-day supply — see "Excluded Expenses" on page 66 Co-pays and co-insurance amounts (if applicable) do not apply to deductible or out-of-pocket maximum.	Generic Drugs: $25 per prescription or refill (or the actual cost, if less than $25) Brand Name Drugs: 25% of the cost of the drug ($150 max) Brand Name Drug When Generic Is Available: $25 per prescription or refill, plus the cost difference between brand and generic prices; no max	Generic Drugs: 20% co-insurance ($10 min/$80 max) Formulary Drugs: 30% co-insurance ($60min/$200 max)*** Non-Formulary Drugs: 50% ($90 min/$300 max)***		Generic Drugs: 15% co-insurance ($5 min/$40 max) Formulary Drugs: 30% co-insurance ($60 min/$200 max)*** Non-Formulary Drugs: 50% co-insurance ($90 min/$300 max)***	
Specialty Medications	Must obtain from Accredo or a retail pharmacy.				
Oral contraceptives	Not covered, unless medically necessary for purposes other than contraception	Oral contraceptives, transdermal and intravaginal contraceptives are covered by Medco by Mail only. This includes both generic and brand name (formulary or non-formulary) contraceptives.			

Features	What You Pay Under the Standard Medical Options	What You Pay Under the Value Option		What You Pay Under the Value Plus Option	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Fertility (infertility) medications	Medications used to treat infertility or to promote fertility are not covered.				
Over-the-counter medication (OTC)	Over-the-counter medications are not covered under the Medical Options. See the Prescription Drug Benefit section under your Medical Benefit Option for information about certain coverage allowances.				
Other Information (Applies to Both Medical and Mental Health Care)					
Pre-determination of benefits	Recommended before hospitalization and surgery				
Hospital pre-authorization	Required for hospitalization and recommended before outpatient surgery	Recommended before hospitalization and surgery			

* Maximum does not include your annual deductible, expenses that are not covered or exceed the usual and prevailing (or MNRP) fee limits, any co-pays or any expenses that are reimbursed at 50%.

** EAP approval is required for all cases resulting from regulatory or Company policy violations.

*** If you select a brand name drug (formulary or non-formulary) when a generic is available, you will pay the $10 generic retail co-pay or 20% generic Mail Order co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.

Mid-Year Medical Benefit Option Change: Impact on Deductibles and Out-of-Pocket Maximums

During the year you may experience one of the following mid-year changes:

- You move from one American Airlines workgroup to another, or
- You move from American Airlines to another AMR Corporation Subsidiary, or
- You retire, or
- You or your dependents move from Active coverage to COBRA coverage.

When you experience one of these changes, you may have to select a different Medical Benefit option. The Medical Benefit options offered vary depending on your workgroup, if you transfer between AMR Corporation Subsidiaries, if you retire and if you elect COBRA continuation of coverage.

If you experience one of these mid-year changes and as a result you select a different Medical Benefit Option, your deductibles and out-of-pocket maximums **may or may not** carryover to your new Medical Benefit option. These are the general guidelines. **Note: They may differ based on your individual situation.**

If…	Your Deductible and Out-of-Pocket Maximum…
You move from one AA workgroup to another AA workgroup	**will** carryover
You transfer/relocate and you have to select a new Medical Benefit option because your existing Medical Benefit option is not offered in your transfer/relocation area	**will not** carryover
You move between AMR Corporation Subsidiaries	**will not** carryover
You retire and move from Active coverage to Retiree coverage	**will not** carryover

If…	Your Deductible and Out-of-Pocket Maximum…
You move from Pre-65 Retiree coverage to Age 65 and Over Retiree coverage	**will not** carryover
You or your dependent(s) move from Active to COBRA continuation coverage	**will** carryover

In the event you experience a mid-year change, you must contact HR Services to determine if your deductibles and out-of-pocket maximums will carryover and if you need to provide information to your network/claims administrator.

Mental Health and Chemical Dependency Care

Regardless of the Medical Benefit Option you elect, each network/claims administrator uses its own mental health care management vendor:

- For UnitedHealthcare (UHC), the mental health administrator is OptumHealth Behavioral Solutions (formerly referred to as UBH)
- For Aetna, the mental health administrator is Aetna Behavioral Health
- For Blue Cross and Blue Shield of Texas, the mental health administrator is Blue Cross and Blue Shield

The Medical Benefit options cover the following medically necessary mental health and chemical dependency care:

Inpatient mental health care: Under the Standard Medical Options or when you use in-network providers under the Value and Value Plus Option, when you are hospitalized for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses (see "Covered Expenses" in this section), up to Plan maximums.

Alternative mental health care center – residential treatment: Under the Standard Options, such treatment is covered at 80%.

Under the Value Plus Option, such treatment is covered at 85% when you use in-network providers and at 65% when you use out-of-network providers.

Under the Value Option, such treatment is covered at 80% if you use in-network providers and at 60% if you use out-of-network providers.

Alternative mental health care center – intensive outpatient and partial hospitalization: Under the Standard Options, such treatment is covered at 80%.

Under the Value Plus Option, such treatment is covered at 85% when you use in-network providers and at 65% when you use out-of-network providers.

Under the Value Option, such treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers.

Outpatient mental health care: Under the Standard Options, such treatment is covered at 80%.

Under the Value Plus Option, for outpatient mental health care through an in-network provider under the Value Plus Option, the co-pay is $20 per PCP visit and $40 per specialist visit. Such treatment is covered at 65% when you use out-of-network providers.

Under the Value Option, for outpatient mental health care through an in-network provider under the Value Plus Option, the co-pay is $25 per PCP visit and $45 per specialist visit. Such treatment is covered at 60% when you use out-of-network providers.

Chemical dependency rehabilitation: Medically necessary chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient or a combination. There are no limits on the number of chemical dependency rehabilitation programs a participant may attend (regardless of whether the program is inpatient or outpatient).

You must obtain EAP approval for all cases resulting from regulatory or Company policy violations. In all other instances, EAP approval is not required for an inpatient or outpatient chemical dependency rehabilitation treatment.

The Plan does not cover expenses for a family member to accompany the patient being treated, although many chemical dependency treatment centers include family care at no additional cost.

Under the Standard Options, inpatient and outpatient treatment is covered at 80%.

Under the Value Plus Option, inpatient treatment is covered at 85% when you use network providers and at 65% when you use out-of-network providers. For outpatient treatment through a network provider under the Value Plus Option, the co-pay is $20 per PCP visit and $40 per specialist visit. Outpatient treatment is covered at 65% when you use out-of-network providers.

Under the Value Medical Option, inpatient and outpatient treatment is covered at 80% when you use network providers and 60% when you use out-of-network providers. For outpatient treatment through a network provider under the Value Option, the co-pay is $25 per PCP visit and $45 per specialist visit. Outpatient treatment is covered at 60% when you use out-of-network providers.

Detoxification: Under the Standard Options, such treatment is covered at 80%.

Under the Value Plus Option, such treatment is covered at 85% when you use network providers and at 65% when you use out-of-network providers.

Under the Value Option, such treatment is covered at 80% when you use network providers and at 60% when you use out-of-network providers.

Gender Reassignment Benefit (GRB)

For information on Company policies about transgender issues, read the Policy.

Effective June 1, 2011, the Gender Reassignment Benefit (GRB) provides coverage for gender reassignment. The GRB is a limited, one-time benefit for the entire time the employee is covered under the Plan. The GRB only offers benefits on an in-network basis. There are no GRB benefits offered out-of-network. The GRB offers a $75,000 surgical benefit and a $10,000 for travel reimbursement.

This benefit applies only to employees or retirees. This benefit is not available to spouses, Company-recognized Domestic Partners and other eligible dependents.

The GRB is offered under the following Medical Benefit Options:

- Value Plus Option
- Value Option

The GRB is not offered under the Standard Medical Option.

Coverage for surgical benefits under the GRB is limited to $75,000, regardless of your network/claims administrator, even if you change administrators. Any co-insurance amounts you pay apply to the $75,000 limit. This $75,000 GRB is available to the employee or retiree only one time during the entire time the employee or retiree is covered under the Plan.

An employee who receives the full benefit amount under the GRB for active employees cannot receive any additional benefits under the GRB for retirees. However, if you have not received the maximum GRB under the Medical Plan for active employees, you may receive a balance GRB under the Retiree Medical Plan, not to exceed a combined benefit of $75,000 for surgical benefits and $10,000 for travel reimbursement.

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

GRB Coverage

The Plan pays the following benefits:

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

Surgical Benefit

Surgical benefits are limited to one bilateral mastectomy or bilateral augmentation mammoplasty, and one genital revision surgery for the entire time the employee is covered under the Plan. Subsequent surgical revisions, modifications or reversals are excluded from coverage. Coverage is limited to treatment performed by in-network providers.

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

Any co-insurance or co-payments amounts for in-network medical visits and prescription drugs do not accumulate towards the $75,000. Prescription drugs and mental health treatment associated with the GRB are considered under the Plan's behavioral and mental health and prescription drug provisions; subject to applicable provisions, limitations and exclusions.

Travel Reimbursement

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

Preauthorization for the GRB

- **You must have approval from the network/claims administrator both at the time you begin your treatment and at the time you are admitted for surgery.** Your failure to obtain preauthorization **both** at the time you begin treatment and at the time you are admitted for surgery will result in denial of your claims.
- See "CheckFirst (Predetermination of Benefits)" and "QuickReview (Pre-Authorization)"

Wellness Resources

These programs and services are not part of the AA-sponsored Health and Welfare Plans. They are offered at no cost to participants and participation is completely voluntary and confidential.

The ActiveHealth Management programs and resources are available to American Airlines employees enrolled in a self-funded Medical Benefit option, and covered family members eligible to participate in the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries. Family member eligibility may vary by program. See the Healthmatters page on Jetnet for more information.

ActiveHealth Management does not determine claim eligibility, nor does it determine whether or not benefits are payable under the Plan.

ActiveHealth Management offers Nurse Advocates. Nurse Advocates are specially trained to provide participants information to help them make wiser health care choices.

The ActiveHealth Management NurseLine offers participants telephone access to nurses who can answer health questions and provide treatment option suggestions.

ActiveHealth Management's Disease Management program offers support for many chronic conditions, including hypertension, asthma and diabetes. See the Healthmatters page on Jetnet for information on the conditions covered under this program.

HMO participants should check with their HMO directly for wellness programs and resources.

Additional Medical Case Management with Your Network/Claims Administrator

In addition to the programs listed in the Wellness Resources section, participants in the self-funded Medical Benefit options also have access to medical case management through their network/claims administrator. Medical case management offers 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.

Contact your network/claims administrator at the member services website or call (see "Contact Information" in the *Reference Information* section).

HMO participants should check with their HMO directly for medical case management resources.

Covered Expenses

Quick Tip

If you have an HMO, check with your HMO directly to find out covered and excluded expenses.

This section contains descriptions of the eligible medical expenses (listed alphabetically) that are covered under the self-funded Medical Options when medically necessary. Benefits for some of these eligible expenses vary depending on the Medical Option you have selected and whether or not you use in-network providers. See "Medical Benefit Options Comparison" on page 45 for information on how most services are covered. For covered expenses under an HMO, check with the HMO directly.

For a list of items that are excluded from coverage, see "Excluded Expenses" on page 66.

- **Acupuncture:** Medically necessary treatment for illness or injury (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 and allergies.)
- **Allergy care:** Charges for medically necessary physician's office visits, allergy testing, shots and serum are covered. See "Excluded Expenses" on page 66 for allergy care not covered.
- **Ambulance:** Medically necessary professional ambulance services and air ambulance once per illness or injury to and from:
  - The nearest hospital qualified to provide necessary treatment in the event of an emergency
  - The nearest hospital or convalescent inpatient care
  - An in-network hospital, if you are covered under the Value Plus Option and your network/claims administrator authorizes the transfer

  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 including, 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:** Only covered 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 that there is an actual expense to the participant.
- **Chiropractic care:** Coverage includes medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered. You are limited to 20 visits per year for combined in-network and out-of-network chiropractic care. With the exception of the Standard Medical Options; if you are enrolled in the one of the Standard Medical Options, your chiropractic benefits are not limited, provided the care meets the requirements of medical necessity.

- **Convalescent or skilled nursing facilities:** To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital for a covered inpatient hospital confinement of at least three consecutive days and be recommended by your physician for the condition that caused the hospitalization. Eligible expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement and your network/claims administrator must approve your stay. Custodial care is not covered.
  - **Value Plus Option:** These facilities are covered the same as hospital (paid at 85% co-insurance for in-network and 65% for out-of-network), for up to 60 days per illness or injury for network and out-of-network facilities.
  - **Standard Medical Options:** These facilities are covered at 50% of the most common semiprivate room rate in that geographic area for inpatient hospital expenses for up to 60 days per illness (for the same or related causes) after you are discharged from the hospital.
  - **Value Option:** These facilities are covered at 80% in-network of the most common semiprivate room rate in that geographic area for inpatient hospital expenses for up to 60 days per illness (for the same or related causes) after you are discharged from the hospital. Out-of-network facilities are covered at 60%.
- **Cosmetic surgery:** Medically necessary expenses for cosmetic surgery are covered only if they are incurred under either of the following conditions:
  - As a result of a non-work related injury.
  - For replacement of diseased tissue surgically removed.
  - Other cosmetic surgery is not covered because it is not medically necessary.
- **Dental expenses for medically necessary dental examination, diagnosis, care and treatment of one or more teeth, the tissue around them, the alveolar process or the gums, only when care is rendered for:**
  - Accidental injury(ies) to sound natural teeth, in which both the cause and the result are accidental, due to an outside and unforeseen traumatic force,
  - Fractures and/or dislocations of the jaw, or
  - Cutting procedures in the mouth (this does not include extractions, dental implants, repair or care of the teeth and gums, etc., unless required as the result of accidental injury, as stated in the first bullet above)
- **Detoxification:** Detoxification is covered as any other medical condition. Contact your network/claims administrator for authorization.
- **Dietician services:**
  - **Standard Medical Options:** Dietician services are not covered.
  - **Value Plus Option**: Coverage includes services recommended by your in-network provider and provided by a licensed in-network dietician. Dietician services are not covered out-of-network under the Value Plus Option.
  - **Value Option:** Coverage includes services recommended by your in-network provider and provided by a licensed in-network dietician. Dietician services are not covered out-of-network under the Value Option.

- **Durable medical equipment (DME):** Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME and/or components (such as batteries or software) resulting from normal wear and tear is not covered. Examples of DME are items such as CPAP or BiPAP machines, wheelchairs, hospital beds, nebulizers, oxygen concentrators, TENS units, passive range of motion devices, joint cooling devices, bone stimulators, etc.
- **Emergency room:** Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. You must call your network/claims administrator for QuickReview approval within 48 hours of an emergency resulting in admission to the hospital.
- **Eyeglasses or contact lenses:** See the Vision Insurance Benefit section.
- **Facility charges:** Charges for the use of an outpatient surgical facility when the facility is either an outpatient surgical center affiliated with a hospital or a freestanding surgical facility.
- **Gender reassignment/sex changes:** Covered under the Gender Reassignment Benefit (GRB) in the following Medical Benefit Options:
  - Value Plus Option
  - Value Option

The GRB is not offered under the Standard Medical Option.

- **Hearing care:** Covered expenses include medically necessary hearing exams and up to one hearing aid for each ear, per year. Coverage for hearing aids is limited to basic hearing aids. Cochlear implants and/or osseointegrated hearing systems are covered only if medically necessary.
- **Hemodialysis:** Coverage provided for medically necessary hemodialysis.
- **Home health care:** Home health care, when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. Custodial care is not covered. You should call your network/claims administrator to initiate the QuickReview process to be sure home health care is considered medically necessary.
- **Hospice care:** Eligible expenses medically necessary for the care and treatment of a terminally ill covered person. Expenses in connection with hospice care include both facility and outpatient care. Hospice care is covered when approved by your network/claims administrator. You should contact your network/claims administrator to initiate the QuickReview process.
- **Inpatient room and board expenses:**
  - **Value Plus Option:** Eligible expenses are based on the negotiated rates with that particular network hospital. For out-of-network, eligible expenses are determined based on the most common semiprivate room rate in that geographic area.
  - **Value Option:** Eligible expenses are based on the negotiated rates with that particular network hospital. For out-of-network, eligible expenses are determined based on the most common semiprivate room rate in that geographic area.

- **Standard Medical Options:** Hospital room and board charges are eligible at 80% up to the most common semiprivate room rate in that geographic area, plus $4. If the hospital does not have semiprivate rooms, the Standard Medical Options consider the eligible expense to be 90% of the hospital's lowest private room rate, plus $4.

- **Intensive care, coronary care or special care units (including isolation units):** Coverage includes room and board and medically necessary services and supplies.
- **IUD:** Insertion or removal of an IUD. Covered if performed in an in-network physician's office (covered as outpatient surgery) for the following plans: Value Option and Value Plus Option. Not covered under the Standard Medical Options.
- **Laboratory or pathology expenses:** Coverage is provided for medically necessary diagnostic laboratory tests. Under the Value Plus Optionor the Value Option, in-network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility.
- **Mammograms:** Medically necessary diagnostic mammograms are covered, regardless of age under all medical options.

  Under the Value Plus Option and the Value Option, routine screening mammograms are covered in-network at 100%. Out-of-network under the Value Plus Option and the Value Option, routine screening mammograms 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 year from ages 40 and up as recommended by your physician.

  Routine screening mammograms are covered under the Standard Medical Options based on the following guidelines:

  - Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared,
  - Once every year from ages 40 and up as recommended by your physician
- **Mastectomy**: Medically necessary mastectomy and certain reconstructive and related services after a mastectomy are covered. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:
  - Reconstruction of the breast on which a mastectomy was performed,
  - Surgery or reconstruction of the other breast to produce a symmetrical appearance,
  - Services in connection with other complications resulting from a mastectomy, such as lymphedemas, and
  - Prostheses.
- **Medical supplies:** Covered medical supplies include, but are not limited to:
  - Oxygen, blood and plasma
  - Sterile items including sterile surgical trays, gloves and dressings
  - Needles and syringes
  - Colostomy bags
  - Diabetic supplies, including needles, chem-strips, lancets and test tape covered under the prescription drug benefit
  - Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered

- **Multiple surgical procedures:** Reimbursement for multiple surgical procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage, and to be sure the charges are within the usual and prevailing fee limits for the Standard Plan Option or within MNRP under out-of-network for the Value Plus Option and Value Option, contact your network/claims administrator to use the CheckFirst pre-determination program. The Value Plus Option and Value Option pays in-network benefits based on the negotiated rate.
- **Newborn nursery care:** The hospital expenses for a newborn baby are considered under the baby's coverage, not the mother's. The hospital expenses for a newborn baby are covered, provided you timely process a Life Event. To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. If you miss the 60-day deadline you will not be able to add your baby to your coverage until the next annual enrollment period, even if you already have other children enrolled in coverage. The filing or payment of a maternity claim does not automatically enroll the baby.
- **Oral surgery:** Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process, only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the Medical Option will pay room and board, anesthesia and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the Medical Options. However, they may be covered under the Dental Benefit.
- **Outpatient surgery:** Charges for services and supplies for a medically necessary surgical procedure performed on an outpatient basis at a hospital, freestanding surgical facility or physician's office. You should pre-authorize the surgery through your network/claims administrator to initiate the QuickReview process to ensure the procedure is medically necessary.
- **Physical or occupational therapy:** Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a physician. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered.
- **Physician's services:** Office visits and other medical care, treatment, surgical procedures and post-operative care for medically necessary diagnosis or treatment of an illness or injury. The Medical Benefit Options cover office visits for certain preventive care, as explained under Preventive Care.
- **Pregnancy:** Charges in connection with pregnancy, only for female employees and female spouses/Company-recognized Domestic Partners. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed or certified by the state in which he or she practices. Within the first 12 weeks of pregnancy, you should call ActiveHealth Management to participate in the MaternityMatters pregnancy program if you are enrolled in the self-funded plans. This is offered at no cost to employees and their covered dependents. Employees enrolled in an HMO should contact their HMO. 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 by Medical Benefit Options. Federal law prohibits the Plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery, or from requiring your provider to obtain pre-authorization for a longer stay. However, federal law does not require you to stay any certain length of time. If, after consulting with your physician, you decide on a shorter stay, benefits will be based on your actual length of stay. Charges in connection with pregnancy for covered dependent children are covered only if due to certain complications of pregnancy, for example: ectopic pregnancy, hemorrhage, toxemia, placental detachment and sepsis.

- **Prescription drugs:** Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition. Prescriptions related to infertility treatment and weight control are not covered. Under the Standard Medical Options oral contraceptives used for family planning or birth control are not covered. See "Excluded Expenses" on page 66 for additional information regarding drugs that are excluded from coverage.

  Medically necessary medications are also covered for the following special situations:

  - Medications provided, administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit.
  - Medications that are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy are covered as part of the facility's ancillary charges.
  - Medications that are administered as part of home health care.
  - Diabetic supplies, including insulin, needles, chem-strips, lancets and test tape.

  Certain types of medicines and drugs that are not covered by the medical benefits may be reimbursed under the Health Care Flexible Spending Accounts (see "Covered Expenses" in the *Health Care Flexible Spending Account* section).

- **Preventive care:**
  - The Value Plus Option covers preventive care, including well-child care, immunizations, routine screening mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages when you use network providers. Non-routine tests for certification, sports or insurance are not covered unless medically necessary.
  - The Value Option covers preventive care, including well-child care, immunizations, routine screening mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages when you use network providers. Non-routine tests for certification, sports or insurance are not covered unless medically necessary.
  - Preventive care covered under the Standard Medical Options and out-of-network care under the Value Plus Option includes routine screening mammograms (see "Mammograms" in this section for guidelines) and well-child care for children up to age two (including initial hospitalization following birth, all immunizations and up to seven well-child care visits). The Value Option does not cover preventive care out-of-network.
- **Private duty nursing care:** Coverage includes medically necessary care by a licensed nurse if it is of a type or nature not normally furnished by hospital floor nurses.
- **Prostheses:** Prostheses (such as a leg, foot, arm, hand or breast) necessary because of illness, injury or surgery. Replacement of prosthesis is only covered when medically necessary because of a change in the patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of a prosthesis resulting from normal wear and tear is not covered.
- **Radiology (X-ray):** Examination and treatment by X-ray or other radioactive substances, imaging/scanning (MRI, PET, CAT and ultrasound), diagnostic laboratory tests and routine mammography screenings for women (see "Mammograms" in this section for guidelines).
- Under the Value Option and the Value Plus Option, in-network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility.

- **Reconstructive surgery:** Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:
  - Reconstruction of the breast on which a mastectomy was performed,
  - Surgery or reconstruction of the other breast to produce a symmetrical appearance,
  - Services in connection with other complications resulting from a mastectomy, such as lymphedemas, and
  - Prostheses.
- **Speech therapy:** Restorative and rehabilitative care and treatment for loss or impairment of speech 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 be performed before the therapy.
- **Surgery:** When medically necessary and performed in a hospital, freestanding surgical facility or physician's office. (See "CheckFirst (Predetermination of Benefits)" on page 70 for details about hospital pre-authorization and pre-determination of benefits.)
- **Temporomandibular joint dysfunction (TMJD):** Eligible expenses under the medical benefits include only the following, if medically necessary:
  - Injection of the joints
  - Bone resection
  - Application of splints, arch bars or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion
  - Manipulation or heat therapy

  Crowns, bridges or orthodontic procedures for treatment of TMJD are not covered.
- **Transplants:** Expenses for transplants or replacement of tissue or organs if they are medically necessary and not experimental, investigational or unproven services. Benefits are payable for natural or artificial replacement materials or devices.

  Donor and recipient coverage is as follows:
  - If the donor and recipient are both covered under the Plan, expenses for both individuals are covered by the Plan.
  - If the donor is not covered under the Plan and the recipient is covered, the donor's expenses are covered to the extent they are not covered under any other medical plan, and only if they are submitted as part of the recipient's claim.
  - If the donor is covered under the Plan but the recipient is not covered under the Plan, no expenses are covered for the donor or the recipient.
  - The total benefit paid under this Plan for the donor's and recipient's expenses will not be more than any Plan maximum medical benefit applicable to the recipient.
  - You may arrange to have the transplant at an in-network transplant facility. Your network/claims administrator can help you locate a transplant facility. These facilities specialize in transplant surgery and may have the most experience, the leading techniques and a highly qualified staff. Using an in-network transplant facility is not required. However, use of an out-of-network facility will be covered at the out-of-network rate.

It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria — not all transplant situations will be eligible for benefits. Therefore, you must contact your network/claims administrator to initiate the QuickReview process as soon as possible for pre-authorization before contemplating or undergoing a proposed transplant. The following transplants are covered if they are medically necessary for the diagnosed condition and are not experimental, investigational, unproven or otherwise excluded from coverage under the Medical Options, as determined in the sole discretion of the Plan Administrator and its delegate, the claims processor:

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

This is not an all-inclusive list. It is subject to change. Contact your network/claims administrator for more information.

- **Transportation expenses:** Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip 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” in this section.

- **Tubal ligation and vasectomy:** These procedures are covered; however, reversal of these procedures is not covered.

- **Urgent/immediate care:**
  - Under the Standard Medical Options, charges for services and supplies provided at an urgent treatment clinic are covered.
  - Under the Value Option and the Value Plus Option, in order to receive the in-network benefit level, you should contact your network provider or your network/claims administrator if you go to an out-of-network provider within 48 hours to ensure that you receive the in-network level of benefits.
- **Well-child care:**
  - Under the Standard Medical Options, well-child care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits.Under the Value Option there are no age or visit limitations when you use in-network providers. Well-child coverage is not provided out-of-network.
  - Under the Value Plus Option there are no age or visit limitations when you use in-network providers. Out-of-network coverage under the Value Plus Option, covered children up to age two are covered for initial hospitalization following birth, all immunizations and up to seven well-child care visits.
- **Wigs and hairpieces:** Eligible expense for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery or severe burns. Only one wig or hairpiece benefit is covered under the Plan for the entire time the individual is covered. This benefit is subject to the usual and prevailing fee limits, MNRP fee limits, deductibles, co-pays, co-insurance and out-of-pocket limits of the selected Medical Option. The maximum benefit available for wigs and hairpieces is $350. Replacement wigs or hairpieces are not covered, regardless of any change in the patient's physical condition. Hair transplants, styling, shampoo and accessories are also excluded.

Excluded Expenses

This section contains a list of alphabetical items that are excluded from coverage under the Medical Benefit Options. For exclusions under an HMO, check with the HMO directly.

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

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

- **Experimental, Investigational or Unproven treatment:** Medical treatment, procedures, drugs, devices or supplies that are generally regarded as experimental, investigational or unproven, including, but not limited to:
  - Treatment for Epstein-Barr Syndrome
  - Hormone pellet implantation
  - Plasmapheresis

  See the Experimental, Investigational or Unproven Treatment definition in the Glossary section.
- **Eye care:** Eye exams, refractions, eyeglasses or the fitting of eyeglasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training and vision therapy.
- **Foot care:** Diagnosis and treatment of weak, strained or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses or toenails. (This exclusion does not apply to the removal of nail roots.)
- **Free care or treatment:** Care, treatment, services or supplies for which payment is not legally required.
- **Gender reassignment/sex changes:** The GRB is not offered under the Standard Medical Option. Any expenses received from an out-of-network provider will not be payable. There is no coverage under the GRB for spouses, Company-recognized Domestic Partners or any other eligible dependents.
- **Government-paid care:** Care, treatment, services or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)
- **Infertility treatment:** Expenses or charges for infertility treatment or testing and charges for treatment or testing for hormonal imbalances that cause male or female infertility, regardless of the primary reason for hormonal therapy.
  - Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction and infertility drugs such as, for example, Clomid or Pergonal, are also excluded.
  - Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.
- **Lenses:** No lenses are covered except the first pair of medically necessary contact lenses or eyeglasses following cataract surgery.
- **Massage therapy:** All forms of massage and soft-tissue therapy, regardless of who performs the service.
- **Medical records:** Charges for requests or production of medical records.
- **Missed appointments:** If you incur a charge for missing an appointment, the Plan will not pay any portion of the charge.

- **MNRP (Maximum Non-Network Reimbursement Program):** Any portion of fees for physicians, hospitals and other medical providers that exceeds 140% of MNRP value. (Applies to out-of-network providers under the Value Option and the Value Plus Option).
- **Nursing care:**
  - Care, treatment, services or supplies received from a nurse that do not require the skill and training of a nurse
  - Private duty nursing care that is not medically necessary, or if medical records establish that such care is within the scope of care normally furnished by hospital floor nurses
  - Certified nurse's aides
- **Organ donation:** Expenses incurred as an organ donor, when the recipient is not covered under the Plan. For additional information, see "Transplant" under "Covered Expenses".
- **Pregnancy for dependents:** Prenatal care and delivery charges are excluded for covered dependent children unless the charges are due to certain complications. Examples of covered complications include ectopic pregnancy, hemorrhage, toxemia, placental detachment and sepsis.
- **Preventive care:** Coverage for preventive care varies, depending on the Medical Option you have elected for coverage. To determine if preventive care is covered by your selected Medical Option, refer to Medical Benefit Options Comparison.
- **Relatives:** Coverage is not provided for treatment by a medical practitioner (including, but not limited to: a nurse, physician, physiotherapist or speech therapist) who is a close relative (spouse/Company-recognized Domestic Partner, child, brother, sister, parent or grandparent of you or your spouse/Company-recognized Domestic Partner, including adopted and step relatives).
- **Sleep disorders:** Treatment of sleep disorders, unless it is considered medically necessary.
- **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.
- **Speech therapy:** Except as described in "Covered Expenses", 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.
- **TMJD:** Except as described in "Covered Expenses", diagnosis or treatment of any kind for temporomandibular joint disease or disorder (TMJD), or syndrome by a similar name, including orthodontia, crowns, bridges or orthodontic procedures to treat TMJD.
- **Transportation:** Transportation by regularly scheduled airline, air ambulance or train for more than one round trip per illness or injury.
- **Usual and prevailing:** Any portion of fees for physicians, hospitals and other providers that exceeds the usual and prevailing fee limits. (Applies to out-of-network providers under the Standard Medical Options.)
- **War-related:** Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.

- **Weight reduction:** Hospitalization, surgery, treatment and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact your network/claims administrator (or HMO if applicable) to determine if treatment is covered.
- **Wellness items:** Items that promote well-being and are not medical in nature and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas and health club memberships). Also excluded are:
  - Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning
  - Services related to vocation, including but not limited to: physical or FAA exams, performance testing and work hardening programs
- **Work-related:** Medical services and supplies for treatment of any work-related injury or illness sustained by you or your covered dependent, whether or not it is covered by Workers' Compensation, occupational disease law or other similar law.

CheckFirst (Predetermination of Benefits)

CheckFirst allows you to find out if:

- The recommended service or treatment is covered by your selected Medical Option
- Your physician's proposed charges fall within the Plan's usual fees (applies to the Standard Medical Options or out-of-network in the Value Option and the Value Plus Option).

If you are covered by the Standard Medical Options and you are receiving discounts, or if you are covered by the Value or Value Plus Option and you are using an in-network provider, the provider's fees are not subject to usual and prevailing fee limits. However, you may want to contact your network/claims administrator at the appropriate CheckFirst number for your Medical Option to determine if the proposed services are covered under your selected Medical Option.

To use CheckFirst under the Standard Medical Options, you may either submit a CheckFirst Pre-determination of Medical Benefits form before your proposed treatment or you may call your network/claims administrator to obtain a pre-determination of benefits by phone or to request the pre-determination form. If you are having surgery your network/claims administrator (as part of your network/claims administrator's hospital pre-authorization process) will determine the medical necessity of your proposed surgery before making a pre-determination of benefits. Your network/claims administrator will mail you a written response.

Even if you use CheckFirst, your network/claims administrator reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different than the information submitted for pre-determination of benefits. Claims are processed in order of receipt. Payment of a claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

For hospital stays, CheckFirst can pre-determine the amount payable by the Plan. A CheckFirst pre-determination does not pre-authorize the length of a hospital stay or determine medical necessity. You must call your network/claims administrator for your Medical Plan Option for pre-authorization (see "QuickReview (Pre-Authorization)" on page 71).

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 procedure.
- **Multiple surgical procedures:** If you are having multiple surgical procedures performed at the same time, any procedure that is not the primary reason for surgery is covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgeon. You must use CheckFirst to find out how the Plan reimburses the cost for any additional procedures.
- For the Gender Reassignment Benefit, you must have approval from the network/claims administrator both at the time you begin your treatment and at the time you are admitted for surgery. See the "Gender Reassignment Benefit (GRB)" section on page 55 for more information.

QuickReview (Pre-Authorization)

You or your provider acting on your behalf are required to request pre-authorization from your network/claims administrator before any hospital admission, or within 48 hours (or the next business day if admitted on a weekend) following emergency care. If you do not contact your network/claims administrator, your expenses are still subject to review and will not be covered under the Plan if they are considered not medically necessary. If you are enrolled in one of the self-funded Medical Benefit Options, request pre-authorization by calling your network/claims administrator. If you are covered by an HMO, contact your HMO before any hospitalization.

When to Request Approval from Your Network/Claims Administrator

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

- Call your network/claims administrator 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
- Before you undergo testing or treatment for sleep disorders
- Before you contemplate or undergo any organ transplant
- Before you undergo procedure that will incur a substantial expense

The list above is not comprehensive. Contact your network/claims administrator for more information.

Under the Value Option and the Value Plus Option, if you are in-network, your provider will call for you. If you are out-of-network in the Value Option and the Value Plus Option, you must call on your behalf.

If your physician recommends surgery or hospitalization, ask your physician for the following information before calling your network/claims administrator for pre-authorization:

- Diagnosis and diagnosis code
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician's name and telephone number
- Name and telephone number of the hospital or clinic where surgery is scheduled
- If your illness or injury prevents you from personally contacting your network/claims administrator, any of the following may call on your behalf:
- A family member or friend
- Your physician
- The hospital
- Your network/claims administrator will tell you:
- Whether the proposed treatment is considered medical necessity and appropriate for your condition
- The number of approved days of hospitalization

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

After you are admitted to the hospital, your network/claims administrator provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, your network/claims administrator consults with your physician and hospital to verify the need for any extension of your stay. If you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness, you must contact your network/claims administrator again to authorize any additional hospitalization.

If you are scheduled for outpatient surgery, you should call your network/claims administrator. If you do not call, you may be subject to a retrospective review of the surgery to determine whether it was medically necessary. This means you or your physician may be asked to provide medical documentation to support the medical necessity.

- For the Gender Reassignment Benefit, you must have approval from the network/claims administrator both at the time you begin your treatment and at the time you are admitted for surgery. See the "Gender Reassignment Benefit (GRB)" section on page 55 for more information.

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

Standard Medical Options

The Standard Medical Options are grandfathered.

As an eligible employee, you can choosefrom two Standard Medical Options. You can cover yourself, your spouse/Company-recognized Domestic Partner and/or dependent children under the Standard Medical Options

- Each option has varying deductibles and out-of-pocket maximums.
- Each covered person, which includes you and any covered dependents, must satisfy an annual deductible before the option begins paying a percentage of the eligible expenses.
- If you use an in-network physician, hospital and other medical service provider, your eligible expense will be based on the negotiated rate, provided it is a covered service.

Your Network/Claims Administrator

The Standard Medical Options are administered by three network/claims administrators: UnitedHealthcare (UHC), Aetna, and Blue Cross and Blue Shield of Texas. The preferred network/claims administrator for each state will be the sole network provider of health care services for the Standard Medical Options. Therefore, you cannot select a different network/claims administrator. The list of the network/claims administrators by state can be found on Jetnet.

Your state is determined by your alternate address. If you do not have an alternate address on Jetnet, your state will be determined by your permanent address.

Benefit Overview

Option	Individual Annual Deductible	Family Annual Deductible	Individual Annual Out-of-Pocket Maximum
Standard Medical Option 1	$150	$400	$1,000
Standard Medical Option 3	$1,000	$3,000	$2,000

In This Section — See Page

How the Standard Medical Options Work

As an eligible employee, you can choose from two Standard Medical Options. Both Standard Medical Options have the same features and cover the same eligible expenses. The differences between Option 1 and Option 3 are in the amount of the individual and family deductibles and the maximum out-of-pocket amount you pay each year. The employee contribution costs of the options also vary.

Both Standard Medical Options offer a voluntary preferred provider network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. You may use any qualified licensed physician you wish, but you will receive the discount if you use an in-network provider for eligible expenses. Contact your network/claims administrator for more information and to access a list of in-network providers. See “Negotiated Rates” under “Special Provisions” in this section for information regarding providers that have agreed to charge negotiated rates for medical services. Medical necessity is determined by your network/claims administrator.

After you and your covered dependents meet the annual deductible, the Standard Medical Option pays 80% of eligible expenses up to usual and prevailing fees. You pay 20% co-insurance for covered services. After you meet the annual out-of-pocket maximum, eligible expenses are covered at 100% for the remainder of the year.

See the “Medical Benefit Options Comparison” in the *Medical Benefit Options Overview* section to see a comparison of your benefits under the Standard Medical Options and the Value Plus Option.

Network/Claims Administrator

The Standard Medical Options are administered by three network/claims administrators: UnitedHealthcare (UHC), Aetna, and Blue Cross and Blue Shield of Texas. The preferred network/claims administrator for each state will be the sole network provider of health care services for the Standard Medical Options. Therefore, you cannot select a different network/claims administrator for the Standard Medical Options.

If you relocate to a new state, your network/claims administrator does not change. Your medical plan option election and contribution rates remain the same for the remainder of the plan year. For more information on how your state is determined, see "Network/Claims Administrator" under "Medical Benefit Options" in the *Medical Benefit Options Overview* section. A state-by-state map can be found on Jetnet.

Special Provisions

The Standard Medical Options include the following special provisions:

Accidental Injury Benefit: If you and/or a covered dependent are injured in a non-work related accident, the Standard Medical Options pay 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 of eligible expenses, you must satisfy the deductible and co-insurance provisions.

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 (up to the family maximum) still apply to each person for expenses not related to the accident.

Annual Individual/Family Deductible: Each individual must satisfy his or her own deductible. The family annual deductible is applicable if three or more family members are covered. Under the Standard Medical Options, once the family annual deductible has been satisfied, all covered individuals are eligible for reimbursement of eligible medical expenses, regardless of whether they have satisfied individual annual deductibles.

Annual Out-of-Pocket Maximum: After you satisfy the annual out-of-pocket maximum for eligible expenses under the option you have selected for coverage, the medical option pays 100% of eligible expenses for the rest of the calendar year (with the exception of mail order drugs). Under the Standard Medical Options, the covered person's co-insurance amounts apply to the annual out-of-pocket maximum, with the exception of expenses covered at 50%.

Negotiated Rates: The Standard Medical Options offer a voluntary network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for eligible medical services. The negotiated rates may save you and the Company money when you or your covered dependent needs medical care and chooses a participating provider.

This negotiated rate is automatic when you present your medical ID card to an in-network provider. In-network providers who contract with your network/claims administrator agree to provide services and supplies at negotiated rates. Some providers charge more than others for the same services. For this reason, using an in-network provider may mean you receive a lower rate. In addition to negotiated rates, in-network providers, in most cases, will file your claims for you. You receive a bill for only the remaining amount that you are responsible for paying, such as your deductible or co-insurance amounts.

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

There may be special situations when you use hospital, lab or X-ray services:

- If you go to an in-network hospital but receive services from a provider who is not an in-network provider, you will receive the in-network negotiated rate for hospital charges, but the physician's fee is not eligible for the in-network negotiated rate.
- If you use an in-network physician or hospital, charges for your lab or X-ray services may not be eligible for the in-network negotiated rate if your provider or hospital uses a lab that is not part of the network. Note, some lab and X-ray services performed in a hospital may be contracted out to an out-of-network provider.

In all cases, the out-of-network provider fees will be subject to usual and prevailing fee limits.

Covered and Excluded Expenses

For a detailed explanation of the Plans' covered expenses and exclusions, see "Covered Expenses" and "Excluded Expenses" in the *Medical Benefit Options Overview* section.

Filing Claims

In most cases, if you received services from an in-network provider, your provider will generally file the claim for you. If you must file the claim yourself, follow the procedures below:

- Complete a Medical Benefit Claim Form.
- Submit the completed form to your network/claims administrator, along with all original itemized receipts from your physician or other health care provider. A cancelled check or credit card receipt is not acceptable.

Each bill or receipt submitted to your network/claims administrator 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 description and charges for the treatment or service, and
- Provider's name, address and tax ID number.

Make copies of the original itemized bill or receipt provided by your physician, hospital or other medical service provider for your own records. All medical claims payments are sent to you with an Explanation of Benefits (EOB) explaining the amount paid, unless your physician, hospital, or other medical provider has agreed to accept assignment of benefits (see "Assignment of Benefits" in the *Plan Administration* section). In most cases, the EOB will be mailed to you and the payment mailed to your provider. EOBs are also available on your network/claims administrator's website.

It is very important that you fully complete the 'other coverage' section of the form. Examples of other coverage include a spouse's group health plan, Workers' Compensation, Medicare, TRICARE and no-fault motor vehicle insurance.

- If you have questions about your coverage or your claim under one of the Standard Medical Options, contact your network/claims administrator (see "Contact Information" in the *Reference Information* section).

Claims Filing Deadline

- **For all claims incurred on or after 1/1/10,** you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- **For all claims incurred on or before 12/31/09,** you must submit all health 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 of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Prescription Drug Benefits

Medco is the prescription drug vendor for the Standard Medical Options. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Medco Mail Service Prescription Drug Benefit. Only eligible expenses for covered prescription drugs purchased at a retail pharmacy apply to your deductible or out-of-pocket maximum.

Medco has a broad network of pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the Medco website or call Medco at 1-800-988-4125.

Retail Drug Coverage

You may have your prescriptions filled at any pharmacy. For most covered drugs you are reimbursed at 80% of the Medco discounted price after satisfying your medical option deductible. You must present your Medco prescription drug card *every time* you purchase prescription drugs 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 and reimbursement from the plan will be based on the discounted price. This means you pay the difference between the non-discounted and the discounted price, in addition to paying the 20% co-insurance (after your deductible has been met).

Here is an example:

If you:	**The cost of your prescription is:**	The amount considered an eligible expense	**Plan pays:**	**You pay:**
Purchase your prescription showing your Medco card	$100 (the discounted amount for that particular drug)	$100	$80 (80% co-insurance)	$20 (20% co-insurance)
Purchase your prescription without showing your Medco card	$250 (the non-discounted price for that particular drug)	$100	$80 (80% co-insurance)	$170 (20% co-insurance plus the $150 difference between the non-discounted price of the drug and the discounted price)

Note: You must present your Medco prescription drug card every time you purchase prescription drugs in order to receive the discounted price.

Filling In-Network Prescriptions with Medco

To fill prescriptions at an in-network pharmacy and file for reimbursement:

- Present your Medco ID card to the pharmacy *every time* you order your prescription from an in-network pharmacy.
- Pay the Medco price for the prescription and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Medco. See *Filing Claims for Prescriptions* for more information on how to file a claim.

Filling Out-of-Network Prescriptions

To fill prescriptions at an out-of-network pharmacy and file for reimbursement:

- Pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Medco. See *Filing Claims for Prescriptions* for more information on how to file a claim.
- **Note:** If you purchase prescription drugs at an out-of-network pharmacy, you will be reimbursed based on the Medco discount price, **not** the actual retail cost of the medication.

Filing Claims for Prescriptions

You will need to send in a completed Medco claim form, along with your receipts to Medco. Once you have submitted your claim to Medco, your network/claims administrator will process your claim, based on the information received from Medco. Medco reports the claim to your network/claims administrator. Your network/claims administrator sends you an Explanation of Benefits (EOB) and applicable payment, advising you of the total charges you submitted, any amounts not covered and the reason and the amounts eligible and paid under the medical option.

If you are enrolled in a Standard Medical Option and you participate in the Health Care Flexible Spending Account, your eligible retail drug out-of-pocket expense is reimbursable under your FSA (see "Covered Expenses" in the *Health Care Flexible Spending Account* section).

If you have questions concerning your prescription drug coverage, call the Medco Member Services number on your Medco ID card. If you have questions about the benefit amount reflected on your EOB, call your network/claims administrator (for specialty medications see "Specialty Pharmacy Services" in this section.

Retail Prescription Clinical Programs

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

Generic Drugs

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

Prior Authorization

To be eligible for benefits, certain covered prescriptions require prior authorization by Medco to determine medical necessity before you can obtain them at a participating pharmacy or through the Medco Mail Order Prescription Drug Benefit. Examples of medications requiring prior authorization include growth hormones and rheumatoid arthritis drugs.

Medco will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

When you fill your prescription, your pharmacist will call Medco. Your pharmacist and a Medco pharmacist will review the request for approval. Medco will send you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for up to one year. Prior authorizations must be renewed periodically. When the renewal date approaches, you should contact Medco for renewal instructions.

Ask your physician to contact Medco or to complete Medco's prior authorization form with 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
- Any other information your physician believes is pertinent

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

Specialty Pharmacy Services

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

Accredo Health Group, a subsidiary of Medco Health, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at a retail pharmacy or one of Accredo's Health Group pharmacies through Medco Health:

- Anemia
- Growth Hormone
- Hemophilia
- Hepatitis C

- Immune Deficiency Therapy
- Metabolic Disorders
- Multiple Sclerosis
- Oral Cancer Drugs
- Osteoporosis
- Pulmonary/Pulmonary Arterial Hypertension
- Rheumatoid Arthritis or Other Autoimmune Conditions
- Other Various Indications

Please note that other conditions are added as appropriate and as required.

Whether these prescriptions are self-administered or administered in a physician's office the prescriptions to treat the above conditions are not reimbursed through your Medical Benefit Option and must be filled at a retail pharmacy using your Medco ID card or through Medco by Mail for you to receive prescription drug benefits. Medco can ship the prescription to your home for self-administration or to your physician's office for medications which are to be administered by a physician.

The applicable deductible and co-insurance associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions.

Medco Prescription Drug Mail Order

You and your covered dependents are eligible for Medco by Mail. You may use this mail service option to order prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration. A registered pharmacist fills your prescription.

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 co-pay or co-insurance (with no annual deductible) for each prescription or refill. Co-pays and co-insurance, which are subject to change, are currently:

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

Although non-medically necessary oral contraceptives (for family planning or birth control) are not covered under the Standard Medical Options, you and your covered dependents may purchase oral contraceptives through Medco by Mail. You pay the full cost of the prescription, but it will cost less than if you purchased it at a retail pharmacy.

Mail Order Prescription Clinical Programs

Medco uses a number of clinical programs to help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, the drugs subject to these clinical programs may change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).

When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these programs may be obtained from Medco see "Contact Information" in the *Reference Information* section).

Generic Drugs

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

Ordering Prescriptions by Mail

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

- Download or print the Initial Mail Order Packet.
- Complete the Medco by Mail Form, and include the health and allergy questionnaire found in your initial packet from Medco. (The questionnaire will not be necessary on refills or future orders unless your health changes significantly.)
- Include the original written prescription signed by your physician.
- Indicate your method of payment on the form.
  - A major credit or debit card, or
  - Personal check or money order.

Medco will bill you when your medications are delivered (up to $100). If paying by check or money order, enclose your payment with the order. Do not send cash. For pricing information, access the Medco website or call Medco (see "Contact Information" in the *Reference Information* section).

- Mail your order to the address on the Medco by Mail Form.
- Generally, your order is shipped within three working days of receipt. All orders are sent by UPS or first class mail. UPS delivers to rural route boxes but not to P.O. Boxes. If you have only a P.O. Box address, your order is sent by first class mail.

Internet Refill Option

You have online access to Medco 24-hours a day, seven days a week. At the Medco website, you can order prescription drug refills, check on the status of your order, request additional forms and envelopes,or locate a network pharmacy near you.

To refill a prescription online, log on to the Medco website. Your prescriptions available for refill will be displayed. Allow up to 14 days for delivery of your prescription.

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Other Refill Options

If you choose not to refill your mail order prescriptions online, place your order at least two weeks before your current supply runs out in one of the following two ways:

- Call 1-800-988-4125 to request a refill. You will be asked for your Medco ID number, current mailing address and Medco Health Rx Services prescription number.
- Complete and mail in your Medco by Mail Form. Attach your Medco refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

Claims Filing Deadline

- **For all claims incurred on or after 1/1/10,** you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- **For all claims incurred on or before 12/31/09,** you must submit all health 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 of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Reimbursement of Co-insurance

Your mail order co-insurance is the out-of-pocket amount you must pay when you fill your prescription drugs. It is not eligible for reimbursement under the Standard Option. However, if you elected to participate in the Health Care Flexible Spending Account, your co-insurance may be eligible for reimbursement. See the Health Care Flexible Spending Account section for more information.

Value Plus Option

This Medical Benefit Option is non-grandfathered.

As an eligible employee, you can choose the Value Plus Option. You can cover yourself, your spouse/Company-recognized Domestic Partner, your dependent children and/or your spouse/Company-recognized Domestic Partner's dependent children under the Value Plus Option.

- For providers' eligible expenses, the annual deductibles are:
  - $100 for in-network services per person
  - $750 for out-of-network services per person
- You have the choice of receiving care from in-network providers or out-of-network providers.
  - If you use an in-network physician, hospital or other medical service providers, your out-of-pocket expenses may be lower.
  - If you use out-of-network providers, your out-of-pocket expenses will be greater.

Your Network/Claims Administrator

The Value Plus Option is administered by three network/claims administrators: UnitedHealthcare (UHC), Aetna and Blue Cross and Blue Shield of Texas. Each state has one preferred network/claims administrator. You may be able to choose a different network/claims administrator, but you will pay more in contributions. The list of the network/claims administrators by state can be found on Jetnet.

Your state is determined by your alternate address on file in Jetnet. If you do not have an alternate address on file in Jetnet, your state will be determined by your permanent address.

Benefit Overview

Services	Per-Person Deductible	Co-Insurance/Co-Pay (after deductible is met)	Per-Person Annual Out-of-Pocket Maximum
In-Network	$100	15%	$1,750 per covered individual (for services covered at 85%)
Out-of-Network	$750 (applies to all services)	35% (applies to all services)	Unlimited out-of-pocket maximum

In-network and out-of-network deductibles do not apply to the out-of-pocket maximum. If you satisfy the individual annual network deductible and later in the year use out-of-network services, you must satisfy the out-of-network deductible separately.

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In This Section	See Page

How the Value Plus Option Works

As an eligible employee, you can choose the Value Plus Option, which offers you access to the network of physicians and hospitals that have agreed to provide medical services to plan participants at preferred rates. When you use a network provider, you pay only a co-pay or co-insurance for most services. Medical necessity is determined by your network/claims administrator.

In-Network Services

Each covered person, which includes you and any covered dependents, must first satisfy an annual in-network deductible of $100 before the option begins paying a percentage of eligible expenses. After you and your covered dependents meet the annual in-network deductible, the Value Plus Option pays 85% of in-network eligible expenses. You pay 15% co-insurance for in-network services. After you and your covered dependents meet the individual annual out-of-pocket maximum of $1,750 for services that require you to pay 15% co-insurance, further eligible expenses are covered at 100% for the remainder of the year.

Out-of-Network Services

Each covered person, which includes you and any covered dependents, must first satisfy an annual out-of-network deductible of $750 before the option begins paying a percentage of eligible expenses. After you and your covered dependents meet the annual out-of-network deductible, the Value Plus Option pays 65% of out-of-network eligible expenses. You pay 35% co-insurance for out-of-network services. There is no out-of-pocket maximum.

Other Information

You can receive in-network benefits for specialist care without a referral from a primary care physician (PCP), but you are encouraged to have a PCP to coordinate in-network services for you. Contact your network/claims administrator to review a list of in-network providers. You can also access your network/claims administrator's website to find a list of in-network providers.

After you have enrolled, you will receive a Value Plus Option ID card from your network/claims administrator indicating that you and your enrolled dependents are covered by the Value Plus Option. The ID card includes important phone numbers and should be presented each time you go to a network physician or hospital. Value Plus members will receive a Medco ID card for prescription drug services.

If you relocate to a new state, your medical plan option election and contribution rates remain the same for the remainder of the plan year. Your elected network/claims administrator does not change based on your relocation. However, if the Value Plus Option is not available in your new location, you must elect another form of medical coverage.

You must wait until the next annual enrollment period to change your medical option election and your network/claims administrator, unless you experience a relocation Life Event. See "Life Events" for more information.

The Value Plus Option is offered in most locations, but if you live outside the network/claims administrator's access area, you are not eligible for the Value Plus Option and must choose a different self-funded Medical Benefit Option or an HMOfor medical coverage.

See the "Medical Benefit Options Comparison" in the *Medical Benefit Options Overview* section to see a comparison of your benefits under the Value Plus Option and the Value and Standard Options.

Network/Claims Administrator

The Value Plus Option is administered by three network/claims administrators — UnitedHealthcare (UHC), Aetna, and Blue Cross and Blue Shield of Texas.

When you enroll for the Value Plus Option, you have a choice among the three network/claims administrators. The administrator with the lowest employee contribution costs will be the preferred network/claims administrator for your state. You can choose a non-preferred network/claims administrator — called Tier 1 or Tier 2 — but you will pay more in employee contributions. The Tier 1 and Tier 2 non-preferred network/claims administrators will vary from state to state. For example, Aetna may be a Tier 1 non-preferred network/claims administrator in one state and a Tier 2 network/claims administrator in another.

Tier 1 and Tier 2 network/claims administrators reflect monthly contributions that are 25% and 50% higher than the cost of the preferred network/claims administrator, as this chart demonstrates:

	Employee Only	Employee + 1 Dependent	Employee + 2 or More Dependents
Preferred network/claims administrator	Preferred Rate	Preferred Rate	Preferred Rate
Tier 1 network/claims administrator	Preferred Rate Plus 25% Increase	Preferred Rate Plus 25% Increase	Preferred Rate Plus 25% Increase
Tier 2 network/claims administrator	Preferred Rate Plus 50% Increase	Preferred Rate Plus 50% Increase	Preferred Rate Plus 50% Increase

Preferred rate increases are subject to change.

The list of the network/claims administrators by state can be found on Jetnet.

Special Features of the Value Plus Option

The Value Plus Option includes the following special provisions:

- **In-network services:** In-network providers who contract with your network/claims administrator agree to provide services and supplies at contracted rates. At the in-network benefit level, you pay a fixed co-pay or co-insurance amount, a $100 per person annual deductible.
- **Out-of-Network services:** If you go to a provider who is not part of the network, you are covered for eligible medically necessary services; however, coverage reimbursement is at a lower level (out-of-network benefit level).

  At the out-of-network benefit level, you pay an annual $750 per person per year deductible and higher out-of-pocket co-insurance amounts. For most services, the Value Plus Option pays 65% and you pay the remaining 35% of covered out-of-network charges, after you satisfy the $750 annual per person deductible. Additionally, you must pay any amount of the provider's billed fee that exceeds the Maximum Out-of-Network Reimbursement Program (MNRP) fee limits.
- **Maximum Out-of-Network Reimbursement Program (MNRP) fee limits:** The Value Plus Option will determine the eligible charge amount for out-of-network expenses by using the MNRP. The eligible amount will be the actual billed fee, up to 140% of the Medicare-allowable expense (whichever is less). MNRP fee limits will apply to all medical services and supplies, for example: hospital charges, physician's fees, lab fees, radiology fees and all other covered, medically necessary out-of-network expenses.

  For the following rare occurrences, the allowable expense is determined according to the following rules:

  - If the claim is for care in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the Value Plus Option will allow the out-of-network provider's full billed charge as an eligible expense.
  - If the claim is for care in a "network gap" (where the nearest source of appropriate medical treatment is greater than the network/claims administrator's network gap mile limit), and covered person has received prior approval from the network/claims administrator, the Value Plus Option will allow the out-of-network provider's full billed charge as an eligible expense.
  - If the claim is for services for which no MNRP data exist, the Value Plus Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.
- **Primary Care Physicians (PCP):** Your PCP is your partner in the services you receive under the Value Plus Option. He or she:

  - Coordinates all phases of your in-network medical care, and
  - Oversees, coordinates and authorizes hospitalization and surgery.

  PCPs may specialize in pediatrics, family practice, general practice or internal medicine. You are encouraged to establish a relationship with a PCP.
- **Preventive care:** You and each covered family member are eligible to receive benefits at 100% for in-network annual routine physical exams, including:

  - Well-woman exams,
  - Well-child exams provided by an in-network provider, and
  - Preventive screening exams, such as mammograms, PSA tests and colonoscopies, as set forth by the U.S. Preventive Services Task Force.

- **No claims to file:** In most cases, when you use network providers, the provider files your claims for you.
- **Co-pays and co-insurance:** Co-pays and co-insurance are the amounts you pay for eligible covered medical services depending on where you receive these services.
  - **Co-pays:** For in-network services such as office visits to your in-network provider PCP or specialist, including any tests or treatment received during the office visit, you pay a fixed dollar co-pay amount, as described in the Medical Benefit Options Comparison table.
  - **Co-insurance:** For services received in-network setting, you pay 15% co-insurance (a percentage of the cost) after you satisfy the $100 per person annual in-network deductible. For all eligible out-of-network services you pay 35% out-of-network co-insurance after you satisfy the annual $750 per person out-of-network deductible.
- **Individual in-network annual out-of-pocket maximum:** After you satisfy the annual individual in-network out-of-pocket maximum of $1,750 per covered person, the Value Plus Option pays 100% of in-network eligible expenses for the rest of the calendar year, excluding prescription drugs.

  The in-network deductible does not apply to the in-network out-of-pocket maximum. Hospital-based services include: hospital facility charges, freestanding surgical facilities, physician charges, room and board, diagnostic testing, X-ray and lab fees, anesthesia, dialysis, chemotherapy and MRIs.

  Co-pays for in-network office visits, prescription drug co-pays and co-insurance, out-of-network deductibles, and other in-network co-insurance amounts (such as, expenses reimbursed at 50%) do not apply to the annual out-of-pocket maximum.
- **Emergency care:** If you have a medical emergency, go directly to an emergency facility. Benefits are paid at the in-network level regardless if your provider is in-network or out-of-network. You should arrange any follow-up treatment through your PCP.
- **Urgent/immediate care:** If you are in your network service area and need urgent or immediate care, but you do not have an actual emergency, contact your PCP first. He or she will direct you to the appropriate place for treatment.

  In order to receive the in-network benefit level, you should contact your network provider or your network/claims administrator for authorization before seeking care at an urgent or immediate care treatment clinic, or if you are traveling and need urgent or immediate medical care. If your network/claims administrator's offices are closed, seek treatment and then call your network/claims administrator within 48 hours to ensure that you receive the in-network level of benefits.

  See the definition of urgent/immediate care in the "Glossary" in the *Reference Information* section).
- **Specialist care:** To receive the in-network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use an in-network specialist, and services must be eligible under the terms of the Plan.

  If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your PCP or your network/claims administrator to determine if a referral to an out-of-network specialist is needed. In these rare instances, your out-of-network care is covered at the in-network benefit level, but only with prior approval through your network/claims administrator. Please note that not all Value Plus area networks may have in-network specialist providers within your network/claims administrator's network gap mile limit. When you enroll, you should check to see if there are specialty providers within a comfortable distance and within the network gap mile limit.

- **Care while traveling:** If you have a medical emergency while traveling, get medical attention immediately. If you need urgent or immediate (not emergency) care, you should call your network/claims administrator for a list of in-network providers and urgent care facilities. If it is after hours, seek treatment and call your network/claims administrator within 48 hours. If you go to an in-network provider, you should only have to pay your co-pay or co-insurance and the provider should file your claim for you.

  If you go to an out-of-network provider, you or a family member must call your network/claims administrator within 48 hours of your care. You must submit a claim. However, you are eligible for the in-network level of benefits if you follow these procedures. See the definition of emergency in the "Glossary" in the *Reference Information* section).

- **Transition of care:**

  - If your network/claims administrator changes (and you or a covered family member has a serious illness, or you or your spouse is in the 20th — or later — week of pregnancy), you can ask your new network/claims administrator to evaluate your need for transition of care. This allows you to continue with your current care provider at the Value Plus in-network benefit level for a period of time, even if that provider is not part of the Value Plus network for your new network/claims administrator. Contact your network/claims administrator for more information.

  - If you are newly enrolled in the Value Plus Option (and you or a covered family member has a serious illness, or you or your spouse is in the 20th — or later — week of pregnancy), you can ask your network/claims administrator to evaluate your need for transition of care. This allows you to continue with your current care provider at the Value Plus in-network benefit level for a period of time, even if that provider is not part of the Value Plus network. Contact your network/claims administrator for more information.

- **Network and/or claim administrator:** Your network/claims administrator establishes standards for participating providers, including physicians, hospitals and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges and medical outcomes. They also periodically monitor whether participating providers continue to meet network standards. Your network/claims administrator also processes claims, negotiates fees and contracts with care providers.

- **Dependents living in different cities**: If you have a dependent who lives in a different state than you (for example: commuters, children away at school, divorced families), your dependent is covered by the preferred network/claims administrator for the state where you reside, not the state where he or she resides. Your network/claims administrator has national in-network providers, providing you and your covered dependents with access to in-network providers. For example, if you live in Texas and your dependent lives in California, your dependent is covered under the network/claims administrator for Texas (your state of residence), not California. This means your dependent will use the same network of providers that you use, regardless if your dependent resides in a different state than you. When you select a network and/or plan administrator, you should carefully evaluate your choices that are available to you and your family members living elsewhere, so your entire family can maximize your in-network benefit levels.

- **Leaving the service area (moving your home address or relocating):**

  - If you move to an area where the Value Plus Option is available, you remain enrolled in the Value Plus Option and retain your current network/claims administrator.

- If the Value Plus Option is not available in your new area, you may select one of the other medical options or an HMO (if available). You may waive coverage if you are covered under another plan.
- You must contact HR Services within 60 days of the event to process a relocation Life Event (see "Life Events"). Click on the "Start a Chat" button on the top of this page. If you do not notify HR Services of your election, you will be enrolled in the Value Plus Option in your new location (if available and previously elected) or in Standard Medical Option 1 (if the Value Plus Option is not available). You will receive a confirmation statement indicating your new coverage.

Covered and Excluded Expenses

For a detailed explanation of the Plans' eligible expenses and exclusions, see "Covered Expenses" and "Excluded Expenses" in the *Medical Benefit Options Overview* section.

Filing Claims

If you use an in-network provider, you do not need to file a claim as the provider will file claims on your behalf.

If you used an out-of-network provider or need medical care while you are traveling, you may need to file a claim. You must submit the original itemized bill or receipt provided by your physician, hospital, pharmacy or other medical service provider, so you should make a copy for your records. Follow the procedures below:

- Complete a Medical Benefit Claim Form.
- Submit the completed form to your network/claims administrator, along with all original itemized receipts from your physician or other health care provider. A cancelled check or credit card receipt is not acceptable.

Each bill or receipt submitted to your network/claims administrator 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 description and charges for the treatment or service, and
- Provider's name, address and tax ID number.

Make copies of the original itemized bill or receipt provided by your physician, hospital or other medical service provider for your own records. All medical claim payments include an Explanation of Benefits (EOB) explaining the amount paid, unless your physician, hospital or other medical provider has agreed to accept assignment of benefits (see "Assignment of Benefits" in the *Plan Administration* section). In most cases, the EOB will be mailed to you and the payment mailed to your provider. EOBs are available online or your network/claims administrator's website.

It is very important that you fully complete the 'other coverage' section of the form. Examples of other coverage include a spouse's group health plan, Workers' Compensation, Medicare, TRICARE and no-fault motor vehicle insurance.

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

If you have questions about your coverage or your claim under the Value Plus Option, contact your network/claims administrator (see "Contact Information" in the *Reference Information* section).

Claim Filing Deadline

- **For all claims incurred on or after 1/1/10,** you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- **For all claims incurred on or before 12/31/09,** you must submit all health 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 of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Prescription Drug Benefits

Prescription drug coverage will be based upon an incentive formulary. The amount of co-insurance paid by the Value Plus Option is based upon whether the medication is a generic drug, formulary drug or non-formulary drug.

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

Medco is the prescription drug vendor for the Value Plus Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Medco Mail Order Prescription Drug Benefit. Only eligible prescription drug expenses are covered under this benefit.

Medco has a broad network of pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the Medco website or call Medco at 1-800-988-4125.

Retail Drug Coverage New![*]

You may have your prescriptions filled at any pharmacy. However, you receive greater benefits when you use a participating in-network pharmacy. Go to the Medco website or call 1-800-988-4125 to locate an in-network pharmacy. You pay, for up to a 30-day supply:

- **Generic Drugs:** 20% co-insurance ($10 min/$20 max per prescription)
- **Formulary Drugs:** 30% co-insurance ($30 min/$100 max per prescription)*
- **Non-Formulary Drugs:** 50% co-insurance ($45 min/$150 max per prescription)*

* If you select a brand name drug (formulary or non-formulary) when a generic is available, you will pay a 20% generic co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.

[*] *The provisions marked by the box that says "New!" have changed since the last Employee Benefits Guide was produced. To review the previous version of the Guide, see the Archives section.*

Filling Prescriptions and Filing Claims

Follow these steps to fill prescriptions:

Network pharmacies:

- Present your Medco ID card at the in-network pharmacy
- Pay your portion of the cost for the prescription
- You do not have to file a claim form because your prescription drug information is submitted directly to your network/claims administrator.

Out-of-network pharmacies:

At the time you purchase your prescription, you will pay the full price. However, only the Medco discount price for drugs is considered an allowable expense for reimbursement. For example, if you have a prescription that costs $250 and the Medco discounted price is $100, you will be responsible for paying the applicable co-insurance, plus the $150 difference between the non-discounted price of the drug and the discounted price.

You will need to file a Medco Reimbursement Form. Follow the instructions on the claim form. Remember to attach the receipt for your prescription.

If you are enrolled in the Value Plus Option and you participate in the Health Care Flexible Spending Account (see "Covered Expenses" in the *Health Care Flexible Spending Account* section), your retail drug out-of-pocket expenses are eligible for reimbursement.

If you have questions concerning your prescription drug benefit, call the Medco Member Services number on your Medco ID card.

Retail Refill Allowance — Long-Term Medications New!*

Beginning January 1, 2012, you and your covered dependents will pay 50% of the drug cost for Long-Term Medications at a retail pharmacy after your third purchase. Long-Term prescriptions include medications taken on an on-going basis for conditions such as high cholesterol, high blood pressure, depression, diabetes, arthritis and other conditions. To determine if your prescription medications fall within the Long-Term Medications listing, go to the Medco website or call 1-800-988-4125.

Beginning with your fourth purchase of a Long-Term Medication, you should utilize Medco by Mail for these refills. You can purchase up to a 90-day supply of your Long-Term Medications, which can ultimately save you money on your prescription costs. See *Medco Prescription Drug Mail Order* in this section for more information.

Beginning with your fourth purchase, you will pay 50% of the drug cost if you continue to refill your Long-Term Medications through a retail pharmacy. Maximums do not apply to Long-Term Medications beginning with your fourth purchase.

Short-term medications should continue to be purchased at a retail pharmacy and you will pay your retail pharmacy co-payment.

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* *The provisions marked by the box that says "New!" have changed since the last Employee Benefits Guide was produced. To review the previous version of the Guide, see the Archives section.*

Retail Prescription Clinical Programs

Medco uses a number of clinical programs that help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, they are subject to change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).

When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these clinical programs and the specific drugs subject to these programs can be obtained from Medco (see "Contact Information" in the *Reference Information* section).

Generic Drugs

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

Prior Authorization

To be eligible for benefits, certain covered prescriptions and specialty pharmacy medications require prior authorization by Medco to determine medical necessity before you can obtain them at a participating pharmacy or through the Medco Mail Order Prescription Drug Benefit. Examples of medications requiring prior authorization include growth hormones and rheumatoid arthritis drugs.

Medco will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

When you fill your prescription, your pharmacist will call Medco. Your pharmacist and a Medco pharmacist will review the request for approval. Medco will send you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for up to one year. Prior authorizations must be renewed periodically. When the renewal date approaches, you should contact Medco for renewal instructions.

Ask your physician to contact Medco or to complete Medco's prior authorization form with 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
- Any other information your physician believes is pertinent

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

Specialty Pharmacy Services

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

Accredo Health Group, a subsidiary of Medco Health, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at a retail pharmacy or one of Accredo's Health Group pharmacies through Medco Health:

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

Please note that other conditions are added as appropriate and as required.

Whether these prescriptions are self-administered or administered in a physician's office, the prescriptions to treat the above conditions are not reimbursed through your Medical Benefit Option and must be filled at a retail pharmacy using your Medco ID card or through Medco by Mail for you to receive prescription drug benefits. Medco can ship the prescription to your home for self-administration or to your physician's office for medications which are to be administered by a physician.

The applicable deductible and co-insurance associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions.

Medco Prescription Drug Mail Order New![*]

You and your covered dependents are eligible for Medco by Mail. You may use this option to order prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration. Ordering medications on a 90-day supply basis

[*] *The provisions marked by the box that says "New!" have changed since the last Employee Benefits Guide was produced. To review the previous version of the Guide, see the Archives section.*

through Medco by Mail will often save you more money than if you fill your prescriptions at a retail pharmacy on a 30-day basis.

When you fill your prescriptions through mail order, you pay:

- **Generic Drugs:** 15% co-insurance ($5 min/$40 max per prescription)
- **Formulary Drugs:** 30% co-insurance ($60 min/$200 max per prescription)*
- **Non-Formulary Drugs:** 50% co-insurance ($90 min/$300 max per prescription)*

* If you select a brand name drug (formulary or non-formulary) when a generic is available, you will pay a 20% generic co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.

Oral contraceptives, transdermal and intravaginal contraceptives are covered by Medco by Mail only. This includes both generic and brand name (formulary or non-formulary) contraceptives.

Mail Order Prescription Clinical Programs

Medco uses a number of clinical programs to help insure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, the drugs subject to these clinical programs may change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).

When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these programs may be obtained from the prescription drug administrator (see "Contact Information" in the *Reference Information* section).

Generic Drugs

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

Ordering Prescriptions by Mail

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

- Download or print the Initial Mail Order Packet.
- Complete the Medco by Mail Form, and include the health and allergy questionnaire found in your initial packet from Medco. (The questionnaire will not be necessary on refills or future orders unless your health changes significantly.)
- Include the original written prescription signed by your physician.
- Indicate your method of payment on the form.
  - Major credit or debit card,
  - Personal check or money order, or
  - Medco will bill you when your medications are delivered (up to $100).

If paying by check or money order, enclose your payment with the order. Do not send cash. For pricing information, access the Medco website or call Medco (see "Contact Information" in the *Reference Information* section).

- Mail your order to the address on the Medco by Mail Form.
- Generally, your order is shipped within three working days of receipt. All orders are sent by UPS or first class mail. UPS delivers to rural route boxes, but not to P.O. Boxes. If you have only a P.O. Box address, your order is sent by first class mail.

Internet Refill Option

You have online access to Medco 24-hours a day, seven days a week. At the Medco website, you can order prescription drug refills, check on the status of your order, request additional forms and envelopes, or locate a network pharmacy near you.

To refill a prescription online, log on to the Medco website. Your prescriptions available for refill will be displayed. Allow up to 14 days for delivery of your prescription.

Other Refill Options

If you choose not to refill your mail order prescriptions online, place your order at least two weeks before your current supply runs out in one of the following two ways:

- Call 1-800-988-4125 to request a refill. You will be asked for your Medco ID number, current mailing address and Medco Health Rx Services prescription number.
- Complete and mail in your Medco by Mail Form. Attach your Medco refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

Reimbursement of Co-insurance

Your mail order co-insurance is the out-of-pocket amount you must pay when you fill your prescription drugs. It is not eligible for reimbursement under the Value Plus Option. However, if you elected to participate in the Health Care Flexible Spending Account, your co-insurance may be eligible for reimbursement. See the Health Care Flexible Spending Account section for more information.

Value Option

This Medical Benefit Option is non-grandfathered.

As an eligible employee, you can choose the Value Option. You can cover yourself, your spouse/Company-recognized Domestic Partner, your dependent children and/or your spouse/Company-recognized Domestic Partner's dependent children under the Value Option.

- For providers' eligible expenses, the annual deductibles are:
  - $500 for in-network services per person
  - $1,500 for all out-of-network services per person
- You have the choice of receiving care from in-network providers or out-of-network providers.
  - If you use an in-network physician, hospital or other medical service providers, your out-of-pocket expenses may be lower.
  - If you use out-of-network providers, your out-of-pocket expenses will be greater.

Your Network/Claims Administrator

The Value Option is administered by three network/claims administrators: UnitedHealthcare (UHC), Aetna and Blue Cross and Blue Shield of Texas. Each state has one preferred network/claims administrator. You may be able to choose a different network/claims administrator, but you will pay more in employee contributions. The list of the network/claims administrators by state can be found on Jetnet.

Your state is determined by your alternate address on file in Jetnet. If you do not have an alternate address on file in Jetnet, your state will be determined by your permanent address.

Benefit Overview

Services	Per-Person Deductible	Co-Insurance/Co-Pay (after deductible is met)	Per-Person Annual Out-of-Pocket Maximum
In-Network	$500	20%	$2,750 per covered individual (for services covered at 80%)
Out-of-Network	$1,500 (applies to all services)	40% (applies to all services)	Unlimited annual out-of-pocket maximum

In-network and out-of-network deductibles do not apply to the out-of-pocket maximum. If you satisfy the individual annual in-network deductible and later in the year use out-of-network services, you must satisfy the out-of-network deductible separately.

In This Section

How the Value Option Works

As an eligible employee, you can choose the Value Option, which offers you access to the network of physicians and hospitals that have agreed to provide medical services to plan participants at preferred rates. When you use an in-network provider, you pay only a co-pay or co-insurance for most services. Medical necessity is determined by your network/claims administrator.

In-Network Services

Each covered person, which includes you and any covered dependents, must first satisfy an annual in-network deductible of $500 before the option begins paying a percentage of eligible expenses. After you and your covered dependents meet the annual in-network deductible, the Value Option pays 80% of in-network eligible expenses. You pay 20% co-insurance for in-network services. After you and your covered dependents each meet the individual annual out-of-pocket maximum of $2,750 for services that require you to pay 20% co-insurance, further eligible expenses are covered at 100% for the remainder of the year.

Out-of-Network Services

Each covered person, which includes you and any covered dependents, must first satisfy an annual out-of-network deductible of $1,500 before the option begins paying a percentage of eligible expenses. After you and your covered dependents meet the annual out-of-network deductible, the Value Option pays 60% of out-of-network eligible expenses. You pay 40% co-insurance for out-of-network services. There is no out-of-pocket maximum.

Other Information

You can receive in-network benefits for specialist care without a referral from a primary care physician (PCP), but you are encouraged to have a PCP to coordinate in-network services for you. Contact your network/claims administrator to review a list of in-network providers. You can also access your network/claims administrator's website to find a list of in-network providers.

After you have enrolled, you will receive a Value Option ID card from your network/claims administrator indicating that you and your enrolled dependents are covered by the Value Option. The ID card includes important phone numbers and should be presented each time you go to a network physician or hospital. Value members will receive a Medco ID card for prescription drug services.

If you relocate to a new state, your medical plan option election and contribution rates remain the same for the remainder of the plan year. Your elected network/claims administrator does not change based on your relocation. However, if the Value Option is not available in your new location, you must elect another form of medical coverage.

You must wait until the next annual enrollment period to change your medical option election and your network/claims administrator, unless you experience a relocation Life Event. See "Life Events" for more information.

The Value Option is offered in most locations, but if you live outside the network/claims administrator's access area, you are not eligible for the Value Option and must choose a different self-funded Medical Benefit Option or an HMO for medical coverage.

See the "Medical Benefit Options Comparison" in the *Medical Benefit Options Overview* section to see a comparison of your benefits under the Value Option, the Value Plus Option, and the Standard Options.

Network/Claims Administrator

The Value Option is administered by three network/claims administrators — UnitedHealthcare (UHC), Aetna, and Blue Cross and Blue Shield of Texas.

When you enroll for the Value Option, you have a choice among the three network/claims administrators. The administrator with the lowest employee contribution costs will be the preferred network/claims administrator for your state. You can choose a non-preferred network/claims administrator — called Tier 1 or Tier 2 — but you will pay more in employee contributions. The Tier 1 and Tier 2 non-preferred network/claims administrators will vary from state to state. For example, Aetna may be a Tier 1 non-preferred network/claims administrator in one state and a Tier 2 network/claims administrator in another.

Tier 1 and Tier 2 network/claims administrators reflect monthly contributions that are 25% and 50% higher than the cost of the preferred network/claims administrator, as this chart demonstrates:

	Employee Only	Employee + Spouse/Company-recognized Domestic Partner	Employee + Child(ren)	Employee+ Family
Preferred network/claims administrator	Preferred Rate	Preferred Rate	Preferred Rate	Preferred Rate
Tier 1 network/claims administrator	Preferred Rate Plus 25% Increase	Preferred Rate Plus 25% Increase	Preferred Rate Plus 25% Increase	Preferred Rate Plus 25% Increase
Tier 2 network/claims administrator	Preferred Rate Plus 50% Increase	Preferred Rate Plus 50% Increase	Preferred Rate Plus 50% Increase	Preferred Rate Plus 50% Increase

Preferred rate increases are subject to change.

The list of the network/claims administrators by state can be found on Jetnet.

Special Features of the Value Option

The Value Option includes the following special provisions:

- **In-network services:** In-network providers who contract with your network/claims administrator agree to provide services and supplies at contracted rates. At the in-network benefit level, you pay a fixed co-pay or co-insurance amount and a $500 per person annual deductible.
- **Out-of-Network services:** If you go to a provider who is not part of the network, you are covered for eligible medically necessary services; however, coverage reimbursement is at a lower level (out-of-network benefit level).

  At the out-of-network benefit level, you pay an annual $1,500 per person per year deductible and higher out-of-pocket co-insurance amounts. For most services, the Value Option pays 60% and you pay the remaining 40% of covered out-of-network charges, after you satisfy the $1,500 annual per person deductible. Additionally, you must pay any amount of the provider's billed fee that exceeds the Maximum Out-of-Network Reimbursement Program **(**MNRP) fee limits.
- **Maximum Out-of-Network Reimbursement Program (MNRP) fee limits:** The Value Option will determine the eligible charge amount for out-of-network expenses by using the MNRP. The eligible amount will be the actual billed fee up to 140% of the Medicare-allowable expense. MNRP fee limits will apply to all medical services and supplies, for example: hospital charges, physician's fees, lab fees, radiology fees and all other covered, medically necessary out-of-network expenses.

  For the following rare occurrences, the allowable expense is determined according to the following rules:

  - If the claim is for care in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the Value Option will allow the out-of-network provider's full billed charge as an eligible expense.
  - If the claim is for care in a "network gap" (where the nearest source of appropriate medical treatment is greater than the network/claims administrator's network gap mile limit), and the covered person has received prior approval from the network/claims administrator, the Value Option will allow the out-of-network provider's full billed charge as an eligible expense.
  - If the claim is for services for which no MNRP data exist, the Value Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.
- **Primary Care Physicians (PCP):** Your PCP is your partner in the services you receive under the Value Option. He or she:

  - Coordinates all phases of your in-network medical care, and
  - Oversees, coordinates and authorizes hospitalization and surgery.

  PCPs may specialize in pediatrics, family practice, general practice or internal medicine. You are encouraged to establish a relationship with a PCP.
- **Preventive care:** You and each covered family member are eligible to receive benefits at 100% for in-network annual routine physical exams, including:

  - Well-woman exams
  - Well-child exams and immunizations

- **No claims to file:** In most cases, when you use network providers, the provider files your claims for you.
- **Co-pays and co-insurance:** Co-pays and co-insurance are the amounts you pay for eligible covered medical services depending on where you receive these services.
  - **Co-pays:** For in-network services such as office visits to your in-network provider PCP or specialist, including any tests or treatment received during the office visit, you pay a fixed dollar co-pay amount, as described in the Medical Benefit Options Comparison table.
  - **Co-insurance:** For services received in-network, you pay 20% co-insurance (a percentage of the cost) after you satisfy the annual $500 per person annual in-network deductible. For all eligible out-of-network services you pay 40% out-of-network co-insurance after you satisfy the annual $1,500 per person out-of-network deductible.
- **Individual in-network annual out-of-pocket maximum:** After you satisfy the annual individual in-network out-of-pocket maximum of $2,750 per covered person, the Value Option pays 100% of in-network eligible expenses for the rest of the calendar year, excluding prescription drugs.

  The in-network deductible does not apply to the in-network out-of-pocket maximum. Hospital-based services include: hospital facility charges, freestanding surgical facilities, physician charges, room and board, diagnostic testing, X-ray and lab fees, anesthesia, dialysis, chemotherapy and MRIs.

  Co-pays for in-network office visits, prescription drug co-pays and co-insurance, out-of-network deductibles and other in-network co-insurance amounts (such as, expenses reimbursed at 50%) do not apply to the annual out-of-pocket maximum.
- **Emergency care:** If you have a medical emergency, go directly to an emergency facility. Benefits are paid at the in-network level regardless if your provider is in-network or out-of-network. You should arrange any follow-up treatment through your PCP.
- **Urgent/immediate care:** If you are in your network service area and need urgent or immediate care, but you do not have an actual emergency, contact your PCP first. He or she will direct you to the appropriate place for treatment.

  In order to receive the in-network benefit level, you should contact your network provider or your network/claims administrator for authorization before seeking care at an urgent or immediate care treatment clinic, or if you are traveling and need urgent or immediate medical care. If your network/claims administrator's offices are closed, seek treatment and then call your network/claims administrator within 48 hours to ensure that you receive the in-network level of benefits.

  See the definition of urgent/immediate care in the "Glossary" in the *Reference Information* section).
- **Specialist care:** To receive the in-network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use an in-network specialist, and services must be eligible under the terms of the Plan.

  If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your PCP or your network/claims administrator to determine if a referral to an out-of-network specialist is needed. In these rare instances, your out-of-network care is covered at the in-network benefit level, but only with prior approval through your network/claims administrator. Please note that not all Value area networks may have in-network specialist providers within your network/claims administrator's network gap mile limit. When you enroll, you should check to see if there are specialty providers within a comfortable distance and within the network gap mile limit.

- **Care while traveling:** If you have a medical emergency while traveling, get medical attention immediately. If you need urgent or immediate (not emergency) care, you should call your network/claims administrator for a list of in-network providers and urgent care facilities. If it is after hours, seek treatment and call your network/claims administrator within 48 hours. If you go to an in-network provider, you should only have to pay your co-pay or co-insurance and the provider should file your claim for you.

  If you go to an out-of-network provider, you or a family member must call your network/claims administrator within 48 hours of your care. You must submit a claim. However, you are eligible for the in-network level of benefits if you follow these procedures. See the definition of emergency in the "Glossary" in the *Reference Information* section).
- **Transition of care:**
  - If your network/claims administrator changes (and you or a covered family member has a serious illness, or you or your spouse is in the 20th (or later) week of pregnancy), you can ask your new network/claims administrator to evaluate your need for transition of care. This allows you to continue with your current care provider at the Value in-network benefit level for a period of time, even if that provider is not part of the Value network for your new network/claims administrator. Contact your network/claims administrator for more information.
  - If you are newly enrolled in the Value Option (and you or a covered family member has a serious illness, or you or your spouse is in the 20th (or later) week of pregnancy), you can ask your network/claims administrator to evaluate your need for transition of care. This allows you to continue with your current care provider at the Value in-network benefit level for a period of time, even if that provider is not part of the Value network. Contact your network/claims administrator for more information.
- **Network/claims administrator:** Your network/claims administrator establishes standards for participating providers, including physicians, hospitals and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges and medical outcomes. They also periodically monitor whether participating providers continue to meet network standards. Your network/claims administrator also processes claims, negotiates fees and contracts with care providers.
- **Dependents living in different cities**: If you have a dependent who lives in a different state than you (for example: commuters, children away at school, divorced families), your dependent is covered by the preferred network/claims administrator for the state where you reside, not the state where he or she resides. Your network/claims administrator has national in-network providers, providing you and your covered dependents with access to in-network providers. For example, if you live in Texas and your dependent lives in California, your dependent is covered under the network/claims administrator for Texas (your state of residence), not California. This means your dependent will use the same network of providers that you use, regardless if your dependent resides in a different state than you. When you select a network and/or plan administrator, you should carefully evaluate your choices that are available to you and your family members living elsewhere, so your entire family can maximize your in-network benefit levels.
- **Leaving the service area (moving your home address or relocating):**
  - If you move to an area where the Value Option is available, you remain enrolled in the Value Option and retain your current network/claims administrator.
  - If the Value Option is not available in your new area, you may select one of the other medical options or an HMO (if available). You may waive coverage if you are covered under another plan.

- You must call HR Services within 60 days of the event to process a relocation Life Event (see "Life Events"). Click on the "Start a Chat" button on the top of this page.
- If you do not notify HR Services of your election, you will be enrolled in the Value Option in your new location (if available and previously elected) or in the Core Option (if the Value Option is not available). You will receive a confirmation statement indicating your new coverage.

Covered and Excluded Expenses

For a detailed explanation of the Plans' eligible expenses and exclusions, see "Covered Expenses and "Excluded Expenses" in the *Medical Benefit Options Overview* section.

Filing Claims

If you use an in-network provider, you do not need to file a claim as the provider will file claims on your behalf.

If you used an out-of-network provider or need medical care while you are traveling, you may need to file a claim. You must submit the original itemized bill or receipt provided by your physician, hospital, pharmacy or other medical service provider, so you should make a copy for your records. Follow the procedures below:

- Complete a Medical Benefit Claim Form.
- Submit the completed Medical Benefit Claim Form to your network/claims administrator, along with all original itemized receipts from your physician or other health care provider. A cancelled check or credit card receipt is not acceptable.

Each bill or receipt submitted to your network/claims administrator 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 description and charges for the treatment or service, and
- Provider's name, address and tax ID number.

Make copies of the original itemized bill or receipt provided by your physician, hospital or other medical service provider for your own records. All medical claim payments include an Explanation of Benefits (EOB) explaining the amount paid, unless your physician, hospital or other medical provider has agreed to accept assignment of benefits (see "Assignment of Benefits" in the *Plan Administration* section). In most cases, the EOB will be mailed to you and the payment mailed to your provider. EOBs are available online or your network/claims administrator's website.

It is very important that you fully complete the 'other coverage' section of the form. Examples of other coverage include a spouse's group health plan, Workers' Compensation, Medicare, TRICARE and no-fault motor vehicle insurance.

If you have questions about your coverage or your claim under the Value Option, contact your network/claims administrator (see "Contact Information" in the *Reference Information* section).

Claim Filing Deadline

- **For all claims incurred on or after 1/1/10,** you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- **For all claims incurred on or before 12/31/09,** you must submit all health 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 of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Prescription Drug Benefits

Prescription drug coverage is based upon an incentive formulary. The amount of co-insurance paid by the Value Option is based upon whether the medication is a generic drug, formulary drug or non-formulary drug.

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

Medco is the prescription drug vendor for the Value Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Medco Mail Order Prescription Drug Benefit. Only eligible prescription drug expenses are covered under this benefit.

Medco has a broad network of pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the Medco website or call Medco at 1-800-988-4125.

Retail Drug Coverage New![*]

You may have your prescriptions filled at any pharmacy. However, you receive greater benefits when you use a participating in-network pharmacy. Go to the Medco website or call 1-800-988-4125 to locate an in-network pharmacy. You pay, for up to a 30-day supply:

- **Generic Drugs:** 20% co-insurance ($20 min/$40 max per prescription)
- **Formulary Drugs:** 30% co-insurance ($30 min/$100 max per prescription)*
- **Non-Formulary Drugs:** 50% co-insurance ($45 min/$150 max per prescription)*

* If you select a brand name drug (formulary or non-formulary) when a generic is available, you will pay the $15 generic retail co-insurance, plus the cost difference between generic and brand name prices. Maximums do not apply.

[*] *The provisions marked by the box that says "New!" have changed since the last Employee Benefits Guide was produced. To review the previous version of the Guide, see the Archives section.*

Filling Prescriptions and Filing Claims

Follow these steps to fill prescriptions:

Network pharmacies:

- Present your Medco ID card at the in-network pharmacy
- Pay your portion of the cost for the prescription
- You do not have to file a claim form because your prescription drug information is submitted directly to your network/claims administrator.

Out-of-network pharmacies:

At the time you purchase your prescription, you will pay the full price. However, only the Medco discount price for drugs is considered an allowable expense for reimbursement. For example, if you have a prescription that costs $250 and the Medco discounted price is $100, you will be responsible for paying the applicable co-insurance, plus the $150 difference between the non-discounted price of the drug and the discounted price.

You will need to file a Medco Reimbursement Form. Follow the instructions on the claim form. Remember to attach the receipt for your prescription.

If you are enrolled in the Value Option and you participate in the Health Care Flexible Spending Account (see "Covered Expenses" in the *Health Care Flexible Spending Account* section), your retail drug out-of-pocket expenses are eligible for reimbursement.

If you have questions concerning your prescription drug benefit, call the Medco Member Services number on your Medco ID card.

Retail Refill Allowance — Long-Term Medications New!*

Beginning January 1, 2012, you and your covered dependents will pay 50% of the drug cost for Long-Term Medications at a retail pharmacy after your third purchase. Long-Term prescriptions include medications taken on an on-going basis for conditions such as high cholesterol, high blood pressure, depression, diabetes, arthritis and other conditions. To determine if your prescription medications fall within the Long-Term Medications listing, go to the Medco website or call 1-800-988-4125.

Beginning with your fourth purchase of a Long-Term Medication, you should utilize Medco by Mail for these refills. You can purchase up to a 90-day supply of your Long-Term Medications, which can ultimately save you money on your prescription costs. See *Medco Prescription Drug Mail Order* in this section for more information.

Beginning with your fourth purchase, you will pay 50% of the drug cost if you continue to refill your Long-Term Medications through a retail pharmacy. Maximums do not apply to Long-Term Medications beginning with your fourth purchase.

Short-term medications should continue to be purchased at a retail pharmacy and you will pay your retail pharmacy co-payment.

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* *The provisions marked by the box that says "New!" have changed since the last Employee Benefits Guide was produced. To review the previous version of the Guide, see the Archives section.*

Retail Prescription Clinical Programs

Medco uses a number of clinical programs that help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, they are subject to change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).

When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these clinical programs and the specific drugs subject to these programs can be obtained from Medco (see "Contact Information" in the *Reference Information* section).

Generic Drugs

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

Prior Authorization

To be eligible for benefits, certain covered prescriptions and specialty pharmacy medications require prior authorization by Medco to determine medical necessity before you can obtain them at a participating pharmacy or through the Medco Mail Order Prescription Drug benefit. Examples of medications requiring prior authorization include growth hormones and rheumatoid arthritis drugs.

Medco will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

When you fill your prescription, your pharmacist will call Medco. Your pharmacist and a Medco pharmacist will review the request for approval. Medco will send you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for up to one year. Prior authorizations must be renewed periodically. When the renewal date approaches, you should contact Medco for renewal instructions.

Ask your physician to contact Medco or to complete Medco's prior authorization form with 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
- Any other information your physician believes is pertinent

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

Specialty Pharmacy Services

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

Accredo Health Group, a subsidiary of Medco Health, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at a retail pharmacy or one of Accredo's Health Group pharmacies through Medco Health:

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

Please note that other conditions are added as appropriate and as required.

Whether these prescriptions are self-administered or administered in a physician's office, the prescriptions to treat the above conditions are not reimbursed through your medical benefit option and must be filled at a retail pharmacy using your Medco ID card or through Medco by Mail for you to receive prescription drug benefits. Medco can ship the prescription to your home for self-administration or to your physician's office for medications which are to be administered by a physician.

The applicable deductible and co-insurance associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions.

Medco Prescription Drug Mail Order New![*]

You and your covered dependents are eligible for Medco by Mail. You may use this option to order prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration. Ordering medications on a 90-day supply basis through Medco by Mail will often save you more money than if you fill your prescriptions at a retail pharmacy on a 30-day basis.

[*] *The provisions marked by the box that says "New!" have changed since the last Employee Benefits Guide was produced. To review the previous version of the Guide, see the Archives section.*

When you fill your prescriptions through mail order, you pay:

- **Generic Drugs:** 20% co-insurance ($10 min/$80 max per prescription)
- **Formulary Drugs:** 30% co-insurance ($60 min/$200 max per prescription)*
- **Non-Formulary Drugs:** 50% co-insurance ($90 min/$300 max per prescription)*

* If you select a brand name drug (formulary or non-formulary) when a generic is available, you will pay a 20% generic mail order co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.

Oral contraceptives, transdermal and intravaginal contraceptives are covered by Medco by Mail only. This includes both generic and brand name (formulary or non-formulary) contraceptives.

Mail Order Prescription Clinical Programs

Medco uses a number of clinical programs to help insure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, the drugs subject to these clinical programs may change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).

When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these programs may be obtained from the prescription drug administrator (see "Contact Information" in the *Reference Information* section).

Generic Drugs

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

Ordering Prescriptions by Mail

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

- Download or print the Initial Mail Order Packet.
- Complete the Medco by Mail Form, and include the health and allergy questionnaire found in your initial packet from Medco. (The questionnaire will not be necessary on refills or future orders unless your health changes significantly.)
- Include the original written prescription signed by your physician.
- Indicate your method of payment on the form.
  - Major credit or debit card,
  - Personal check or money order, or
  - Medco will bill you when your medications are delivered (up to $100).
- If paying by check or money order, enclose your payment with the order. Do not send cash. For pricing information, access the Medco website or call Medco (see "Contact Information" in the *Reference Information* section).
- Mail your order to the address on the Medco by Mail Form.
- Generally, your order is shipped within three working days of receipt. All orders are sent by UPS or first class mail. UPS delivers to rural route boxes, but not to P.O. Boxes. If you have only a P.O. Box address, your order is sent by first class mail.

Internet Refill Option

You have online access to Medco 24-hours a day, seven days a week. At the Medco website, you can order prescription drug refills, check on the status of your order, request additional forms and envelopes, or locate a network pharmacy near you.

To refill a prescription online, log on to the Medco website. Your prescriptions available for refill will be displayed. Allow up to 14 days for delivery of your prescription.

Other Refill Options

If you choose not to refill your mail order prescriptions online, place your order at least two weeks before your current supply runs out in one of the following two ways:

- Call 1-800-988-4125 to request a refill. You will be asked for your Medco ID number, current mailing address and Medco Health Rx Services prescription number
- Complete and mail in your Medco by Mail Form. Attach your Medco refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

Reimbursement of Co-insurance

Your mail order co-insurance is the out-of-pocket amount you must pay when you fill your prescription drugs. It is not eligible for reimbursement under the Value Option. However, if you elected to participate in the Health Care Flexible Spending Account, your co-insurance may be eligible for reimbursement. See the Health Care Flexible Spending Account section for more information.

Health Maintenance Organizations (HMOs)

Your HMO may be either grandfathered or non-grandfathered, depending upon the HMO; contact your specific HMO for this information.

HMOs are fully insured programs that provide medical care through a network of physicians, hospitals and other medical service providers.

- If you enroll in an HMO, you will receive information from the HMO describing the services and exclusions of that HMO.
- Company-recognized Domestic Partners may be eligible for coverage under HMOs. Contact your HMO directly to learn about their eligibility rules.
- Most HMOs require you to choose a primary care physician (PCP) who coordinates your medical care.
- Expenses such as prescription drugs and mental health care may be covered by HMOs.

HMO Eligibility

HMO eligibility is determined by the ZIP code of your Jetnet alternate address on record. If you are eligible to enroll in an HMO, the names of the HMOs will appear as options in the Benefits Service Center during annual enrollment (or as a new employee when you enroll for benefits the first time).

In This Section

Eligibility

Company-recognized Domestic Partners may be eligible for coverage under your HMO. If your Company-recognized Domestic Partner can be covered under your HMO, you will be able to choose coverage for him or her when you enroll. The decision to offer coverage to Company-recognized Domestic Partners is made by individual HMO plan provisions, not by American Airlines.

FAQ: How do I know if I'm eligible for an HMO?

HMO eligibility is determined by your ZIP code. If you are eligible, your HMO option(s) will appear in the Benefits Service Center when you enroll for benefits.

HMO offerings vary by location. You must reside within the HMO's service area in order to be eligible for the HMO. Your eligibility is determined by the ZIP code of your Jetnet alternate address on record. Jetnet allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (a P.O. Box or street address other than your permanent residence). Since many employees maintain more than one residence, you may list both addresses in Jetnet; however, your alternate address determines your eligibility. If you do not have an alternate address listed in Jetnet, your eligibility is based on your permanent address.

If you are eligible to enroll in an HMO, the names of the HMOs will appear as options in the Benefits Service Center during annual enrollment (or as a new employee when you enroll for benefits the first time). If you elect coverage under an HMO, all your claims for benefits are solely under the HMO contract or policy and all benefits are provided solely through the HMO.

There are some additional rules regarding your coverage when you are enrolled in an HMO.

Children Living Outside of the Service Area

If your child does not live with you, contact the HMO to find out if your child can be covered.

If you are providing the child's coverage under a Qualified Medical Child Support Order (QMCSO) and the HMO cannot cover your child, you may be required to select a different Medical Benefit Option for your entire family. See "Qualified Medical Child Support Orders (QMCSO) Procedures" in the *Additional Health Benefit Rules* section.

Termination of Coverage

Your HMO coverage terminates on the date when:

- **Your employment terminates.** If your employment terminates, you may be eligible to continue HMO coverage under COBRA. You may also apply for individual HMO coverage. You will automatically be solicited for continuation of your HMO coverage under COBRA by Benefit Concepts, Inc., the COBRA administrator.
- **You leave the service area.** You must register this move as a Life Event on Jetnet, and enroll in another HMO (if available) or self-funded Medical Benefit Option. Contact HR Services within 60 days of your move. Click on the "Start a Chat" button on the top of this page. If you do not notify HR Services of your move, you will be enrolled the default Medical Benefit Option for your workgroup and will receive a confirmation statement indicating your new coverage.
- **You retire.** If you retire while covered by an HMO, your coverage will change. See the Retiree Medical Benefit Guide for your workgroup eligibility. HMO membership is not currently available to retirees unless you live in Puerto Rico. Retirees in Puerto Rico may enroll in the Triple-S HMO.
- However, you may continue coverage in an HMO through COBRA for a period of 18 months at the time of your retirement. You will automatically be solicited for continuation of your HMO coverage under COBRA by Benefit Concepts, Inc., the COBRA administrator.

If You Reach Age 65 and are Still an Active Employee

If you or your covered eligible dependant reaches age 65 or becomes eligible for Medicare while covered under an HMO, most HMOs allow you to continue coverage. Coordination of benefits with Medicare applies. The HMO is primary and Medicare is secondary as long as you are an active employee (see "Coordination of Benefits" in the *Additional Health Benefit Rules* section).

How HMOs Work

HMOs are fully insured programs whose covered services are paid by the HMO. HMOs provide medical care through a network of physicians, hospitals and other medical service providers. You must use network providers to receive benefits under the HMO. Most HMOs require you to:

- Choose a primary care physician (PCP) who coordinates all your medical care, and
- Obtain a referral from your PCP before receiving care from a specialist.

HMOs are completely independent of the Company. Because each HMO is an independent organization, the benefits, restrictions and conditions of coverage vary from one HMO to another. The Company cannot influence or dictate the coverage provided.

If you enroll in an HMO, you will receive information from the HMO describing the services and exclusions of that HMO. Review this material carefully. Benefits provided by the HMO often differ from benefits provided under the other medical plans offered by the Company.

In general, features of HMOs include:

- A network of providers,
- A PCP who coordinates your covered medical care,
- Covered preventive care, and
- No claims to file.

If you elect an HMO, your HMO coverage replaces medical coverage offered through self-funded Medical Benefit Options. Your benefits, including prescription drugs and mental health care, are covered according to the rules of your HMO.

Glossary Term: Primary Care Physician (PCP)

A PCP is a physician who coordinates all of your covered medical care, including specialist visits.

HMO Contact Information

For more information on HMOs, contact the individual HMO.

New![*]

HMO Name	Phone Number	Website Address	Group Number
Aetna Health (Pennsylvania)	1-800-323-9930	http://www.aetna.com/	US 002271
CommunityCare Managed Healthcare Plans of Oklahoma	1-800-777-4890	http://www.ccok.com/	960102
Health Plan Hawaii	1-808-948-6372	http://www.hmsa.com/	24759-1
Humana Health Plans of Puerto Rico	1-800-314-3121	http://www.humana.com/	3262
Kaiser Northern California	1-800-464-4000	http://www.my.kp.org/americanairlines	8653
Kaiser Southern California	1-800-464-4000	http://www.my.kp.org/americanairlines	102105
Kaiser Mid-Atlantic States (Maryland and Washington, D.C.)	1-800-777-7902	http://www.my.kp.org/americanairlines	3381
TRIPLE-S Inc. (Puerto Rico only)	1-787-774-6060	http://www.ssspr.com/	1-08500 AA

Problems and Complaints

Each HMO has a grievance procedure or policy to appeal claim denials or other issues involving the HMO. Call your HMO for information on filing complaints or grievances.

[*] *The provisions marked by the box that says "New!" have changed since the last Employee Benefits Guide was produced. To review the previous version of the Guide, see the Archives section.*

Supplemental Medical Plan

The Supplemental Medical Plan for active employees and their spouses/Company-recognized Domestic Partners terminated effective December 31, 2010. Eligible/enrolled retirees and their eligible spouses/Company-recognized Domestic Partners may enroll in or maintain Supplemental Medical Plan coverage through December 31, 2013. Eligible retirees will have the opportunity to enroll upon commencement of their retiree medical coverage. For more information you can view the Retiree Medical Benefit Guide.

Dental Benefits

Dental benefits help you and your covered dependents take care of your dental needs. Coverage is provided for routine dental care and treatment for disease, defect and injury. Orthodontia coverage is included for eligible children.

- Eligible employees and their eligible dependents can enroll in Dental Benefits, even if you do not elect medical coverage.
- You must enroll yourself in the Dental Benefit if you would like to cover any dependents under the Dental Benefit.
- MetLife administers a Preferred Dental Provider (PDP) network that offer services at discounted rates; you may use any dentist you wish, but you may pay less if you use a PDP provider.
- You can choose from two Dental Benefit Options – Option 1 and Option 2.
- The Dental Benefit covers medically necessary dental and orthodontic items and services for covered eligible adults and children, depending on the option you choose.

MetLife's Role
Your Dental Benefit is self-funded by the Company. MetLife is the network/claims administrator for the Dental Benefit. Visit the MetLife website or contact MetLife at 1-866-838-1072 for more information on the Dental Benefit.

Benefit Overview

Option	Eligibility	Coverage Levels	Key Features
Dental Option 1	All eligible employees and their eligible dependents	▪ Employee ▪ Employee + One ▪ Employee + Two or more	▪ Annual deductible of $50 ▪ Preventive care at 100% ▪ Basic and major care at 80% ▪ Orthodontia services at 50%
Dental Option 2	All eligible employees and their eligible dependents	▪ Employee ▪ Employee + One ▪ Employee + Two or more	▪ Annual deductible of $50 ▪ Preventive care at 80% ▪ Basic and major care at 50% ▪ Child orthodontia services at 50%

Start a Chat

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

In This Section — See Page

How the Dental Benefit Works

FAQ: How do I find a PDP network dentist?

Visit the MetLife website or call 1-866-838-1072. Take a copy of the Dental Claim Form with you when you visit your dentist

The Dental Benefit offers a network of participating dentists and specialists nationwide who provide fee discounts to Dental Benefit participants.

You are not required to use Preferred Dentist Program (PDP) network dentists, but may benefit from cost savings when you do. You can request a customized directory of participating dentists in your area by visiting the MetLife website or calling MetLife at 1-866-838-1072.

You will not receive an ID card when you enroll for the Dental Benefit. When you need dental care, tell your provider that you have coverage through MetLife. You can also print off a temporary ID card from the MetLife website. The provider's office is responsible for verifying your eligibility. You may be asked to provide your Social Security number or your employee ID number for verification.

Eligibility

You must enroll yourself in the Dental Benefit if would like to cover any eligible dependents in the Dental Benefits. See "Dependent Eligibility by Benefit" in the *General Eligibility* section for age requirements.

Plan Comparison Chart

These are the features of the Dental Benefit options:

Feature	Dental Option 1	Dental Option 2
Annual Deductible (You pay this amount before benefits are paid)	$50 per person	$50 per person
Dental Services Plan pays:		
Preventive Service (exams, cleanings, routine X-rays; maximum 2 visits per year)	100% (Deductible does not apply)	80% (Deductible does apply)
Basic & Major Services (fillings, extractions, crowns, bridges, dentures)	80%	50%
Maximum Benefit (per person per year)	$1,500	$1,000
Orthodontia Services Plan pays:		

Feature	Dental Option 1	Dental Option 2
Orthodontia Services (annual deductible does not apply)	50%	50% (Eligible dependent children only)
Maximum Lifetime Orthodontia Benefit	$1,500 (Adult or eligible dependent children)	$1,000 (Eligible dependent children only)

Special Provisions

- **Alternative treatment:** If you undergo a more expensive treatment or procedure when a less expensive alternative is available, the Dental Benefit pays benefits based on the less expensive procedure that is consistent with generally accepted standards of appropriate dental care.
- **Coordination of benefits:** If you or a covered dependent has coverage under any other group dental plan, the Dental Benefit coordinates benefits with the other plan. (see "Coordination of Benefits" in the *Additional Health Benefit Rules* section for additional information.)
- **Medically necessary:** Only dental services that are medically necessary are covered by the Dental Benefit. Cosmetic services are not covered.
- **Pre-determination of benefits:** If your dentist estimates that charges for a procedure will be substantial, you should request pre-determination of benefits before you receive treatment. You also have the option to request a pre-determination for any proposed procedure. To request a pre-determination, ask your dentist to complete the Dental Plan Claim Form and indicate that it is for pre-determination of benefits.
- **Usual and prevailing fee limits:** The amount of benefits paid for eligible expenses is based on the usual and prevailing fee limits for that service in that geographic location.
- **When expenses are incurred:** For purposes of determining Dental Benefit coverage and benefits, the dental expense is deemed to be incurred at the time of the initial treatment or preparation of the tooth.

Covered Expenses

There are two types of Covered Expenses:

- Preventive Services
- Basic and Major Services

Preventive Services

Preventive treatment:

- Exams twice per calendar year
- Routine X-rays twice per calendar year
- Full mouth X-rays once every three years
- Teeth cleaning twice per calendar year
- Fluoride treatments once a year for children under age 18 (not covered on or after the child's 18th birthday)
- Sealants for children under age 15 (not covered on or after the child's 15th birthday)
- Space maintainers

Basic and Major Services

Glossary Term: Usual and Prevailing Fee Limits

The maximum amount that the Plan will consider as an eligible expense for dental services and supplies.

The following dental services and supplies are covered by the Dental Benefit:

- **Dentures and bridgework:** Full and partial dentures and fixed or removable 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, medically necessary surgery and medically necessary related anesthetics:** These services are considered covered dental treatments. Treatment of certain injuries and conditions may be covered under Medical Benefit Options. See "Covered Expenses" in the *Medical Benefits Options Overview* section.
- **Fillings and crowns:** Silver, porcelain or composite 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.
- **Dental implants, implant restorations:** Only if medically necessary and approved by independent dental consultants selected by the Company.
- **Inlays and onlays:** Only if medically necessary and approved by independent dental consultants selected by the Company.
- **Oral examinations, X-rays and laboratory tests:** These are covered if medically necessary to determine dental treatment.
- **Oral surgery:** If you have medically necessary oral surgery and it requires medically necessary hospitalization, the expenses for the hospitalization would be payable under the Medical Benefit Option. See "Covered Expenses" in the *Medical Benefits Option Overview* section.
- **Periodontal treatment:** Medically necessary periodontal treatment of the gums and supporting structures of the teeth and medically necessary anesthetics are covered, with the frequency of treatment based on generally accepted standards of good periodontal care. Examples are scaling and root planing, and gingivectomy.
- **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.

Orthodontia

The Dental Benefit Option 1 covers orthodontic treatment for eligible individuals only to a maximum benefit of $1,500 during the entire time the individual is covered under the Dental Benefit.

The Dental Benefit Option 2 covers orthodontic treatment for eligible dependent children only to a maximum benefit of $1,000 during the entire time the child is covered under the Dental Benefit.

Orthodontic coverage includes:

- Examinations
- X-rays
- Laboratory tests
- Other necessary treatments and appliances

There is no deductible for orthodontic treatments, and payments for orthodontia do not reduce the annual maximum benefit for other services.

The following explains additional information about orthodontia coverage:

Ongoing orthodontic coverage: To remain eligible for coverage of orthodontic treatments that extend into a new coverage period (for example, the next calendar year), you must continue to cover the patient under your Dental Benefit during each annual enrollment period.

Paying orthodontia claims: Payment is made according to the following procedures (regardless of the payment method you arrange with your provider):

- The provider of service (orthodontist) should submit one billing that reflects the total cost of the patient's orthodontic treatment – even if the duration of treatment moves across calendar years. The Dental Benefit will pay up to the maximum benefit, in one lump sum, based upon the orthodontist's lump-sum billing for orthodontia treatment (provided the treatment is determined to be an eligible expense under the Dental Benefit).
- Coordination of benefits applies if the patient has other orthodontia coverage. If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the maximum benefit.

Excluded Expenses

The following expenses are not eligible for reimbursement under the Dental Benefit:

- **Anesthesia:** General anesthetics (unless medically necessary and required for oral surgery or periodontics).
- **Cosmetic treatment:** Treatment or services partly or completely for cosmetic purposes or characterization or personalization of dentures or appliances for specialized techniques.
- **Crowns or appliances:** Crowns, adjustments or appliances used to splint teeth, increase vertical dimensions or restore occlusion. Replacement of crowns less than five years old will not be covered, regardless of the reason for replacement.
- **Education or training:** Education, training or supplies for dietary or nutritional counseling, personal oral hygiene or dental plaque control.
- **Free care:** Charges for services or supplies that you are not legally required to pay.

- **Medical expenses:** Any charge for dental care or treatment that is an eligible expense under your Medical Benefit Option.
- **Night guards:** Also referred to as occlusal guards and bruxism appliances.
- **Prescription drugs:** Dental prescriptions are covered under your Prescription Drug Benefit, not under your Dental Benefit. If you are enrolled in an HMO, check with your HMO to find out if your HMO covers dental prescriptions.
- **Relatives:** Treatment by a dentist or physician who is a close relative, including your spouse/Company-recognized Domestic Partner, children, adopted and step relatives, sisters and brothers, parents and grandparents of you or your spouse/Company-recognized Domestic Partner.
- **Replacement dentures or bridges:** Replacement charges for full or partial dentures or a fixed or removable bridge that is less than five years old. Appliances that are over five years old but can be made serviceable will be repaired, not replaced. Also excluded are any charges that exceed the cost of a standard prosthetic appliance.
- **Services not provided by dentist or physician:** Any service not provided by a dentist or physician, unless performed by a licensed dental hygienist under the supervision of a dentist or physician or for X-ray or laboratory tests ordered by a dentist or physician.
- **Temporary dentures, crowns or bridges after 12 months:** A temporary fixture, such as a temporary denture, crown or bridge that remains in place for 12 months or more is considered permanent and the cost of replacement is only covered when the item is more than five years old.
- **Temporomandibular joint dysfunction (TMJD):** TMJD is considered a medical condition and has limited coverage only under the Medical Benefit Options.
- **U. S. government services or supplies:** Charges for services or supplies furnished by or for the U. S. government.
- **Usual and prevailing:** Charges that exceed the usual and prevailing fee limits.
- **War-related:** Services or supplies received as a result of a declared or undeclared act of war or armed aggression.
- **Work-related claims:** Dental care received because of a work-related injury or illness sustained by you or your covered dependent, whether or not it is covered under Workers' Compensation, occupational disease law or similar law.

Filing Claims

MetLife is the claims processor for the Dental Benefit. To file claims for dental expense benefits:

- Complete the top portion of the Dental Plan Claim Form. Follow the instructions on the form and provide the form to your dental provider, who should complete the remaining portion.
- You or your provider, if completing the form on your behalf, will mail the completed claim form to MetLife at the address on the form.
- You will receive an Explanation of Benefits (EOB) detailing the amount paid for each dental claim submitted.
- Payments may be sent to you or to your dentist or other dental provider if your provider accepts Assignment of Benefits.
- Claims are processed in order of receipt. Payment of claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

Health Care Flexible Spending Account: Certain out-of-pocket dental expenses may be eligible for reimbursement from your Health Care Flexible Spending Account. (See "Covered Expenses" in the *Health Care Flexible Spending Account* section.)

Injury by others: If you are injured by someone else and your AA dental option pays a benefit, the Company will recover payment from the third party (see "Subrogation" under the "Claims" section in the *Plan Administration* section).

Claim Filing Deadline

- **For all claims incurred on or after 1/1/10,** you must submit all dental claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- **For all claims incurred on or before 12/31/09,** 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 of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Vision Insurance Benefit

Vision benefits help you and your covered dependents take care of your vision needs. Coverage is provided for routine eye exams, eyeglass frames and lenses or contact lenses.

- Eligible employees and their dependents can enroll in the Vision Insurance Benefit.
- You have the option of in-network or out-of-network coverage. You have a co-pay if you use an in-network provider.
- If you use an out-of-network provider, a reimbursement rate applies. Co-pays do not apply to out-of-network benefits.

OptumHealth Vision's Role

Your Vision Insurance Benefit is insured and administered by OptumHealth Vision. OptumHealth Vision is the claims administrator for the Vision Insurance Benefit. Visit the OptumHealth Vision website or contact OptumHealth Vision at 1-800-217-0094 for more information on the Vision Insurance Benefit.

Benefit Overview

Benefit	Coverage Tiers	Key Features
Vision Insurance Benefit	▪ Employee ▪ Employee + One ▪ Employee + Two or more	▪ $10 co-pay for in-network eye exam ▪ $25 co-pay for in-network eyeglass lenses with a $130 frame allowance ▪ $25 co-pay for in-network contact lenses (in lieu of eyeglass lenses and frames) ▪ Out-of-network reimbursement rates

In This Section

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

How the Vision Insurance Benefit Works

FAQ: How do I find a participating provider?

Visit the OptumHealth Vision website or call 1-800-638-3120.

OptumHealth Vision's network of providers includes retail chains, such as Eyemasters, Wal-Mart or Sam's Club, as well as independent providers. You can locate participating providers by visiting the OptumHealth Vision website or you can contact OptumHealth Vision at 1-800-839-3242 to locate a provider near you. Or see "Contact Information" in the *Reference Information* section).

To review your vision benefits, refer to the OptumHealth Vision Rates and Services Chart and OptumHealth's Vision Care Brochure on the OptumHealth Vision website or on the Benefits page of Jetnet.

You will receive an OptumHealth Vision ID card when you enroll for vision benefits. Show your ID card at your eye care provider to receive negotiated fees and services. If you don't have your card with you, your provider can verify your participation using your Social Security number.

When you use the Vision Insurance Benefit, services are covered once each calendar year for each covered member. This means you do not have to wait a full 12 months until benefits are available again.

Eligibility

You must elect Vision Insurance for yourself if you would like to cover any of your dependents under the vision plan.

Covered Expenses

In-Network Provider Benefits

Glossary Term: In-Network Provider

An in-network provider is part of OptumHealth Vision's provider database. If you use an in-network provider you receive discounted fees and services.

When you use an in-network provider, you pay the co-pay directly to your provider. No claims forms are necessary. Co-pays do not apply to out-of-network benefits.

In most cases, it will cost you $35 for glasses or contact lenses:

- $10 for comprehensive vision
- $25 for frames or contact lenses

Covered Services	Cost
Comprehensive Vision Exam	$10 co-pay
Glasses (lenses and frames)	
▪ Clear single vision, lined bifocal or lined trifocal ▪ Selection frames (minimum frame allowance is $130 for frames purchased at an in-network retail chain provider)	$25 co-pay
▪ Clear single vision, lined bifocal or lined trifocal ▪ Non-selection frame	$25 co-pay, plus the difference, if any, of OptumHealth Vision's preferred price and the $130 frame allowance

Covered Services	Cost
Contact Lenses (in lieu of lenses and frames)	
▪ Selection contact lenses ▪ Non-disposable	$25 co-pay (per single pair of contacts)
▪ Non-selection contact lenses or special contact lenses (gas permeable, bifocal, astigmatism lenses, etc.) ▪ Non-disposable	$150 allowance toward the evaluation, fitting fees and a single pair of contact lenses
Patient Options	
▪ Selection contact lenses, disposable	$25 co-pay (up to 6 boxes per year included in $25 co-pay)
▪ Progressive lenses and tints, etc.	No additional charge (included in the $25 co-pay)
▪ Scratch-coating protection for lenses	No additional charge (included in the $25 co-pay)

Out-of-Network Provider Benefits

When you use an out-of-network provider, a reimbursement rate applies. Co-pays do not apply to out-of-network benefits. Vision Insurance Benefit will reimburse you expenses based on the following chart:

Service	Reimbursement Rate
Exam	Up to $40
Single vision lenses	Up to $40
Bifocal lenses	Up to $60
Trifocal lenses	Up to $80
Lenticular lenses	Up to $80
Frame	Up to $45
Elective contact lenses	Up to $150
Medically necessary contact lenses	Up to $210

Filing Claims

When you use an in-network provider your provider files claims for you.

When you use an out-of-network provider, you must pay the full fee to the provider and file claims with OptumHealth Vision. OptumHealth Vision reimburses services rendered up to the maximum allowance.

Fast Fact

You don't need to file claims if you use an in-network provider. If you use an out-of-network provider call 1-800-839-3242 to get a claim form.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is primarily for employees to obtain care for substance abuse cases that involve Company policy or regulation violations. EAP management is required for all substance abuse cases that involve Company policy or governmental regulation violations.

For EAP managed cases, medical necessity is determined by the EAP. In these cases the EAP will work with your network/claims administrator to locate an in-network facility. The Medical Benefit Options will provide benefits for eligible medically necessary treatment and rehabilitation programs, regardless if your case requires EAP management or not.

If you fail to go through the EAP for substance abuse cases that involve Company policy or regulation violations, this will not reduce the benefit for which you are eligible. However, your job status may be impacted. See the EAP Policy.

For cases that are not EAP managed, medical necessity will be determined by your network/claims administrator. This includes cases not related to Company policy or regulation violations, such as spouse and dependent cases. The benefit will be paid at the medical benefit option benefit level. See "Mental Health Benefits" in the Medical Benefit Options Comparison" chart in the *Medical Benefit Options Overview* section.

To contact the EAP, call 1-800-555-8810.

Life Insurance Benefits

Term Life Insurance pays a benefit in the event of your death, but has no cash value and remains in effect only during the time premiums are being paid.

- The Company provides Basic Term Life Insurance to you at no cost.
- You may purchase Voluntary Term Life Insurance, Spouse Term Life Insurance and Child Term Life Insurance at an additional cost.
- You can designate your Term Life Insurance Benefits to go to your spouse, Company-recognized Domestic Partner, children, other family members, friends or your estate at the time of your death.

FAQ: Do I have to pay for coverage?

Basic Term is offered at no cost to you. You pay the full cost of Voluntary Term, Spouse Term and Child Term Life Insurance.

Met Life's Role

Your Term Life Insurance Benefits are insured and processed by MetLife. You pay the cost of any voluntary coverage you elect, through payroll deduction. Visit the MetLife website or contact MetLife at 1-800-638-6420 for more information.

Benefit Overview

Benefit	Coverage Levels	Key Features
Basic Term Life Insurance	▪ 2 times your pay up to a maximum of $70,000 (only if your annual pay is less than $35,000) ▪ 1 times pay (if annual salary is less than $70,000) ▪ $15,000	▪ No cost to employees
Voluntary Term Life Insurance	▪ 1 times your pay ▪ 2 times your pay ▪ 3 times your pay ▪ 4 times your pay ▪ 5 times your pay ▪ 6 times your pay ▪ 7 times your pay ▪ 8 times your pay	▪ Employee pays the entire cost of coverage ▪ Before-tax contributions ▪ Cost based on age and level of coverage

In This Section

How the Life Insurance Benefit Works

The Company provides all eligible employees with Basic Term Life Insurance at no cost to you. You are auto-enrolled in this benefit and may not waive this benefit.

You may purchase Voluntary Term Life Insurance coverage over and above your Basic Term Life Insurance Benefit.

Basic Term Life Insurance Benefit

Basic Term Life Insurance covers you only and pays a benefit to your designated beneficiary in the event of your death.

As an eligible employee, the Company provides coverage equal to two times your pay up to a maximum of $70,000, at no cost to you.

Coverage After Age 65

Basic Term Life Insurance coverage for active employees age 65 and over decreases annually, as shown below.

Age	Percentage Of Total Benefit Elected	Age	Percentage Of Total Benefit Elected
65	92%	71	56%
66	85%	72	52%
67	78%	73	48%
68	72%	74	44%
69	66%	75	41%
70	61%	76 and over	38%

If you were a member of the Retirement Benefit Plan on or before December 31, 1955, and die while you are an active employee, you are insured for an additional $1,000.

Voluntary Term Life Insurance Benefit

In addition to Basic coverage, you may elect to purchase one of eight levels of Voluntary Term Life Insurance at your expense. When you are first eligible for benefits, you may elect the lowest level of coverage (1 times your pay) without providing proof of good health. You must submit a Statement of Health if you wish to elect a higher level of coverage (2 times your pay to 8 times your pay). This means that as a new employee you can elect any level of coverage with a Statement of Health.

After you enroll, you may only increase your coverage by one level per year with proof of good health. Coverage that requires proof of good health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution either directly or through payroll deduction.

If you do not enroll in Voluntary Term Life Insurance as a new employee, you will only be eligible to elect the lowest level of coverage at a later date with proof of good health and then will only be eligible to increase coverage by one level per year thereafter, with proof of good health.

Below are the available Voluntary options:

Coverage
1 times your pay
2 times your pay
3 times your pay
4 times your pay
5 times your pay
6 times your pay
7 times your pay
8 times your pay

Cost of Coverage

You pay the entire cost for any Voluntary Term Life Insurance coverage you select. You elect coverage at the rate shown in the Benefits Service Center with before-tax contributions based on your age and selected option.

The following table defines pay for Employee Term Life Insurance:

Employee Status	Definition of Pay
Regular Full-time Employees	Base annual salary or annualized hourly play plus market rate differentials, but excluding bonus and overtime
Converted Part-time Employees	Annualized hourly pay
Regular Part-time, Part-time Extendable and Job Share Employees	Average base salary
Commissioned Employees	Annual target earnings
Employees on Temporary Assignment	Pay for the last permanent position held

You pay the entire cost of Spouse and Child Term Life Insurance coverage that you select. You elect coverage at the rate shown on your Flexible Benefits enrollment screen in the Benefits Service Center and pay for this coverage with after-tax contributions. Your spouse's rate is based on your spouse's age, but coverage for your child(ren) is based on a flat rate, regardless of the number of children covered.

The cost of coverage for both the employee and spouse plans will increase or decrease during the year if the amount of your coverage fluctuates due to changes in your pay.

Spouse and Child Term Life Insurance Benefit

You may cover either your spouse (under Spouse Term Life Insurance) or your children (under Child Term Life Insurance), or you may cover both your spouse and your children.

Spouse and Child Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse Term Life Insurance	Option 1 - 1 × pay
	Option 2 - 2 × pay
	Option 3 - 3 × pay
Child Term Life Insurance	$15,000 for each covered child

Spouse Term Life Insurance

To add or increase Spouse Term Life Insurance, your spouse must complete a Statement of Health Form. You must then forward the completed form to MetLife for review. Upon approval from MetLife, coverage will be added or increased. Coverage that requires *proof of good health* becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction. New employees may elect any of the three levels of spouse life with proof of good health.

If you do not enroll in Spouse Term Life Insurance as a new employee, you will only be eligible to elect Option 1 at a later date with proof of good health and then will only be eligible to increase coverage by one level per year thereafter, with proof of good health.

Child Term Life Insurance

Coverage is offered at $15,000 for each child. When you enroll in Child Term Life Insurance, you automatically enroll all of your children. Eligible children are not required to be enrolled in other benefits (e.g., medical, dental, etc.) or listed as dependents in the Benefits Service Center in order for you to elect Child Term Life Insurance. Child Term Life Insurance does not require a Statement of Health (proof of good health).

Filing a Claim

All life insurance benefits are provided under a group insurance policy issued by MetLife. MetLife also processes and pays all claims.

The following is a short summary of the procedures for filing a claim for Spouse or Child Term Life Insurance benefits:

- Upon the death of your covered spouse or child, you or your supervisor should inform HR Services of the death. You are the sole beneficiary for your spouse or child's term life insurance.

- After HR Services is notified of the death, it sends you a letter verifying the amount of life insurance payable. The letter will include a Beneficiary Life Insurance Claim Statement.
- Complete the Beneficiary Life Insurance Claim Statement and return it, along with a certified copy of the death certificate, to HR Services. Upon receipt of both items, HR Services will submit the claim to MetLife on your behalf.
- The life insurance claim will be paid in approximately four to six weeks after MetLife receives all necessary documentation. You may assign part of the benefits to pay funeral expenses, (see "Assignment of Benefits."
- When a spouse or covered dependent dies, you may want to make changes to your benefits coverages. To process these changes, contact HR Services. Click on the "Start a Chat" button on the top of this page. For a list of allowable changes that may be appropriate at this time, see the Life Events section. For your convenience, the letter you receive includes a Beneficiary Designation Form. This can be completed online through the Benefits Service Center. You can use this form to make any necessary changes to the beneficiary designations you have on file, if appropriate and as applicable.

Designating Beneficiaries

In the event of your death, Basic and Voluntary Term Life Insurance coverage benefits are paid to the named beneficiaries on file with HR Services. You have one set of beneficiaries for both your Basic and Voluntary Term Life Insurance coverage. When you enroll for benefits when you are first eligible as a new employee, or during annual enrollment, you designate your beneficiaries. You may change your beneficiary designation at any time during the year by accessing the Benefits Service Center.

Quick Tip

Your beneficiary or beneficiaries can be your spouse, Company-recognized Domestic Partner, children, grandchildren, other relatives, friends or your estate.

Unless prohibited by law, your Term Life Insurance Benefits are distributed as indicated on your Beneficiary Designation Form on file with HR Services. For this reason, you should consider updating your beneficiary designation periodically, especially if you get married, declare a Company-recognized Domestic Partner, you or your spouse give birth or adopt a child, or if you get divorced or cease to have a Company-recognized Domestic Partner relationship.

When you select your beneficiary, the wording is important. The table below provides sample wording for the most common beneficiary designations:

Type of Designation	Sample Wording (always include your beneficiary's address)
One person, related	Jane Doe, spouse
One person, not related	Jane Doe, friend
Your estate	Estate
Member of a given religious order	Mary L. Jones, known in religious life as Sister Mary Agnes, niece
Two beneficiaries with the right of survivorship	John J. Jones, father, and Mary R. Jones, mother, equally or to the survivor
Three or more beneficiaries with the right of survivorship	James O. Jones, brother; Peter I. Jones, brother; Martha N. Jones, sister; equally or to the survivor(s)

Type of Designation	Sample Wording (always include your beneficiary's address)
Unnamed children	My children living at my death
One contingent beneficiary	Lois P. Jones, wife, if living; otherwise, Herbert I. Jones, son
Unnamed children as contingent beneficiaries	Lois P. Jones, wife, if living; otherwise, my children living at my death
Trustee (a trust agreement must be in existence)	ABC Trust Company of Newark, NJ, Michael W. Jones, Trustee, in one sum, under Trust Agreement dated (insert date)

If none of the suggested designations meets your needs, contact an attorney for assistance.

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 Term 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 Term Life Insurance Benefits will be retained by MetLife and interest will be 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 that has been legally established). If you designate a trust, MetLife assumes that the designated trustee is acting in 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 or if you have not designated a beneficiary, the benefits under your coverage are paid to the first class of surviving family members in the order outlined below:

- Spouse or Company-recognized Domestic Partner
- Children or stepchildren (or children or stepchildren of Company-recognized Domestic Partner)
- Parents
- Brothers and sisters
- Estate

Coverage if You Become Disabled

If you become permanently and totally disabled (PTD) while covered, your Term Life Insurance coverage may continue at no cost to you. To qualify for this PTD benefit, you must become permanently and totally disabled before age 60 and be absent from work at least nine consecutive months because of your disability.

Permanent and total disability exists if all of the following requirements are met:

- You are not engaged in any gainful occupation,
- Because of illness, injury, or both, you are completely unable to engage in any occupation for which you are reasonably fit, and
- Your disability is such that your inability to work will probably continue for the rest of your life.

To apply for a waiver of Voluntary Term Life Insurance contributions, you must file a claim with MetLife between the 9th and 12th month after the date your disability began. Claims filed after the 12th month will not be considered. Contact HR Services to request a claim form. Click on the "Start a Chat" button on the top of this page.

If you became disabled before January 1, 1995, your insurance coverage will be reduced to the retiree level when you begin collecting your pension benefit. If you are not eligible for a pension benefit or Retiree Life Insurance, your coverage stops at age 65.

MetLife requires you to submit proof of your continuing disability at least once a year. Proof may include examination by doctors designated by the insurance company. If this proof is not submitted, coverage will terminate.

FAQ: What should I do if I become disabled?

Contact HR Services. Click on the "Start a Chat" button on the top of this page.

Special Provisions

Accelerated Benefit Option (ABO)

The ABO allows terminally ill people the opportunity to receive a portion of their life insurance during their lifetime. This money can be used to defray medical expenses or replace lost income during the last months of an illness and is not subject to income tax. The remaining portion of the Life Insurance Benefit is payable to the named beneficiary when the covered person dies.

The ABO is available to employees who have Company-provided Basic and/or Voluntary Term Life Insurance. Employees who are approved as permanently and totally disabled are also eligible for an ABO. (Spouse and Child Term Life Insurance are not eligible for ABO.)

To qualify for an ABO payout, you must have an injury or illness that is expected to result in death within six months, with no reasonable prospect for recovery. A physician's certification is required, and all applications are subject to review and approval by MetLife's medical department. Based on this review, the claim is either paid or denied. If it is paid, you cannot later change the amount of your life insurance coverage.

ABO payout for approved claims is 50% of your total Term Life Insurance (Basic and Voluntary) coverage, up to a maximum of $250,000. Therefore, any life insurance coverage in excess of $500,000 is not eligible for the ABO.

Your life insurance premiums must be current at the time of the ABO application. If you are on sick leave and have allowed your coverage to default to the Company-provided amount, you are only eligible to receive ABO on that coverage amount. After an ABO payout, you are no longer permitted to change life insurance coverage levels. Employees who have irrevocably assigned their life insurance benefits and retirees or employees who have applied for retirement benefits are not eligible for ABO benefits. See "Assignment of Benefits."

Contact HR Services for information on filing a request for an ABO. Click on the "Start a Chat" button on the top of this page.

Taxation of Life Insurance

If your total coverage is more than $50,000, you may owe taxes on the value of your coverage over $50,000. This value is called imputed income. IRS regulations require the Company to report employee federal wages and deduct Social Security taxes (FICA) on imputed income from your paycheck and report it on your Form W-2 each year.

Imputed income is based on your age and the monthly cost per $1,000 of life insurance over $50,000. To determine your monthly amount of imputed income, multiply the rate in the following IRS table by the amount of your insurance coverage over $50,000.

Age of Employee on December 31	Monthly Cost of $1,000 of Insurance
Under 25	$0.05
25-29	0.06
30-34	0.08
35-39	0.09
40-44	0.10
45-49	0.15
50-54	0.23
55-59	0.43
60-64	0.66
65-69	1.27
70+	2.06

An example of how imputed income works:

Assume a 30-year-old employee has a total of $108,000 in Basic and Voluntary Term Life coverage. The following calculations show the employee's taxable imputed income:

1. Figure the taxable amount of coverage (amount over $50,000):

   $108,000 – $50,000 = $58,000

2. Divide that amount by $1,000:

   58,000 / $1,000 = 58

3. Multiply the result by the IRS rate from the table above for an employee who is age 30:

   58 × $0.08 = $4.64

The monthly imputed income shown on this employee's paycheck will be $4.64. This is the amount that is subject to federal income and Social Security taxes.

Conversion and Portability

Conversion

Subject to policy provisions, you can convert all or any part of your Basic and/or Voluntary Term Life Insurance coverage to an individual life insurance policy (other than term life insurance) offered by MetLife without providing Statement of Health, if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for Term Life Insurance coverage,
- The coverage ends, and you have been covered under this insurance for at least five years,
- Coverage for your particular job classification ends, and you have been covered under this insurance for at least five years, or
- You retire and your Retiree Life Insurance coverage is less than the coverage you had as an active employee.

If you are applying for an individual policy because your employment terminated, the amount of the policy may not be more than the amount of your Term Life Insurance on the day your coverage ended.

If you are applying for an individual policy because this coverage ended or changed, and you have been covered for at least five years, the amount of your policy will not be more than:

- The amount of your coverage on the day it ended, less any amount of life insurance you may be eligible for under any group policy that takes effect within 31 days of the termination of this coverage
- $10,000,

whichever is less.

Spouse Term Life Insurance may also be converted to an individual life insurance policy (other than term life insurance).

Requesting Conversion

To convert to an individual policy, a *Life Insurance Conversion Form* and your first payment must be received by MetLife within 31 days of the date coverage terminates. Call MetLife at 1-877-275-6387 to discuss conversion and request a form. If you apply within this 31-day period, MetLife will not require you to provide a Statement of Health.

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

If you are a retiree and you die within the first 31 days of Retiree Life Insurance coverage, your beneficiary will receive a death benefit based on the amount of life insurance coverage you had as an active employee.

To discuss conversion options and to request forms, contact MetLife at 1-877-275-6387.

Portability

Voluntary Term Life Insurance is portable. This means you may continue your Voluntary Term Life Insurance coverage under a separate group policy if you leave the Company or retire. The rates for this continuing coverage are not the same as those you pay as an active employee, but they are preferred group rates based on your age. MetLife will provide the rate schedule if you apply for portability. The minimum amount of coverage you may continue is $20,000 and the maximum amount is your current amount of Voluntary Term Life Insurance coverage. To apply for this continuing coverage, you must submit an application form to MetLife within 31 days after you leave or retire from the Company.

To discuss portability options and to request forms, contact HR Services. Click on the “Start a Chat” button on the top of this page.

Assignment of Benefits

You may irrevocably assign the value of your life insurance coverage. This permanently transfers all right, title, interest, and incidents of ownership, both present and future, in the benefits under this insurance coverage. Anyone considering assignment of life insurance coverage should consult a legal or tax advisor before taking such action.

If you assign your benefits, you are obligated to fulfill any conditions you have agreed to with your assignee. MetLife’s only obligation is to pay the Life Insurance Benefits due at your death.

Your beneficiary may assign a portion of his or her benefit directly to the funeral home to cover the cost of the funeral. To assign benefits to a funeral home, the beneficiary signs an agreement with the funeral home. The funeral home sends a copy of the signed agreement and an itemized statement of funeral expenses to HR Services. When MetLife processes the claim, a separate check for this portion of the benefit will be paid directly to the funeral home.

Total Control Account

When a claim is processed, MetLife establishes a Total Control Account for each beneficiary whose share is $5,000 or more. (Smaller amounts are paid in a lump sum.) All insurance proceeds are deposited into this interest-bearing checking account that pays competitive money market interest rates and is guaranteed by MetLife.

MetLife sends a personalized checkbook to your beneficiary, who may withdraw some or all of the proceeds and interest whenever necessary. In addition, MetLife sends descriptions of alternative investment options to your beneficiary. The Total Control Account gives your beneficiary complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

For income tax purposes, proceeds deposited into the Total Control Account are treated the same as a lump sum settlement. Because the tax consequences of life insurance proceeds may vary, the Company strongly recommends that you or your beneficiary contact your tax advisor.

MetLife will only pay interest on a life insurance claim (to cover the time between death and date of payment) if the beneficiary lives in a state that requires interest payments. Because state insurance laws vary, calculation of interest differs from state to state.

Verbal Representation

Nothing you say or that you are told regarding this insurance is binding on anyone unless you or your beneficiary has something in writing from the Company and MetLife confirming your coverage.

Filing Claims

MetLife insures all Life Insurance Benefits under a group insurance policy. They also process all claims.

Contact HR Services and you will receive instructions on how to file your claim. Click on the “Start a Chat” button on the top of this page.

The life insurance claim will be processed after MetLife receives all necessary documentation.

Accident Insurance Benefits

Accident Insurance Benefits may provide benefits to you and your eligible family members in the event of an accident or injury.

- As an eligible employee, you may elect to purchase Accidental Death and Dismemberment (AD&D) Insurance for yourself and your family.
- Special Risk and Accident Insurance (SRAI) pays a benefit up to a maximum of $500,000 if accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world.
- Special Purpose Accident Insurance (SPAI) coverage provides two types of insurance coverage:
  - Up to $100,000 if injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device.
  - Pays up to $100,000 for accidental death or dismemberment for non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft.

LINA's and CIGNA's Roles

Accident coverage is provided under group insurance policies issued by the Life Insurance Company of North America (LINA). CIGNA processes and pays all claims for LINA. Contact HR Services for more information. Click on the "Start a Chat" button on the top of this page.

Benefit Overview

Option	Key Features
Accidental Death & Dismemberment (AD&D) Insurance	▪ Benefit paid in the event of your covered accidental injury or death ▪ You pay premiums through after-tax payroll deduction. ▪ Coverage in $10,000 increments up to $500,000 for employee coverage and up to $350,000 for spouse coverage. $10,000 coverage for each dependent child, regardless of the number of children covered.
Special Risk Accident Insurance (SRAI)	▪ Coverage is paid for by the Company ▪ Pays a benefit of five times your annual base salary, up to a maximum of $500,000 if accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world.

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Option	Key Features
Special Purpose Accident Insurance (SPAI)	▪ Coverage is paid for by the Company. ▪ Pays up to $100,000 to each employee injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne. ▪ Covers non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft, and pays up to $100,000 for accidental death or dismemberment.

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Accidental Death & Dismemberment Insurance (AD&D)

As an eligible employee, you may elect to purchase Accidental Death and Dismemberment (AD&D) Insurance Benefits for yourself and your family. In the event of an accidental injury, AD&D insurance pays benefits to:

- You, in the case of certain accidental injuries to you or your covered dependent(s)
- You, in the event of your covered dependent's death
- Your named beneficiary, in the event of your death

A covered loss includes death, paralysis or loss of limb, sight, speech or hearing. The AD&D coverage pays a benefit if you have a loss within one year of an accidental injury. If you experience more than one loss from the same accident, the coverages pay the largest amount applicable to one loss.

What is Covered

The following table explains when an injury is covered as a loss:

If Injury Is to:	It Must Be:
Hand or foot	Severed through or above the wrist or ankle joint
Arm or leg	Severed through or above the elbow or knee joint
Eye	The entire, irrecoverable loss of sight
Thumb and index finger	Severed through or above the metacarpophalangeal joint (the point where the finger is connected to the hand)
Speech	An irrecoverable loss of speech that does not allow audible communication in any degree
Hearing	An irrecoverable loss of hearing in both ears that cannot be corrected with any hearing aid or device

The following table shows the portion of benefits that the AD&D coverage pays if you have an accidental injury which results in a loss:

If Injury Results in:	Benefit Is:
Death	Full benefit amount
Loss of two or more members (hand, foot, eye, leg or arm)	Full benefit amount
Loss of speech and hearing in both ears	Full benefit amount
Quadriplegia (total paralysis of both upper and both lower limbs)	Full benefit amount
Paraplegia (total paralysis of both legs)	Full benefit amount
Hemiplegia (total paralysis of the arm and leg on one side of the body)	Full benefit amount
Loss of one arm	3/4 benefit amount
Loss of one leg	3/4 benefit amount
Loss of one hand, foot or eye	1/2 benefit amount
Loss of speech	1/2 benefit amount
Loss of hearing in both ears	1/2 benefit amount
Loss of thumb and index finger on the same hand	1/4 benefit amount

If your accidental injury results in the loss of use of a limb (arm or leg) within one year from the date of an accident, you receive the following benefits:

Injury	Benefit
Loss of use of two limbs	***2/3 benefit amount***
Loss of use of one limb	***1/2 benefit amount***

Loss of use must be complete and irreversible in the opinion of a competent medical authority.

Special Benefit Features

Air bag benefit: If you or your covered dependent dies in a motor vehicle accident and the safety airbag (as defined by the Plan) is deployed as a result of such an accident, the participant will receive a benefit equivalent to 10% of the AD&D principal sum benefit, up to a maximum of $10,000. A seat belt must be worn in order for the Air Bag Benefit to be payable.

Child care benefit: If you or your spouse dies as the result of an accident and your child is covered under the family AD&D, the coverage pays the surviving spouse an annual benefit of 5% of the total coverage amount (up to $7,500 per year) for the cost of surviving children's care in a licensed child care facility. This benefit is payable up to five years or until the child enters first grade, whichever occurs first.

COBRA reimbursement: If you die as a result of an accident and your spouse and child are covered under the family AD&D, the coverage pays your dependents an additional annual benefit up to 3% of your AD&D coverage amount to assist them in paying for continuation of group medical coverage, up to a maximum of $6,000 per year. This COBRA reimbursement benefit may be paid for up to three years or for the duration of your dependents' COBRA eligibility, whichever is longer. To be eligible for this benefit, your spouse and dependent child(ren) must be covered under the family AD&D, as well as your Medical Benefit Option.

Coma benefit: If you or a covered dependent becomes comatose as the result of an accident within 31 days of the accident, you receive 1% per month of the AD&D death benefit amount each month for up to 11 months. This benefit ends the earliest of:

- The month the covered person dies,
- The end of the 11th month for which the benefit is payable, or
- The end of the month in which the covered person recovers.

This benefit is payable after a 31-day waiting period that begins on the day the covered person becomes comatose.

If the covered person remains comatose after 11 months, the coverage pays the amount of coverage for accidental death reduced by benefits already paid for injury or paralysis. If the covered person dies as the result of the accident while the coma benefit is payable, the coverage pays benefits for accidental death.

In addition to other AD&D exclusions, the coma benefit has one other exclusion. Benefits are not payable for a loss resulting from illness, disease, bodily infirmity, medical or surgical treatment or bacterial or viral infection, regardless of how it was contracted. However, a bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning is covered.

Coma benefits are paid to the legal guardian or person responsible for the care of the comatose patient. The claims processor determines who is most responsible if a legal guardian is not named.

Payment of the coma benefit to the legal guardian or person responsible for care does not change the designated beneficiary in the event of death.

Common disaster benefit: If you elect family AD&D coverage and, as the result of a common accident, you or your spouse dies within one year of the covered accident, the spouse's loss of life benefits will be increased to 100% of your amount of coverage. However, the combined benefits of you and your spouse will not be more than $1 million.

Counseling and bereavement benefits: AD&D pays an additional benefit if you or an insured family member dies, becomes comatose or is paralyzed or suffers accidental dismemberment as a result of a covered accident. AD&D will pay for up to five sessions of medically necessary bereavement and trauma counseling, at a maximum of $100 per session, for expenses incurred within one year of the date of the covered accident. Benefits are payable for the insured and any of the insured's immediate family members including mothers/fathers-in-law, and brothers/sisters-in-law.

Double benefit for dismemberment of children: If a covered child experiences a loss as the result of an accident, the benefit amount is double (to a maximum benefit of $60,000). This provision does not apply if death occurs within 90 days of the accident.

Home/vehicle modification benefit: If, as the result of an accident, the participant's covered injury(ies) require use accommodations to his/her home or motor vehicle, the participant will receive a benefit equivalent to 10% of his/her principal sum benefit, up to a maximum benefit of $10,000.

Escalator benefit: Your AD&D benefits will automatically increase by 3% of your elected benefit amount each year, up to a maximum of 15% after five continuous years. This increased coverage is provided at no additional cost. If coverage ends for any reason, such as layoff, unpaid sick leave of absence or termination of contributions, any previous escalator benefit is lost. A new five-year escalator benefit period starts if you decrease your coverage or re-enroll. If you increase your level of coverage, you will retain the escalator benefit that has accrued on the previous amount and will begin a new five-year escalator period for the additional amount of coverage.

Seat belt benefit: If you or your covered dependent dies in an accident as the driver or passenger of any land vehicle (including Company-owned cars, pickups and commercial vehicles) and the covered person was properly wearing a seat belt at the time of the accident, the coverage pays an additional 20% of the benefit applicable to you or your dependent, to a maximum of $25,000. If the vehicle was not equipped with seat belts or the accident report shows seat belts were not in proper use, no seat belt benefit is payable.

Rehabilitation benefit: If a participant suffers injury from an accident resulting in a loss for which benefits are payable under the AD&D insurance benefit, this coverage will reimburse the participant for covered rehabilitative expenses that are due to the injury causing the loss. These covered rehabilitative expenses must be incurred within two years after the date of the accident causing the loss, and will be payable up to a maximum of $50,000 for all injuries caused by the same accident.

Covered rehabilitative expense means an expense that:

- Is charged for a medically necessary rehabilitative training session of the participant, performed under the care, supervision or order of a physician,
- Does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for hospital room and board charges, does not exceed the most common charge for hospital semi-private room and board in the hospital where the expense is incurred, and
- Does not include charges that would not have been made if no insurance existed.

Medically necessary rehabilitative training service means any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that:

- Is essential for physical rehabilitative training due to the injury for which it is prescribed or performed,
- Meets generally accepted standards of medical practice, and
- Is ordered by a doctor.

Covered rehabilitative expense does not include any expenses for or resulting from any condition for which the participant is entitled to benefits under any Workers' Compensation Act or similar law.

Hospital means a facility that:

- Is operating according to law for the care and treatment of injured people,
- Has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a pre-arranged basis,
- Has 24-hour nursing service by registered nurses, and
- Is supervised by one or more physicians.

A hospital does not include:

- A nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care,
- A facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, or
- Any military or veteran hospital or soldiers' home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Special education benefit: If either you or your spouse dies as the result of an accident and your children are all covered by the family AD&D, the coverage pays 5% of that parent's total coverage amount (up to $10,000 per year) to each dependent child for higher education. This benefit is payable for up to four consecutive years, as long as the child is enrolled in school beyond 12th grade. If coverage is in force but there are no children who qualify at the time of the accident, the coverage pays an additional $1,000 to the designated beneficiary.

Spouse critical period: If you or your covered spouse dies as a result of an accident, AD&D pays the surviving spouse an additional monthly benefit of a half of a percent (0.5%) of the deceased person's coverage amount. This benefit, provided to help the surviving spouse cope with the difficult period immediately following a death, is paid monthly for 12 months.

Spouse retraining or refreshing skills benefit: If you die accidentally and your spouse is also covered by the family AD&D, the coverage pays up to a maximum of $10,000 for your spouse to enroll as a student in an accredited school within 365 days of your death. This benefit is in addition to all other benefits.

Uniplegia benefit: If a participant is involved in an accident resulting in the loss of use of only one arm or one leg, the participant will receive a benefit equivalent to 50% of his/her principal sum benefit.

Waiver of premium: If you elect AD&D coverage for you and your dependents and you die as the result of an accident, any AD&D coverage you have elected for your spouse and children continues without charge for 24 months.

Travel Assistance Services

If you elect AD&D coverage for yourself, you may also take advantage of travel assistance services when you and your covered family members travel internationally. This package of valuable services and benefits is called CIGNA Secure Travel and is provided by Worldwide Assistance Services, Inc.

Through CIGNA Secure Travel, you have access to more than 250,000 service professionals in over 200 countries. These agents are available 24 hours a day, seven days a week to provide you with the highest level of service whenever you need it.

CIGNA Secure Travel offers the following services for international travel:

- Services before your departure, including:
  - Immunization requirements
  - Visa and passport requirements
  - Foreign exchange rates
  - Embassy/consular referral
  - Travel/tourist advisories
  - Temperature and weather conditions
  - Cultural information
- Prescription assistance to refill a prescription that has been lost, stolen or depleted
- Assistance in replacing lost luggage, documents and personal items
- Legal referrals to local attorneys, embassies and consulates; you will need to pay for any professional services rendered
- Medical referrals to local physicians, dentists and medical treatment centers in the event of an accident or illness; you must follow your Medical Benefit Option rules to receive reimbursement for any eligible expenses
- Emergency message relay to notify friends, relatives or business associates if you have a serious accident or illness while traveling
- Emergency medical evacuation for transportation to the nearest adequate hospital or treatment facility, if medically necessary
- Repatriation of remains in the event of death overseas to cover the cost of returning remains to the place of residence and arranging necessary government authorizations to transfer remains
- Return of dependent children (who are under age 16) traveling with a covered member and who are left unattended when the covered member is hospitalized. Worldwide Assistance Services will arrange and pay for their transportation home. If someone is needed to accompany the children, a qualified escort will be arranged and expenses paid.

If a covered member is traveling alone and must be hospitalized for 10 or more consecutive days, arrangements will be made and paid to provide round-trip economy class transportation for an immediate family member or friend designated by the covered member from his or her home to the place where the covered member is hospitalized.

Worldwide Assistance Services will also arrange and pay for a maximum of $100 per day for up to seven days for meals and accommodations for the family member or friend while they are visiting the hospitalized covered member.

Exclusions

AD&D coverage does not cover loss caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, suicide or attempted suicide
- Declared or undeclared act of war within the U.S. or any nation of which you are a citizen
- An accident that occurs while you are serving full-time active duty for more than 30 days in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from the vehicle or device while:
  - The vehicle is being used for experimental purposes
  - You are operating, learning to operate or serving as a member of the crew of an aircraft other than an aircraft operated by or under contract with the Company
- Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed physician (accidental ingestion of a poisonous substance is covered, as well as accidents caused by use of legal, over-the-counter drugs)
- Commission of a felony including, but not limited to: robbery, rape, arson, murder, kidnapping or burglary

Filing a Claim

AD&D is provided under group insurance policies issued by the Life Insurance Company of North America (LINA). CIGNA processes all claims for LINA. To file a claim for AD&D benefits:

- Contact HR Services to request a CIGNA AD&D Claim Form within 30 days of the death or injury. Complete the form according to accompanying directions. All claims must be submitted on CIGNA forms. Click on the “Start a Chat” button on the top of this page.
- In the event of your death, your manager/supervisor will notify Survivor Support Services, who will coordinate filing for benefits, similar to the procedures outlined for life insurance claims in Filing Claims.
- Send the completed claim form to HR Services along with documentation of the claim, such as a police report of an accident and a certified copy of the death certificate. HR Services sends the claim to CIGNA for processing.
- CIGNA processes claims within 90 days from the day they are received. In some cases, however, more time may be needed. If this is the case with your claim, CIGNA will notify you that an additional 90 days will be required. At any point during the claim review period, you may be asked to supply additional information and/or submit to a medical examination at LINA’s expense.
- If your claim is approved, the insurance proceeds will be deposited into a CIGNA Resource Manager Account (similar to a money market checking account) that earns interest.

- If your claim is denied, you or your beneficiary will be notified in writing. Notification explains the reasons for the denial and specifies the provisions of the LINA group policy that prevent approval of the claim. The notification may also describe what additional information, if any, could change the outcome of the decision.
- If your claim is denied or you have not received a response by the end of the second 90-day review period, you may request a review of your claim.
- No one may take legal action regarding the claim until 60 days after filing the claim. No legal action may be taken more than three years after filing the claim (with the exception of five years in Kansas and six years in South Carolina). You must exhaust your administrative appeals before filing any legal action regarding a claim denial.

Conversion Rights

You can convert up to $250,000 in Accidental Death and Dismemberment (AD&D) Insurance Benefits coverage for you and your spouse and up to $10,000 in coverage for each eligible child to individual policies offered by LINA within 31 days of termination of coverage if coverage terminates for one of the following reasons:

- Your employment ends,
- Your eligibility ends (however, a dependent who is no longer eligible for coverage may not convert to an individual policy while you remain eligible for coverage), or
- The coverage ends.

Contact LINA at 1-800-238-2125 for details on conversion.

Insurance Policy

The terms and conditions of this AD&D coverage are set forth in the group insurance policies issued by LINA. These group policies are available for review from LINA. In the event of a conflict between the description in this Guide and the provisions of the insurance policies, the insurance policies will govern.

Other Accident Insurance: Special Risk Accident Insurance (SRAI) Benefit and Special Purpose Accident Insurance (SPAI) Benefit

The Company provides other accident insurance for certain situations described in this section. Other accident insurance programs include Special Risk Accident Insurance (SRAI) Benefit and Special Purpose Accident Insurance (SPAI) Benefit. These insurance coverages all have the following features:

- Premiums are paid by the Company.
- Coverage is provided without regard to your health history.
- The insurance provides 24-hour protection while you are traveling on Company business, from the time you leave until you return home or to your base, whichever occurs first.
- Benefits are payable in addition to any other insurance you may have.
- Covered losses include death or loss of limb, sight, speech or hearing. The insurance pays a benefit if you have a loss within one year of an accidental injury.
- No more than one Other Accident Insurance Benefit will be paid with respect to injuries resulting from one accident. If you have more than one loss from the same accident, you are entitled to the largest benefit amount for a single loss.
- Benefits payable under these other accident coverages do not reduce any accident benefits you may receive under the AD&D Insurance Benefits coverage.

SRAI Benefit

SRAI Benefit provides insurance coverage for employees for accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world. You are covered while performing daily assignments at your home base and during business travel. Hostile acts of foreign governments are also covered for any occurrences outside the U.S.

SRAI pays a benefit of five times your annual base salary, up to a maximum of $500,000. This coverage only applies to employees on active payroll.

SPAI Benefits

This insurance coverage pays up to $100,000 to each employee who is injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.

SPAI Benefit also covers non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft, and pays up to $100,000 for accidental death or dismemberment.

Policy Aggregates

An accident may involve more than one employee. Total benefits to all covered employees involved in a single incident are limited to:

- $10,000,000 under SRAI Benefit.
- $2,000,000 per aircraft accident under SPAI Benefit.

If benefits for one incident would exceed the limit, benefits are distributed to beneficiaries in proportion to the amounts of insurance covering all employees who suffer losses in the same incident.

Exclusions

These accident insurance policies do not cover losses caused by or resulting from any of the following:

- Suicide, attempted suicide or intentional self-inflicted injuries.
- Declared or undeclared act of war (Under SRAI Benefit, hostile acts of foreign governments are not covered within the U.S.)
- An accident that occurs while you are serving on full-time, active duty in the armed forces of any country or international authority.
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound.

- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting, while:
  - The vehicle is used for test or experimental purposes.
  - You are operating, learning to operate or serving as a member of the crew except while riding solely as a passenger, mechanic, substitute flight attendant or acting as a crewmember on any aircraft owned by or under contract to American Airlines.
  - Being operated under the direction of any military authority other than transport-type aircraft operated by the Military Airlift Command (MAC) of the U.S. or a similar air transport service of any other country.
  - Commuting to and from work (SRAI Benefit).

Insurance Policy

The terms and conditions of the coverages are set forth in the group insurance policies issued by the Life Insurance Company of North America (LINA). The group policies are available for review from the Plan Administrator.

In the event of a conflict between the description and the provisions of the insurance policies, the insurance policies will govern.

Disability Benefits

The Company provides Optional Short Term Disability (OSTD) Insurance in the event you are unable to return to work when your sick pay ends.

- OSTD Insurance:
  - Replaces a portion of your salary when you are unable to work as a result of a non-work related disability.
  - Is a fully-insured benefit from MetLife. Eligibility ends when your employment terminates.
- Your union provides you with Long-Term Disability Plan coverage.

MetLife's Role – OSTD/LTD Pay

MetLife is the claims processor for OSTD/LTD pay. Visit the MetLife website or contact MetLife at 1-888-533-6287 for more information.

Overview

The following table helps you understand the benefits you may be eligible to receive in event of an illness or disability.

Program Name	When Benefits Begin	When Benefits End	Amount of Benefit
Optional Short Term Disability (OSTD) Insurance	The later of: ▪ Eighth day of your illness or disability; or ▪ When sick pay is exhausted.	The earlier of the date: ▪ The claims processor determines you are no longer disabled; or ▪ You become gainfully employed in any type of job except under the Return-to-Work Program (see Return-to-Work Program); or ▪ The 26-week maximum period ends; or ▪ You die.	The amount of benefit: ▪ 50% of adjusted monthly salary (reduced by any state disability benefits you are eligible to receive). ▪ If you are enrolled in Long-Term Disability (LTD) Plan coverage, you will receive the full OSTD Insurance coverage, plus the benefit you receive from your LTD coverage. Once the 26 weeks of OSTD Insurance are exhausted. Contact your union or LTD administrator for benefit details.

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Optional Short Term Disability (OSTD) Insurance

The Company provides a certain amount of paid sick time for salary continuance during disabilities. However, a gap may occur between the time accrued sick pay ends and Long-Term Disability (LTD) Plan benefits begin. In this case, the Company also offers Optional Short Term Disability (OSTD) Insurance benefits to provide income protection until LTD Plan benefits begin.

How the OSTD Insurance Benefit Works

OSTD Insurance benefits replace a portion of your salary when you are unable to work as a result of a non-work related disability. Before electing OSTD Insurance coverage, you should consider your accrued sick time because OSTD Insurance benefits are not payable until all of your accrued sick pay is used.

OSTD Insurance is insured through MetLife and is designed to supplement any other similar benefits to equal 50% of your adjusted monthly salary. For regular, full-time employees, “adjusted monthly salary” is defined as your annual base salary or annualized hourly pay, plus skill and license premiums and market differentials. It does not include profit sharing, bonus, overtime or incentive pay.

For converted and part-time employees, “adjusted monthly salary” is based on average weekly earnings for the last six months.

If you are enrolled LTD Plan coverage, you will receive the full OSTD Insurance benefit, plus you will receive a minimum benefit from LTD Plan coverage (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD Insurance are exhausted, the full LTD Plan benefit will be payable.

OSTD Insurance also offers a Return-to-Work Program that allows you to go back to work on a trial basis while recovering from a disability.

The cost of OSTD Insurance is collected through payroll deductions. If you enroll, your selection remains in effect for two calendar years. If you choose not to enroll when you are first eligible and decide to enroll later, proof of good health is required. You may add coverage if you experience a Life Event. Your OSTD Insurance will not become effective until you are actively at work and a payroll deduction has been taken.

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive OSTD Insurance benefits.

Definition of Total Disability

You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

Appropriate Care and Treatment

You will be required to receive Appropriate Care and Treatment (during your disability). Appropriate Care and Treatment means medical care and treatment that is:

- Given by a physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- Consistent with a physician's diagnosis of your disability; and
- Intended to maximize your medical and functional improvement.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

OSTD Insurance Benefits

If you have a qualifying disability, the OSTD Insurance benefit covers the difference between any state-provided benefit and 50% of your adjusted weekly salary on your last date worked. The maximum covered salary is $200,000.

In some cases, OSTD Insurance benefits may be limited:

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico, you may be eligible for state disability benefits. Employees based in California, Hawaii and Rhode Island must apply directly to the state for benefits.
- If you have accrued a significant number of unused sick days, you would not be able to collect OSTD Insurance until you have used all those days.
- If you are enrolled in the Long-Term Disability (LTD) Plan, you will receive the full benefit of OSTD Insurance, plus you will receive a minimum benefit from LTD Plan coverage (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD Insurance are exhausted, the full LTD Plan benefit will be payable.

The OSTD Insurance benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

Filing a Claim

If your disability continues for eight or more days, you should file your disability claim immediately. Do not wait until your sick pay is used up; file by the eighth day of your disability. The sooner you file, the sooner your claim can begin processing. However, the latest you can file your claim is six months after your disability began. If you are covered under a state-mandated short-term disability plan and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim beyond the six-month deadline (or the state-mandated deadline, if sooner), your claim will not be accepted and you will not be eligible for benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance benefit, state disability plans (other than California, Rhode Island and Hawaii, which have their own forms that must be filed directly with the respective states) and LTD Plan. You or your supervisor should request the Disability Claim Form as soon as you become disabled.
- You, your supervisor and your attending physician must each complete part of the form:
  - Disability Claim Employer Statement: Your supervisor completes this page.
  - Disability Claim Employee Statement: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see Benefits from Other Sources).
  - Disability Claim Attending Physician Statement: Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

MetLife is the claims processor for the Optional Short Term Disability Insurance Benefit. The OSTD Insurance and state disability coverages are insured plans (including state plans in New Jersey, New York and Puerto Rico). The states of California, Hawaii and Rhode Island administer their own disability plans.

Return-to-Work Program

You will collect a 50% OSTD Insurance benefit that is adjusted for income from other sources, a 10% Return-to-Work Program incentive and the amount you earn from participating in the voluntary Return-to-Work Program while you are disabled. Your OSTD Insurance benefit will be adjusted to reflect income from other sources (such as state disability, income from another employer, no-fault auto, third party recovery) and any amount of your work earnings while participating in the Return-to-Work Program that causes your income from all sources to exceed 100% of your pre-disability earnings. In no event can the total amount you collect from all sources or income exceed 100% of your pre-disability earnings while you are disabled. Your pre-disability earnings are determined as of the date you become disabled. For part-time employees, pre-disability earnings are based on a 20-hour work week.

Family Care Incentive

If you work part-time or participate in the Return-to-Work Program while you are disabled, MetLife will reimburse you for up to $100 for weekly expenses you incur for each child or family member incapable of independent living.

To provide care for your or your spouse's child, legally adopted child or a child for whom you or your spouse are legal guardian and who is:

- Living with you as part of your household;
- Dependent on you for support; and
- Under age 13,

child care must be provided by a licensed child care provider who may not be member of your immediate family or living in your residence.

This benefit also includes care for your family member who is living with you as part of your household and who is

- Chiefly dependent on your for support; and
- Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to your family member may not be provided by a member of your immediate family.

When Benefits Begin

Provided you qualify, OSTD Insurance benefits are payable on the eighth day of disability or when your accrued paid sick time is exhausted, whichever occurs later. If you are collecting vacation pay when OSTD Insurance benefits become payable, OSTD Insurance benefits will not begin until your vacation pay ends. Benefits are payable for a maximum of 26 weeks.

There is no limit to the number of times you may receive these benefits for different periods of disability. However, successive periods of disability separated by less than 60 days of full-time active work are considered a single period of disability. Such disability will be considered to be a part of the original disability. MetLife will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used for the original disability. This benefits you because if you become disabled again due to the same or related sickness or accidental injury, you will not be required to meet a new elimination period. The only exception is if the later disability is unrelated to the previous disability and begins after you return to full-time active work for at least one full day.

Benefits from Other Sources

Your OSTD Insurance benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- No-Fault Auto Laws: Periodic loss of income payments you receive under no-fault auto laws. Such payments will offset your OSTD Insurance benefit.
- Third Party Recovery: Recovery amounts that you receive from loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings may offset your OSTD Insurance benefit.

When Benefits End

Your OSTD Insurance benefit payments end automatically on the earliest of the following dates:

- The date the claims processor determines you are no longer disabled (e.g., you no longer meet the definition of total disability, you are no longer receiving Appropriate Care and Treatment, etc.); or
- The date you become gainfully employed in any type of job for any employer, except under the Return-to-Work Program; or
- The end of the maximum benefit period of 26 weeks; or
- The date you die.

If and when you return to work, you or your supervisor must notify MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repaying any overpayments you receive.

Exclusions and Limitations

The OSTD Insurance benefit has the following exclusions and limitations:

- Preexisting conditions exclusion: You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation of disability no longer applies, and you may receive benefits.
- If you are based in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island, then OSTD Insurance benefits are offset. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. If the state benefit is less than the OSTD Insurance benefit, an OSTD Insurance benefit is payable. If the state benefit is more than the OSTD Insurance benefit, an OSTD Insurance benefit is not payable.
- Benefits are not payable if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered work-related for OSTD Insurance purposes if the claim is denied by Workers' Compensation.
- If you become disabled before the effective date, you are not covered under this insurance until you return to work and deductions are taken from your pay.
- Benefits are payable to employees. Dependents are not eligible for this benefit.
- Benefits are not payable if you are disabled as a result of committing or trying to commit a felony, assault or other serious crime.
- Benefits are not payable if you are disabled as a result of self-inflicted injuries or attempted suicide.
- Benefits are not payable if caused by a declared or undeclared act of war.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling condition from a duly qualified physician.
- Benefits may be reduced if you participate in the Return-to-Work program.

Long-Term Disability

As a TWU employee, long term disability coverage is available to you through a disability plan sponsored by the Transport Workers Union of America, AFL-CIO. For information on this plan, contact your local union office.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account (HCFSA) allows you to set aside money on a pre-tax basis to help pay for eligible health care expenses for yourself and eligible dependents.

- Eligible health care expenses include medical, dental and vision expenses, prescription drugs and certain eligible over-the-counter items.
- Employees can contribute to an HCFSA without being enrolled in medical, vision or dental coverage.
- Pay for expenses with pre-tax money to reduce taxes.
- Each employee may deposit up to $5,000 per calendar year in his or her HCFSA.
- Company-recognized Domestic Partners and their dependents do not qualify for reimbursement under the HCFSA.
- Following your first payroll deposit, the full amount of your elected HCFSA amount for the entire year is available for your use, regardless of the actual balance in your account.
- You have until March 15 to use your prior year's balance and until June 15 to file claims for the previous year's eligible expenses.

PayFlex's Role

The HCFSA administrator is PayFlex. The PayFlex website allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access "Frequently Asked Questions (FAQs)," and manage direct deposit.

Benefit Overview

Option	Who Can Be Reimbursed	Key Features
Health Care FSA	You can be reimbursed for expenses for your: ▪ Spouse ▪ Children and young adults ▪ Parents ▪ Other dependents, if you claim them as dependents on your federal income tax return ▪ Company-recognized Domestic Partners and their dependents are not considered eligible dependents, per IRS regulations	▪ Deposit up to $5,000 a year ▪ Pre-tax contributions ▪ Have until March 15 to use your prior year's balance ▪ Have until June 15 to file claims for previous year's eligible expenses ▪ Eligible dependents do not have to be covered under your medical, dental or vision plan to be eligible for reimbursement ▪ If both you and your spouse are employed by AA, both employees may each deposit up to $5,000 in an HCFSA

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How the Health Care Flexible Spending Account (HCFSA) Works

The Health Care Flexible Spending Account (HCFSA) allows you to set aside money on a pre-tax basis to pay for eligible health care expenses. Paying for these expenses pre-tax helps reduce your taxes.

IRS rules specify the types of expenses eligible for reimbursement from your HCFSA. Eligible health care expenses that can be reimbursed from your HCFSA include:

- Medical
- Dental
- Vision
- Prescription drugs

- Certain over-the-counter items. See "Covered Expenses" on page 162 and "Excluded Expenses" on page 164 in this section for a list of eligible and ineligible expenses.
- Other expenses not paid by your Medical Benefit Option, such as deductibles, co-insurance, co-pays and any amounts above the usual and prevailing fee limits.

See "Covered Expenses" on page 162 in this section for a list of eligible expenses under the HCFSA.

You can contribute through payroll deduction up to $5,000 a year in your HCFSA.

Following your first payroll deposit, the full amount of your elected HCFSA amount for the entire year is available for your use, regardless of the actual balance in your account.

You may carry over any unused funds remaining in your HCFSA as of December 31 into the next calendar year. You have until March 15 of the following year to use your HCFSA balance and until June 15 to file claims on your previous year's eligible expenses.

Special Provisions

- You can only stop or change your election mid-year if you experience certain Life Events.
- If you experience a Life Event and decide to reduce the amount of your HCFSA, you cannot reduce your account balance to an amount that is less than the claims that have already been paid.
- If you incur expenses after your Life Event, your claims are payable up to the amount of your newly elected deposit amount.
- If you decide to stop the amount of your HCFSA deposits mid-year, this will affect how your claims are paid. You cannot stop if you have already received reimbursement exceeding the amount contributed into your HCFSA account.
- If your eligible health care expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your HCFSA. You cannot receive reimbursement for expenses incurred after the date you stopped making contributions to your HCFSA; however you can submit claims up to the amount in your account, provided they were incurred before the date you stopped.
- If you chose to stop the amount of your HCFSA mid-year, you will lose any remaining balance you have if the contributions you made before your Life Event are greater than your claims before the Life Event.
- If your employment terminates for any reason (i.e., furlough, resignation, etc.), your FSA terminates. You may elect to continue your HCFSA as part of your COBRA Continuation of Coverage options. If you do not continue your HCFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any contributions that were made and not used before your termination date.

Covered Expenses

You receive reimbursement from your HCFSA only for eligible expenses through March 15 of the following year. You have until June 15 to file your claims for the previous year's eligible expenses.

Expenses that can be reimbursed through an HCFSA include the following:

- Out-of-pocket expenses, deductibles, co-insurance, co-pays, prescription medications and supplies not paid by your medical, dental or vision benefit options, whether your coverage is under an AA-sponsored plan or any other health plan.
- Certain types of over-the-counter items purchased without a prescription and used to alleviate or treat personal injuries or sicknesses of the employee and/or the eligible dependents may be eligible for reimbursement through your HCFSA. For instance, insulin, bandages, crutches and contact lens solution, and the like. Refer to the list of eligible items by visiting the PayFlex website.

FAQ: How do I know if my OTC items are covered?

Go to the PayFlex website or the IRS website.

Reimbursable Medical Expenses

Some medical expenses may not be covered at all by your Medical Benefit Option. However, they may be reimbursed under your HCFSA. Examples include:

- Acupuncture
- Ambulance service
- Artificial insemination
- Bandages, support hose, other pressure garments (when prescribed by a physician to treat a specific ailment)
- Blood, blood plasma or blood substitutes
- Braces, appliances or equipment, including procurement or use
- Car controls for the handicapped
- Charges in excess of usual and prevailing fee limits
- Confinement to a facility primarily for screening tests and physical therapy
- Experimental procedures
- Foot disorders and treatments such as corns, bunions, calluses and structural disorders
- Halfway house care
- Home health care, hospice care, nurse or home health care aides
- Hypnosis for treatment of illness
- Immunizations
- In-vitro fertilization and infertility treatment
- Learning disability tutoring or therapy
- Nursing home care
- Physical therapy
- Prescription vitamins

- Psychiatric or psychological counseling
- Radial keratotomies, lasik and vision correction procedures
- Sexual transformation or treatment of sexual dysfunctions or inadequacies
- Smoking cessation program costs and prescription nicotine withdrawal medications
- Speech therapy
- Syringes, needles and injections
- Transportation expenses to receive medical care, including fares for public transportation and private auto expenses (consult your tax advisor for the current IRS mileage allowance)
- Work-related sickness or injury (not covered by Workers' Compensation)
- For a full list of covered medical expenses, go to the IRS website.

Reimbursable Hearing and Vision Expenses

Some hearing and vision expenses that may be reimbursed under your HCFSA include:

- Hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading) and the cost of acquiring and training a dog for the deaf
- Vision expenses, including eyeglasses, contact lenses, ophthalmologist fees, the cost of a guide dog for the blind and special education devices for the blind (such as an interpreter)
- For a full list of covered hearing and vision expenses, go to the IRS website.

Reimbursable Dental Expenses

Some medical expenses may not be covered at all by your Dental Benefit. However, they may be reimbursed under your HCFSA. Examples include:

- Anesthesia
- Cleaning more than twice per year
- Charges in excess of usual and prevailing fee limits
- Drugs and their administration
- Experimental procedures
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents
- Myofunctional therapy
- Replacement of dentures or bridgework less than five years old
- Replacement of lost, stolen, or missing dentures or orthodontic devices
- For a full list of covered dental expenses, go to the IRS website.

Excluded Expenses

Some expenses may not be reimbursed through your HCFSA; examples include:

- Medical insurance premiums/contributions
- Air conditioning units
- Capital expenses
- Cosmetic medical treatment, surgery, and prescriptions and cosmetic dental procedures, such as cosmetic tooth bonding or whitening
- Electrolysis
- Health club fees and exercise classes (except in rare cases for treatment of medically diagnosed obesity where weight loss is part of the program)
- Marriage and family counseling
- Massage therapy
- Over-the-counter medications without a prescription
- Personal care items including cosmetics and toiletries
- Structural additions or changes
- Swimming pools
- Transportation expenses for the handicapped to and from work
- Vacation travel for health purposes
- Vitamins and nutritional supplements, unless prescribed by a doctor
- Weight loss programs (unless for treatment of medically diagnosed morbid obesity)
- Wheelchair ramps
- Whirlpools
- For a full list of excluded expenses, go to the IRS website.

Filing Claims

The full amount of your elected HCFSA amount for the entire year is available for your use, regardless of the actual balance in your account. You may access the funds via the following claim methods:

- Auto reimbursement (availability based on your Medical Benefit Option)
- Online Express Claims (online Express Claims is listed as manual reimbursement in the Benefits Service Center)
- With auto reimbursement your claims are automatically sent from your network/claims administrator to PayFlex for reimbursement. Once claims are submitted, the cost of your expenses will be deposited into your checking or savings account once you submit your receipts. See the PayFlex website for more information.

- You may elect to have your reimbursements deposited directly into your checking or savings account simply by providing your account information online via the Direct Deposit link on the PayFlex website.

Per IRS regulations, expenses for your Company-recognized Domestic Partner and their dependents are not eligible for HCFSA reimbursement. Thus, HCFSA claims for you and your eligible dependents must be filed via paper, online or fax submissions. This is so claims can be verified by patient identity. Auto reimbursement is not permitted if you have a covered Company-recognized Domestic Partner.

- You have until March 15 to use your prior year's balance and until June 15 to file claims for the previous year's eligible expenses.

If You Elect Both a Health Care and a Dependent Day Care FSA

If you elect both an HCFSA and an Dependent Day Care FSA (DDFSA), for your HCFSA you will choose between auto reimbursement (availability based on your Medical Benefit Option) or online Express Claims (listed as manual reimbursement in the Benefits Service Center) at the time of enrollment.

For your DDFSA, you will submit online Express Claims (listed as manual reimbursement in the Benefits Service Center). You submit claims for reimbursement online on the PayFlex website or complete a paper claim and send it to PayFlex by fax or mail. The fax number and mailing address are available on the PayFlex website.

Auto reimbursement is not permitted if you have a covered Company-recognized Domestic Partner. Per IRS regulations, expenses for your Company-recognized Domestic Partner and his or her dependents are not eligible for HCFSA reimbursement. Thus, HCFSA claims for you and your eligible dependents must be filed via paper, online or fax submissions. This is so claims can be verified by patient identity.

- The full amount of your elected HCFSA amount for the entire year is available for your use, regardless of the actual balance in your account. The funds in your DDFSA are only available as funds are contributed into your account.
- With auto reimbursement (only applies to HCFSA, based on your elected Medical Benefit Option), your claims are automatically sent from your network and/or claims administrator to PayFlex for reimbursement. Once claims are submitted, the cost of your expenses will be deposited into your checking or savings account once you submit your receipts. See the PayFlex website for more information. You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the PayFlex website.

You have until March 15 to use your prior year's balance and until June 15 to file claims for the previous year's eligible expenses.

Quick Tip

For more information the Dependent Day Care FSA, see the Dependent Day Care FSA section.

Dependent Day Care Flexible Spending Account

The Dependent Day Care Flexible Spending Account (DDFSA) allows you to set aside money on a pre-tax basis to help pay for eligible day care expenses for your children and certain adult dependents while you (or you and your spouse, if you are married) work.

- Eligible day care expenses include child and adult day care services, private kindergarten, summer day camp, babysitters and au pairs.
- Company-recognized Domestic Partners (and the children of Company-recognized Domestic Partners) are not eligible under the DDFSA, per IRS rules.
- Pay for expenses with pre-tax money to reduce taxes.
- You cannot use your funds until they are deposited into your account.
- You may contribute up to $5,000 per calendar year to your DDFSA. (If both you and your spouse work for American Airlines, your combined DDFSA total contribution cannot exceed $5,000.)
- You have until March 15 to use your prior year's balance and until June 15 to file claims for the previous year's eligible expenses.

PayFlex's Role

The DDFSA administrator is PayFlex. The PayFlex website allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access "Frequently Asked Questions (FAQs)" and manage direct deposit.

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

Benefit Overview

Option	Reimbursement	Key Features
Dependent Day Care FSA	You can be reimbursed for: ▪ Licensed child and adult day care centers ▪ Private kindergarten ▪ Babysitters ▪ Au pairs	▪ Contribute up to $5,000 a year ▪ Pre-tax contributions ▪ Have until March 15 to use your prior year's balance ▪ Have until June 15 to file claims for previous year's eligible expenses ▪ You cannot use your funds until they are deposited in your account

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How the Dependent Day Care Flexible Spending Account Works

The Dependent Day Care Flexible Spending Account (DDFSA) allows you to set aside money on a pre-tax basis to help pay for dependent day care expenses for your eligible dependents. Paying for these expenses with pre-tax money helps reduce your taxes.

A single employee or an employee who files a joint income tax return with his or her spouse and both earn over $5,000 for the year, may contribute up to $5,000 per calendar year (a lower limit applies to employees who file separate returns and special rules apply if your spouse does not work).

You may carry over any unused funds remaining in your DDFSA as of December 31 into the next year calendar year. You have until March 15 to use your prior year's balance and until June 15 to file claims for the previous year's eligible expenses.

Important Note: If you put money into a DDFSA and you do not have any eligible dependents, once the plan year begins that money cannot be refunded to you, per IRS regulations.

Special Provisions

You and your spouse (if you are married) must be employed or actively seeking employment to be eligible to receive reimbursement from your DDFSA. This benefit limits the amount you may contribute and the type of expenses that may be paid from your DDFSA.

Your family and tax filing status determine the maximum amount you can contribute per calendar year:

- A single employee may contribute up to $5,000.
- A couple filing a joint income tax return, where both spouses participate in DDFSAs, may contribute a combined amount of up to $5,000.
- A couple filing separate income tax returns may each contribute up to $2,500.
- A couple (if both individuals are employed) may contribute up to $5,000, or the income amount of the lower-paid spouse (if it is less than $5,000).
- If your spouse has no income because he or she is a full-time student, is disabled and needs day care, or is unable to take care of your dependents because of a disability, you can still make contributions to your DDFSA. These circumstances allow you to contribute up to $200 per month if you have one eligible dependent, or up to $400 per month for two or more dependents.
- If you are a Highly Compensated Employee, as defined by the Internal Revenue Code, your allowable annual pre-tax contribution may be less than $5,000 per calendar year. For example, as defined by the Internal Revenue Code in 2012, a Highly Compensated Employee is an individual who has an annual income of $115,000 or more. This amount may be subject to change, and you will be notified if your maximum contribution changes. For more information about Highly Compensated Employee limits, go to the IRS website.
- You can only stop or change your election mid-year if you experience certain Life Events.
- If you experience a Life Event and decide to reduce the amount of your DDFSA, you cannot reduce your account balance to an amount that is less than the claims that have already been paid.
- If you incur expenses after your Life Event, your claims are payable up to the amount of your newly elected deposit amount.
- If you decide to stop the amount of your DDFSA deposits mid-year, this will affect how your claims are paid.
- You cannot stop if you have already received reimbursement exceeding that amount contributed into your DDFSA account.
- If your eligible expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your DDFSA.
- You cannot receive reimbursement for expenses incurred after the date you stopped making contributions to your DDFSA; however you can submit claims up to the amount in your account, provided they were incurred before the date you stopped.
- If you chose to stop the amount of your DDFSA mid-year, you will lose any remaining balance you have if the contributions you made before your Life Event are greater than your claims before the Life Event.
- If your employment terminates for any reason (i.e., furlough, resignation, etc.), your DDFSA terminates. You may elect to continue your DDFSA as part of your COBRA Continuation of Coverage options. If you do not continue your DDFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any contributions that were made and not used before your termination date.

Fast Fact

If you are single or married and file your taxes jointly, you can contribute up to $5,000 a year in your DDFSA.

Who is Covered

Glossary Term: Eligible Dependent (under the DDFSA)

Children under 13 and anyone over 13 who lives with you, is your dependent, is not capable of self-care and makes less than the federal income tax personal exemption is considered an eligible dependent under the DDFSA.

You may claim dependent day care expenses for your eligible dependents including:

- Children under age 13
- A person over age 13 (including your child, spouse, or parent), if the person meets all of the following criteria:
  - Lives with you and depends on you for support,
  - Is claimed as a dependent on your federal income tax return,
  - Is physically or mentally incapable of self-care, and
  - Has a gross income less than the federal income tax personal exemption. Go to the IRS website for more information.

Because of IRS rules, Company-recognized Domestic Partners and their dependents are not considered eligible dependents under your DDFSA.

Covered Expenses

Expenses paid to the following providers may be reimbursed through your DDFSA, if you can provide their Social Security or taxpayer identification number:

- Someone who cares for an elderly or disabled dependent inside or outside your home
- A licensed child-care center or adult day care center, including churches or non-profit centers
- A private kindergarten (used for day care of child(ren), rather than for educational purposes
  - If the private kindergarten provides both day care and educational services for your dependent child(ren), only the day care portion of the kindergarten's charges are eligible for reimbursement
  - The private kindergarten must separate and itemize the charges on its invoices for payment, clearly separating the day care expenses from the educational expenses
  - If you cannot provide a separation/itemization of charges on the invoice, you will not receive reimbursement from your DDFSA
- A babysitter inside or outside your home if the sitter does not care for more than six children at a time (not including the sitter's own dependents)
- A housekeeper whose duties include dependent day care
- A relative who cares for your dependents, but is neither your spouse nor your dependent child under age 19
- Au pairs (foreign visitors to the U.S. who perform day care and domestic services in exchange for living expenses, provided the au pair agency is a non-profit organization or the au pair obtains a U.S. Social Security number for identification purposes)

Filing Claims

Participants who have a DDFSA must file online paper or fax claims. Go to the PayFlex website for more information.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the PayFlex website.

If you do not have adequate funds in your DDFSA account, your claim will be denied.

You have until March 15 to use your prior year's balance and until June 15 to file claims and the previous year's eligible expenses.

If You Elect Both a Health Care and a Dependent Day Care FSA

If you have both a DDFSA and a Health Care FSA, see "If You Elect Both a Health Care and a Dependent Day Care FSA" in the *Health Care Flexible Spending Account* section.

Long-Term Care Insurance Plan

Long-Term Care Insurance helps pay nursing home and home care costs if future illness, injury or the effects of aging prevent you from living independently.

- If you enroll in coverage within 60 days of your hire date, you do not need to provide proof of good health.
- You may enroll after the 60-day window, but will be required to provide proof of good health.
- Spouses, Company-recognized Domestic Partners, parents, parents-in-law, grandparents and grandparents-in-law are eligible for Long-Term Care Insurance and must provide proof of good health to be covered.
- Children are not eligible for Long-Term Care Insurance.

Met Life's Role

MetLife insures and administers Long-Term Care Insurance. Visit the MetLife website or contact MetLife at 1-888-526-8495 for more information.

How Long-Term Care Insurance Works

As an eligible employee, you may elect Long-Term Care Insurance to help you pay nursing home and home care costs if future illness, injury or the effects of aging prevent you from living independently. This insurance is also available for your spouse, Company-recognized Domestic Partner, parents, parents-in-law, grandparents and grandparents-in-law. Children are not eligible for Long-Term Care Insurance.

Enrolling for Coverage

You are first eligible to enroll for Long-Term Care Insurance when you are hired. If you enroll in Long-Term Care Insurance within 60 days of your hire date, you do not need to provide proof of good health.

If you do not enroll for coverage when first eligible, you may add coverage at any time, but you will be required to provide proof of good health.

Spouses, Company-recognized Domestic Partners, parents, parents-in-law, grandparents and grandparents-in-law must provide proof of good health in order to be covered under this insurance.

Your Long-Term Care Insurance becomes effective only after MetLife has approved your enrollment/application and you have paid the initial premium. MetLife will send you a certificate of insurance/coverage document that provides you with specific information and coverage provisions.

Paying for Coverage

All premiums for this coverage are paid by you with after-tax dollars through payroll deduction. MetLife insures and administers this coverage and processes your enrollment form. Contact MetLife (see "Contact Information" in the *Reference Information* section).

Filing Claims

Claims for Long-Term Care Insurance are administered by MetLife. In the event that you have a claim, contact MetLife directly. See "Contact Information" in the *Reference Information* section).

Retiree Benefits

The Company provides medical and life insurance benefits for eligible retirees.

- Eligible retirees under age 65 can choose the Retiree Value Plus Option. You must pay monthly contributions for this coverage.
- Eligible retirees can choose the Retiree Standard Medical (RSM) Option. If you are covered by the RSM option, you do not have to pay contributions for that coverage.
- Eligible retirees under age 65 who live in Puerto Rico also have the option of choosing the Retiree HMO (RHMO) Option. You must pay monthly contributions for this coverage.
- If you are in the Retiree Value Plus Option or RHMO and your coverage terminates when you reach age 65, you can transfer into the RSM Option and you have to pay contributions for coverage.

Retiree Benefits

Read the Retiree Medical Benefit Guide for details about the benefit options available.

Retiree Benefits Overview

After you retire from the Company, retiree benefits can provide protection for you and your eligible dependents in the event of illness or injury. The Company offers medical and life insurance benefits for eligible retirees. Whether or not you are required to pay ongoing contributions for your retiree medical coverage depends on the Retiree Medical Benefit Option you select.

In This Section

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

Retiree Medical Benefits

How the Plan Works

- There are two medical options available to eligible retirees. Eligible retirees residing in Puerto Rico have a third option.

Option	Contributions
Retiree Value Plus Option (retirees under age 65 only)	You pay ongoing monthly contributions to maintain coverage
Retiree Standard Medical (RSM) Option	There are no contributions to maintain coverage, if you meet the prefunding and eligibility requirements.
Retiree HMO (RHMO) Option (retirees under age 65 residing in Puerto Rico only)	You pay ongoing monthly contributions to maintain coverage

- If you elect the Retiree Value Plus Option, you must pay monthly contributions.
- If you later elect the RSM Option or return to it at age 65, you are required to pay monthly contributions for this coverage.
- The Retiree Value Plus Option and the RHMO Option coverages terminate when you reach age 65. At that time, your coverage changes to the RSM Option for age 65 and over participants and you pay monthly contributions for your coverage.
- See the Retiree Medical Benefit Guide for a full description and comparison of the features of your Retiree Medical Benefit Options.

Prefunding Retiree Medical Benefit Coverage

Prefunding provides a way for you to pre-pay a portion of the cost of your Retiree Medical Benefit coverage, making it unnecessary for you to pay for certain coverage options during retirement.

To receive Retiree Medical Benefit coverage, you must prefund your benefit for the 10 consecutive years immediately before your retirement. You prefund through payroll deductions. The Company matches your after-tax contributions on a dollar-for-dollar basis. Your after-tax contributions, together with the Company's matching contributions, are deposited in a Voluntary Employees Beneficiary Association (VEBA) trust. Assets of the trust can only be used to pay for benefits.

Former TWALLC employees who became American Airlines, Inc. employees on January 1, 2002 must continuously prefund for at least the 10 years immediately preceding retirement in order to receive Retiree Medical Benefits coverage. Former TWALLC employees who became American Airlines, Inc. employees on January 1, 2002, who retire prior to January 1, 2012, who have prefunded continuously since January 1, 2002 (or since first eligible to prefund), and who otherwise meet the eligibility requirements will receive Retiree Medical Benefits.

To prefund Retiree Medical Benefit coverage, you must:

- Be at least age 30
- Have worked for the Company at least one year
- Be an American Airlines, Inc. employee on U.S. payroll
- Be a regular full-time, part-time, part-time extendable or job share employee.

If you decide not to prefund, you will not be eligible for Retiree Medical Benefit coverage as a retiree or in the event of certain qualifying disabilities.

If you elect not to participate in prefunding when you are first eligible and later elect to begin prefunding (or if you begin participating in prefunding, then discontinue prefunding and later resume participation), you must pay the rate in effect when you begin (or resume) prefunding. You must also pay a $250 nonrefundable late enrollment or re-enrollment fee.

Tax Advantages

Prefunding offers several important tax advantages:

- You pay no taxes on investment returns credited to your account during your employment.
- You pay no taxes on investment returns when the value of your account is used to purchase coverage for your retirement or disability. Thus, you pay no taxes on investment returns used to prefund your Retiree Medical Benefit coverage.
- If the value of your account is paid out as a termination or death benefit (as explained later in this section), you or your beneficiary pay taxes on the account's investment returns only at the time benefits are paid.

The trust does not report investment returns earned by your account until it refunds contributions to you or your beneficiary. At that time, an IRS Form W-2 reports the taxable and non-taxable portions of your account to you and the IRS.

Contributions

When you first become eligible, you are automatically enrolled in prefunding unless you elect to waive participation. Prefunding rates are provided in the solicitation package you receive when you are first eligible to prefund. If you were hired on or before December 31, 1989, you pay according to a flat rate. If you were hired after December 31, 1989, the rate you pay is based on your age at the time you begin prefunding. If you initially waive participation and later decide to prefund, you pay a $250 late enrollment fee and the prefunding rates in effect for your age at the time you enroll.

Rates increase annually only if the cost of Retiree Medical Benefit coverage increases. You and the Company share the cost increase equally. However, your rate increase for each month in any year will be no more than the amounts shown in the following table:

Age at Date of Hire	Maximum Increase in Monthly Rate Charged Each Year
Employee Hired on or before December 31, 1989	
Any Age	$1.00
Employee Hired on or after January 1, 1990	
Under age 35	$1.50
35-39	$2.50
40-45	$3.50
46-48	$5.00
49 or over	$5.50

You will be automatically enrolled in prefunding when you become eligible unless you return the waiver enclosed in your solicitation package. Payroll deductions for prefunding begin on the first of the month following the date you become eligible. If you decline participation by the deadline on your solicitation, you will not have payroll deductions. Under IRS rules, prefunding contributions are made on an after-tax basis.

If you decide to discontinue prefunding at some point, your payroll deductions will stop. However, your contributions will not be refunded until you terminate your employment with the Company. Also, if you transfer to a subsidiary or Company workgroup that does not participate in prefunding, your contributions will stop, but you will not receive a refund until you terminate your employment. If you return to an eligible subsidiary or Company workgroup, your prefunding deductions will resume at the applicable current rate that applied to you when they stopped, subject to any annual increases that have taken effect during the time you did not participate.

Your contributions, together with the Company's matching contributions, are recorded in an individual account as part of a trust. There are three separate trusts. One is for TWU employees; one is for APFA employees; and one is for non-union employees (Agent/Representative/Planner). These trusts are operated according to IRS Code Section 501(c)(9) as Voluntary Employee Beneficiary Association (VEBA) Trusts. The trustee is State Street Bank & Trust. Under IRS rules for VEBAs, the Company cannot divert or use the funds for any purpose other than paying employee benefits. A team of investment managers invests the funds in a manner similar to the Pension funds. Gains and losses on the investment of funds are allocated to your account. The value of your prefunding account is equal to the amounts you contributed (prefunding contributions) and associated investment experience.

Circumstances That Affect Prefunding

Employees Married to Employees: When you become eligible, you and your spouse **must** each prefund Retiree Medical Benefit coverage as individuals (if applicable). By prefunding separately, the death of your spouse, a divorce or the end of a Company-recognized Domestic Partner relationship would not jeopardize your individual Retiree Medical Benefit coverage.

If an employee is discharged for gross misconduct, he or she cannot be covered as a dependent of the retiree spouse.

Leaves of Absence: During a sick, maternity or injury-on-duty leave, prefunding contributions are waived, except if you are subject to the Age 50 and Over rule; then you must continue prefunding. When you return to work, your prefunding deductions resume at the applicable current rate that applied to you when they stopped, subject to any annual increases that have taken effect during your absence. You are not required to pay a re-enrollment fee.

During any other leave of absence (such as a personal or educational leave) you are responsible for continuing to make prefunding contributions. If you do not make contributions while on leave, prefunding contributions will accumulate and be collected from your paycheck(s) when you return to work. During an overage leave, you are required to continue to pay your prefunding contributions to maintain your eligibility for retiree medical benefits.

Layoff: If you are subject to the Age 50 and Over rule when you are laid off, you must continue to prefund during a layoff to preserve your eligibility for Retiree Medical Benefits. For all other employees who participate in the prefunding program, except those subject to the Age 50 and Over rule (whether or not you have recall rights under collective bargaining agreements or any other agreement) — in the event of your separation resulting from layoff/reduction in force, you will receive a refund of your prefunding contributions (with associated investment experience) without the six-month for non-recall rights employees (or the five- or 10-year for recall rights

employees) waiting period required before receiving the refund. If you are laid off and not subject to the Age 50 and Over rule, and then called back to work for American Airlines, Inc. within six months (for non-recall rights employees) or within the applicable five- or 10-year recall rights period (for recall rights employees) following your layoff date, you can resume participation in prefunding, as follows:

- Retaining credit for the period during which you made prefunding contributions before the layoff (the time period during which you were laid off and not making prefunding contributions will not count toward your 10 consecutive years of prefunding eligibility requirement);
- Resuming prefunding contributions at the same rate you paid before the layoff (subject to any annual increases that have taken effect during the layoff), and
- Not being required to pay the re-enrollment fee for re-entering the program;

HOWEVER….

- You must repay into the program the exact amount of the prefunding refund you received from the program as a result of your layoff, repaid in full, in one lump sum, within 90 days of your return to work.

If you do not repay the prefunding refund in full within 90 days of your return to work, you lose all prior prefunding credit and must again meet the 10 consecutive years of prefunding requirement.

Should you come back to work for American Airlines, Inc. after the end of the six-month period (for non-recall rights employees) or after the end of the applicable five or 10-year period (for recall rights employees), you must begin prefunding as a new employee, at the age-based rates in effect at that time. You will be required to satisfy the one-year waiting period for participant eligibility, and will be required to accumulate a new 10 years of prefunding.

If for any reason you are recalled and do not/cannot repay the full amount of your prefunding refund back into the program within 90 days of your return to work, but want to participate in prefunding, you will be required to satisfy the one-year waiting period for participant eligibility. If you do this, you will be required to accumulate another 10 continuous years of prefunding, as you will not receive credit for satisfaction of any prior prefunding requirement.

Retirement: When you retire and elect Retiree Standard Medical Option coverage, the value of your prefunding account is drawn down in equal monthly installments over the first 10 years of your retirement to help pay for your Retiree Standard Medical Option coverage.

A balance remains in your account until the tenth year, at which time the final installment is drawn down, bringing your account balance to zero. Please note, however, even though your account is completely withdrawn after the tenth year, you continue to receive Retiree Standard Medical Option benefits according to the RSM provisions and up to the limits specified in the RSM Option.

If you die during the first 10 years of your retirement and you have no surviving spouse, the remaining value of your prefunding contributions is distributed to the beneficiary of your Retiree Life Insurance.

When you retire and elect Retiree Value Plus Option coverage, the value of your prefunding contributions will be refunded to you, and you must pay ongoing monthly contributions for the Retiree Value Plus Option. If you later elect Retiree Standard Medical (RSM) Option, you must pay ongoing monthly contributions for RSM. Retiree Value Plus Option coverage terminates upon your reaching age 65. At that time, your coverage changes to RSM Option for age 65 and over participants, and you must pay ongoing monthly contributions for this coverage.

Disability: During the initial part of a disability (while you are receiving accrued sick pay and during the first year (12 months) of an unpaid sick or injury-on-duty leave of absence), the Company continues to pay its part toward the cost of your medical coverage for active employees, and you must pay your part of the cost, as well.

After one year (12 months) of an unpaid sick or injury-on-duty leave of absence, Company-provided health coverage (your selected Medical Benefit Option) ends. You may elect continuation of coverage through COBRA, or you may begin using your Retiree Standard Medical Option coverage if you:

- Have at least 10 years of Company seniority, and
- Are age 55 or over or become eligible for Social Security Disability Benefits before the end of your one-year sick leave, and
- Have continuously prefunded for the 10 consecutive years immediately preceding retirement, or if you retire prior to January 1, 2012, and have prefunded continuously from the date you were first eligible to prefund the Retiree Medical Benefits until retirement. If you transferred from a workgroup that was eligible for the Retiree Medical Benefits but was not required to prefund, you must have prefunded continuously from the date you were first eligible to prefund until retirement.

Termination of Employment: If your employment terminates and you no longer work for any subsidiary of the Company before you become eligible to receive Retiree Medical Benefit coverage, you receive a refund of the value of your prefunding contributions as a severance payment. However, you do not receive the Company's matching contributions. You receive payment approximately 10 – 12 weeks after the end of the calendar month during which your employment ends.

If you are later rehired by the Company, you are treated as a new employee for the purpose of prefunding and cannot revert to the prior prefunding rates, even if your Company seniority date is adjusted.

Age 50 and Over Rule: Employees age 50 and over who have at least 10 years of Company seniority at the time they terminate employment (and who qualify for the Age 50 – 55 Rule, as defined in the Employee Policy Guide) are eligible to continue participation in prefunding, as follows:

- You have 15 or more years of Company seniority, BUT
- You have not yet continuously prefunded for at least 10 years, AND
- You want to remain eligible for Retiree Medical Benefit coverage, you must continue to prefund for the Retiree Medical Benefits until you have prefunded continuously for at least 10 years. You must continue prefunding until you retire even if you are laid off. At that time, you will be eligible to enter the Retiree Medical Benefits. If you stop prefunding before you reach a minimum of 10 years of continuous prefunding, you will receive a refund of the value of your prefunding contributions, and you are no longer eligible for Retiree Medical Benefit coverage.

Employees age 50 and over and less than age 56 must continue to prefund during any lay off, in order to maintain eligibility for retiree medical benefit coverage.

Transfer Rule Between Subsidiaries: If you meet the age and service requirements to be eligible for Retiree Medical Benefit coverage — age 55 or older with 10 years of Company seniority — but you have not prefunded continuously for a full 10 years due to inter-Company transfers, you may resume prefunding (at the rate you paid prior to your transfer) upon your transfer back to a participating subsidiary. (***Example***: If you began prefunding with a

participating subsidiary, then transferred to a subsidiary that does not participate in prefunding, then transferred back to a subsidiary that participates in prefunding, you are eligible to resume prefunding.) While the time you were employed with the non-participating subsidiary (and were not making prefunding contributions) does not count toward your 10-year continuous prefunding eligibility requirement, you do retain credit for the period you prefunded before your transfer to the non-participating subsidiary.

Transfer Rule Between American Airlines Workgroups: Effective May 1, 2003, the Officer, Management/Specialist and Support Staff workgroup no longer prefunded for their retiree medical coverage, and were required to pay ongoing monthly contributions during their retirement for their Retiree Medical Benefit. Effective January 1, 2011, the Agent, Representative and Planner workgroup no longer prefunded for their retiree medical coverage, and were required to pay ongoing monthly contributions during their retirement for their Retiree Medical Benefit. If you were in a workgroup that prefunded and later transferred to an Officer, Management/Specialist and Support Staff or Agent, Representative and Planner workgroup (that no longer prefunded), you received a refund of all your prefunding contributions with associated investment experience. If you transfer back to a prefunding workgroup (TWU-represented or Flight Attendant workgroup), you may repay the entire prefunding refund amount, in one lump sum, within 90 days of your transfer back to a prefunding workgroup (TWU-represented or Flight Attendant workgroup). You may resume prefunding with no $250 re-enrollment fee and at the same table rates as you paid before you left the prefunding workgroup.

Death: If you prefund Retiree Medical Benefit coverage and die before becoming eligible to use the coverage, the value of your contributions is paid, as a death benefit, to the beneficiary you designated for your Employee Term Life Insurance. However, your beneficiary does not receive the Company's matching contributions.

Termination of the Retiree Medical Benefit: If the Retiree Medical Benefit is terminated before you retire, you receive the value of your prefunding contributions.

Eligibility

You must meet the age and Company years of service requirements to be eligible for participation in Retiree Medical Benefits, regardless of whether you select the RSM Option, Retiree Value Plus Option (or the RHMO Option if you are a retiree residing in Puerto Rico). See the Retiree Medical Benefit Guide for eligibility requirements.

Retiree Life Insurance Benefit

Home-Based Reservations, Reduced Workweek Reservations and Premium Service Guest Relations Representatives are not eligible for any retiree benefits.

Your Retiree Life Insurance Benefit provides group term life insurance in an amount based on one or more of these factors:

- Your base monthly salary as an active employee,
- Your date of hire,
- Your age, or
- Your date of retirement.

Refer to the Retiree Medical Benefit Guide for details on the Retiree Life Insurance Benefit.

Right to Amend

The Company reserves the right to alter, amend, modify or terminate all or any part of the Retiree Benefits at its discretion. Changes will not affect valid claims incurred before the change(s) allowed under the appropriate plan or program terms. For more information, contact HR Services (see "Contact Information" in the *Reference Information* section).

Additional Health Benefit Rules

This section applies to the following benefits (except as noted in the text):

- Value Plus Option
- Standard Medical Options
- Value Option
- HMOs
- Dental Benefits
- Vision Insurance Benefits
- Health Care Flexible Spending Account

In This Section **See Page**

Qualified Medical Child Support Orders (QMCSO) Procedures

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

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

- Value Plus Option
- Standard Medical Options
- Value Option
- HMOs
- Dental Benefits
- Vision Insurance Benefits
- Health Care Flexible Spending Account

Use of Terms

- The term "Plan" as used in these procedures refers to the options and benefits described above, except to the extent that a plan is separately identified.
- The term "Participant," as used in these procedures, refers to a Participant who is covered under the Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.
- The term "Alternate Recipient," as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.
- The term "Order," as used in these procedures, refers to a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.
- The term "QMCSO" or "NMSN," as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these Procedures, or a notice from a state agency ordering the coverage of an Alternate Recipient under health benefits with respect to a Participant under a plan and that meets the requirements to be an NMSM decreed to be a QMCSO.
- The term "Plan Administrator," as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at P.O. Box 619616, MD 5146-HDQ, DFW Airport, TX 75261-9616. In addition, QMCSOs or NMSNs should be delivered to the same address.

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

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

- Must be a "medical child support order", which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.
- Must relate to the provision of medical child support and create or recognize the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a Plan and that meets the requirements set out in these procedures.
- Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.
- Does not require the Plan to provide any type or form of benefit or option that is not otherwise available under the Plan.
- Must clearly specify:
    - The name and last known mailing address of the participant and the name and address of each alternate recipient covered by the Order
    - A reasonable description of the coverage that is to be provided by the Plan to each Alternate Recipient or the manner that the coverage shall be determined
    - The period to which the Order applies (if no date of commencement of coverage is provided, or if the date of commencement of coverage has passed when the Order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the Order)
    - The name of each Plan to which the order applies (or a description of the coverage to be provided)

- A statement that the Order does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan (except as a condition of receiving federal assistance for Medicaid)
- The fact that all Plan contributions with regard to the Alternate Recipient shall be deducted from the Participant's pay.

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

Review of a Medical Child Support Order or Notice

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

Procedures upon Final Determination

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

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

Appeal Process

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

Coordination of Benefits

This section explains how to coordinate coverage between the Company-sponsored Medical, Dental and Vision Insurance Benefits and any other benefits/plans that provide coverage for you or your eligible dependents.

If you or any other covered dependents have primary coverage (see "Which Plan Is Primary" in this section) under any other group medical, group dental benefits/plans or vision insurance plans, your Company-sponsored Medical, Dental and Vision Insurance Benefits will coordinate to avoid duplication of payment for the same expenses. The benefit program will take into account all payments you have received under any other benefits/plans, and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical, Dental and Vision Insurance Benefits were your only coverage.

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

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

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

Other Plans

The term "other group medical benefit/plan" or "other group dental benefit/plan" or "other group vision insurance benefit/plan" in this section includes any of the following:

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

Which Plan Is Primary

This section explains how to coordinate coverage between the Company-sponsored Medical, Dental and Vision Insurance Benefits and any other benefits/plans that provide coverage for you or your eligible dependents.

If you or any other covered dependents have primary coverage (see "Which Plan Is Primary" in this section) under any other group medical or group dental benefits/plans, your Company-sponsored Medical, Dental and Vision Insurance Benefits will coordinate to avoid duplication of payment for the same expenses. The benefit program will take into account all payments you have received under any other benefits/plans, and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical, Dental and Vision Insurance Benefits were your only coverage.

For example, if your dependent is covered by another benefit/plan and the Value Plus Option is his or her secondary coverage, the Value Plus Option pays only up to the maximum benefit amount payable under the Value Plus Option, and only after the primary benefit/plan has paid.

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

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

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

The term "other group medical benefit/plan" or "other group dental benefit/plan" or "other group vision benefit/plan" in this section includes any of the following:

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

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

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.

- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.
- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under Medical, Dental and Vision Insurance Benefits and Medicare are paid according to federal regulations. In case of a conflict between Medical, Dental and Vision Insurance Benefits provisions and federal law, federal law prevails.
- If the coordination of benefits is on behalf of a covered child:
  - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise (see "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" on page 185 in the *Qualified Medical Child Support Order* section).
  - For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. A stepchild not living in the employee's home is not an eligible dependent under the benefit program, regardless of any child support order.
- If the other plan has a gender rule, that plan determines which plan is primary.

Coordination with Medicare

Benefits for Individuals Who Are Eligible for Medicare

If you (or one of your dependents) are eligible for Medicare benefits, the following rules apply:

- The AMR Corporation plan is the primary payer – in other words, your claims go to the AMR Corporation plan first – if you are currently working for a participating AMR Corporation subsidiary.
- If you become eligible for Medicare due to you (or your dependent) having end-stage renal disease, then AMR Corporation is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer.
- If you become eligible for Medicare due to becoming eligible for Social Security disability and if your coverage under this plan is due to the current employment status of the employee, then this plan (the AMR Corporation plan) pays primary.
- Effective January 1, 2006, the federal Medicare program activates the Medicare Part D Benefit – Medicare benefits for prescription drug expenses. If you (or your dependent(s)) are eligible for Medicare benefits, including Medicare Part D, the aforementioned rules apply.
- The AMR Corporation plan pays secondary and Medicare is the primary payer if you (or your dependent) are covered by Medicare, do not have end-stage renal disease and you are not currently working for the AMR Corporation.
- If you (or your dependent) are over age 65 and the AMR Corporation plan would otherwise be the primary payer because you are still working, you or your dependent may elect Medicare as the primary payer of benefits. If you do, benefits under the AMR Corporation plan will terminate.

Benefits for Disabled Individuals

If you stop working for a participating AMR Corporation subsidiary because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you must apply for Medicare Parts A, B and D, or Parts C and D, whichever is applicable. Medicare Part A provides inpatient hospitalization benefits, Medicare Part B provides outpatient medical benefits, such as doctor's office visits and Medicare Part D provides prescription drug benefits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the AMR Corporation plan, the AMR Corporation plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the AMR Corporation plan considers eligible, the AMR Corporation plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any.

When Medicare is the primary payer, no benefits will be payable under the AMR Corporation plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

When Coverage Ends

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

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

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

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

Expenses incurred after the date your coverage (or your spouse's coverage) terminates are not eligible for reimbursement under the plan or benefit option.

Continuation of Coverage – COBRA Continuation

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your health benefits are cancelled, along with your other benefits. You may elect to continue your health benefits as part of your continuation of coverage options available through Benefit Concepts, Inc., the COBRA administrator. Benefit Concepts, Inc. will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your medical coverage through COBRA, claims incurred after the date of your termination are not payable.

Several of American Airlines, Inc. benefits or plans (Standard Medical Options, Value Plus Option, Value Option, Dental Benefits, Vision Insurance Benefits, HMOs and the Health Care Flexible Spending Account) provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain Qualifying Events. If you and/or your dependents have coverage at the time of the Qualifying Event, you may be eligible to elect continuation of coverage under the following:

- Medical Benefits
- Dental Benefits
- Vision Insurance Benefits
- Health Care Flexible Spending Account Benefit, for the remainder of the calendar year in which you became eligible for continuation of coverage. (Although you would not be able to make contributions on a pre-tax basis, by electing continuation of coverage for this account, you would still have the opportunity to file claims for reimbursement based on your account balance for the year.)

The coverage under COBRA is identical to coverage provided under the benefits or plans for similarly situated employees or their dependents, including future changes. Although your Company-recognized Domestic Partner and his or her children do not have rights to COBRA coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur. This is subject to change.

Eligibility

Eligibility for continuation of coverage depends on the circumstances that result in the loss of existing coverage for you and your eligible dependents. The sections below explain who is eligible to elect continuation of coverage and the circumstances that result in eligibility for this coverage continuation.

Continuation of Coverage for You and Your Dependents Qualifying Events

- You may elect continuation of coverage for yourself and your eligible dependents, including a Company-recognized Domestic Partner and his or her children, for a maximum period of 18 months if your coverage would otherwise end because of layoff or termination of your employment for any reason (except in the event of termination for gross misconduct).
- If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you (or any eligible dependent) are disabled at any time during the first 60 days of continuation of coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself and your dependents, including a Company-recognized Domestic Partner and his or her children. To qualify for this additional coverage, the Qualified Beneficiary must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (Benefit Concepts, Inc.) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.

Continuation of Coverage for Your Dependents Only (Qualifying Events)

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

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

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

How to Elect Continuation of Coverage

Solicitation of Coverage

Solicitation following layoff or termination: In the event that your employment ends through layoff or termination, you will automatically receive information from Benefit Concepts, Inc., the COBRA administrator, about electing continuation of coverage through COBRA.

Solicitation following a Qualifying Event: In the event of a Qualifying Event (as shown above as for your dependents only), you must notify American Airlines, Inc. by processing a Qualifying Event within 60 days of the event. You can process most Life Events on the Benefits Service Center. For more information, see "Life Events" in the *Life Events* section.

If you want your over-age dependent to be solicited for COBRA continuation of coverage, you must complete the Life Event within 60 days of the date of the event's occurrence, and you must request that your dependent who is losing coverage be solicited for COBRA. If you do not complete the Life Event within this 60-day period and request that your dependent be solicited for COBRA, your dependent will lose his or her opportunity to continue coverage under COBRA.

If you fail to notify the Company of a dependent's loss of eligibility within 60 days after the Qualifying Event, the dependent will not be eligible for continuation of coverage through COBRA, and you will be responsible for reimbursing the Company for any benefits paid for the ineligible person. You are also required to repay the Company for premium amounts that were overpaid for fully insured coverages.

Enrolling for Coverage

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

You (or your dependents) must provide written notification of your desire to elect to purchase continuation of coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage, or else you lose your right to elect to continue coverage. See "Contact Information" in the *Reference Information* section for Benefit Concepts, Inc.'s address.

You and your dependents may each independently elect continuation of coverage. Once you elect continuation of coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election.

If you waive continuation of coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify Benefit Concepts, Inc. before your 60-day election period expires.

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

Processing Life Events After Continuation of Coverage Is in Effect

If you elect continuation of coverage for yourself and later marry or declare a Company-recognized Domestic Partner, give birth, or adopt a child while covered by continuation of coverage, you may elect coverage for your newly acquired dependents after the Life Event. To add your dependents, contact Benefit Concepts, Inc., within 60 days of the marriage, Company-recognized Domestic Partner relationship, birth, or adoption.

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

All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to continuation of coverage.

Paying for or Discontinuing COBRA Coverage

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

Refund of Premium Payments

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

If claims have been paid during this three-month time period, the Plan will request reimbursement from you. If the amount of your premium payments for continuation of coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the Plan receives reimbursement for your claim, the Plan will refund your premiums. Although a Company-recognized Domestic Partner and his or her children do not have rights to COBRA coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur.

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

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

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

- The maximum continuation period (18, 29 or 36 months) expires. (See “Processing Life Events After Continuation of Coverage Is in Effect” in this section.)
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds (“NSF” or “bounced”) are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the participant is eligible for continuation of coverage up to the maximum time period.
- The Plan participant continuing coverage becomes eligible for Medicare
- The Company no longer provides the coverage for any of its employees or their dependents

See “Dependent Eligibility Requirements” in the *General Eligibility* section.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are eligible for the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your medical coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a two percent administrative fee.

The maximum period of continuation of coverage available to you and your eligible dependents is the lesser of 24 months (for elections of coverage on or after December 10, 2004) or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, you are eligible for reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days

The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Employee Policy Guide.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition

Depending on your state of residence, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Other Employee Obligations

In order to protect you and your family’s rights, you should keep both Benefit Concepts, Inc. and the Company informed of any changes in the addresses of your family members.

Other Special Rules

If your event that qualified you for COBRA coverage was either a Company-mandated reduction in hours or termination of employment and your employment termination or reduction was due to reduced sales due to increased imports and it was certified by the U.S. Department of Labor so that you are a Trade Adjustment Act (TAA)-eligible individual, then you may be eligible for a second chance to elect COBRA continuation of coverage. You are only eligible for the second chance to elect COBRA coverage if all of the events described in this paragraph occurred within six months of your loss of coverage. If you are a TAA-eligible individual, you must elect coverage within six months of the date you lost coverage, or you lose the right to elect COBRA coverage as a TAA-eligible individual.

Trade Adjustment Act

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation of coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

Impact of Failing to Elect Continuation of Coverage on Future Coverage

In considering whether to elect continuation of coverage, you should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation of coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation of coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Plan coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment rights at the end of continuation of coverage if you get continuation of coverage for the maximum time available to you.

Additional Questions

If you have any additional questions on continuation of coverage under COBRA, you should contact Benefit Concepts, Inc. (see "Contact Information" in the *Reference Information* section).

American Recovery and Reinvestment Act of 2009 (ARRA)

If you (the retiree) were recalled back to active employment with American Airlines, Inc. and subsequently experience(d) involuntary termination of your employment during the period beginning September 1, 2008 and ending May 31, 2010, and are eligible for COBRA continuation of coverage, you might be eligible to participate in the COBRA contribution subsidy program provided under ARRA. If you are eligible, this program pays 65 percent of the contribution amount you are required to pay for COBRA continuation coverage, and you are required to pay 35 percent. This subsidy will be paid for up to nine (9) months.

Retirees whose employment was terminated between September 1, 2008 and May 31, 2010 will receive information from the COBRA administrator, advising who is eligible to receive this subsidy, how to elect this subsidy, income qualifications and other information. Not all employees whose employment was terminated during this period of time will be eligible for the COBRA subsidy; thus, read your information carefully. If you have questions, contact your COBRA administrator (see "Contact Information" in the *Reference Information* section). You can also find more information about this COBRA subsidy on the U.S. Department of Labor website.

HIPAA Certificate of Creditable Coverage

If you lose your coverage (or when you notify HR 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 of 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 Services (see "Contact Information" in the *Reference Information* section) and ask for a HIPAA certificate of creditable coverage.

Plan Administration

This section includes administrative information about your benefits.

In This Section **See Page**

Plan Information

The Plans listed below are sponsored by American Airlines, Inc. as that term is defined under ERISA Section 3(16)(B), and comprise the plans, benefits and options in the benefit program for TWU-represented employees.

Plan Name	Plan Number
The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries This plan includes: ▪ Medical Benefits ▫ Standard Medical Option (two options) ▫ Value Plus Option ▫ Value Option ▫ Health Maintenance Organizations ▪ Dental Benefits (Active Employees) ▫ Dental Option 1 ▫ Dental Option 2 ▪ Vision Insurance Benefit ▪ Employee Term Life Insurance Benefits ▪ Spouse Term Life Insurance Benefits ▪ Child Term Life Insurance Benefits ▪ Accidental Death & Dismemberment Insurance Benefits (Employee, Spouse, Child) ▪ Special Purpose Accident Insurance Benefit ▪ Special Risk and Accident Insurance ▪ Optional Short Term Disability Insurance ▪ Health Care Flexible Spending Account Benefit ▪ Dependent Day Care Flexible Spending Account Benefit	501
Long-term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries	510
Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries	515

Administrative Information

Plan Sponsor and Administrator

American Airlines, Inc.

Mailing address:

Mail Drop 5141-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Street address (do not mail to this address):

4333 Amon Carter Blvd.
Fort Worth, Texas 76155

The Plan Administrator for Urgent and Second Level Claim Appeals

Pension Benefits Administration Committee (PBAC)

American Airlines
Mail Drop 5134-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Agent for Service of the Legal Process

Managing Director, Benefits and Productivity

American Airlines, Inc.

Mailing address:

Mail Drop 5126-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Express Delivery address:

4333 Amon Carter Blvd.
Fort Worth, TX 76155

Network/Claims Administrator

The network/claims administrator for each benefit or plan vary and are listed in *Contact Information*.

Trustee

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

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Participating Subsidiaries

American Airlines, Inc.

Plan Amendments

The 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), under the authority granted to it by the Benefit Strategy Committee, has the sole authority to interpret, construe, determine claims and adopt and/or amend the Plans, as well as to make recommendations to the Benefit Strategy Committee for material amendments to the Plans. The PBAC, in consultation with actuaries, consultants, Employee Relations, Human Resources and the Legal Department, has the discretion to adopt such rules, forms, procedures and amendments it determines are necessary for the administration of the Plans according to their terms, applicable law, regulation, collective bargaining agreements or to further the objectives of the Plans. The PBAC may take action during a meeting if at least half the members are present or by a unanimous written decision taken without a meeting and filed with the Chairman of the PBAC.

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

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plans, including the establishment of any claims procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information
- To interpret and construe the terms of the Plans, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plans
- To decide all questions concerning the Plans, and to determine the eligibility of any person to participate in or receive benefits under the Plans and to determine if any exceptional circumstances exist to justify any extensions
- To compute the amount of benefits that will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plans and the applicable requirements of law
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plans
- To allocate and delegate its responsibilities under the Plans and to designate other persons to carry out any of its responsibilities under the Plans, any such action to be by written instrument and in accordance with ERISA Section 405
- To delegate its authority to administer Claims for benefits under the Plans by written contract with a licensed third party administrator
- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions and reports that are furnished by accountants, counsel or other experts employed or engaged by the PBAC

Plan Funding

This section describes the funding arrangements for the plans, benefits and options in the Flexible Benefits Program.

The coverage for the following benefits is self-funded through both Company and employee contributions:

- Standard Medical Options
- Value Plus Option
- Value Option
- Dental Benefits
- Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries

The network and/or claims administrators are independent companies that provide claim payment services. They do not insure these benefits.

- Health Maintenance Organizations (HMOs) and Vision Insurance Benefits are fully insured and are funded through both Company and employee contributions.

Coverage for the following benefits is fully insured and premiums are paid by the Company:

- Employee Term Life Insurance Benefit
- Special Purpose Accident Insurance Benefit

The following benefits are fully insured and paid entirely by employee contributions:

- Optional Short Term Disability Insurance
- Accidental Death & Dismemberment Insurance Benefit
- Optional (Additional) Levels of Employee Life Insurance Benefit
- Spouse Term Life Insurance Benefit
- Child Term Life Insurance Benefit
- Long-term Care Insurance Plan

Collective Bargaining Agreement

The types of benefits (medical and dental benefits, life insurance benefits, retiree medical benefits) described in this Guide are maintained subject to a collective bargaining agreement. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator. This agreement is also available for review during normal business hours at the corporate offices of American Airlines, Inc. (see "Contact Information" in the *Reference Information* section).

Assignment of Benefits

You may request that the network and/or claims administrator pay your service provider directly by assigning your benefits.

You may assign medical, dental and vision benefits for eligible expenses incurred for hospital care, surgery, dental care 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.

For information about assigning Life Insurance Benefits, see "Assignment of Benefits" under "Special Provisions" in the *Life Insurance* section.

Claims — for Grandfathered Medical Options (Standard Medical Options) and for Other Health and Welfare Benefits

This information regarding claims is for the above referenced grandfathered plans. This contains appeal information and requirements specific to the Standard Medical Options and other health and welfare benefits listed above.

Confidentiality of Claims

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

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

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see "Notice of Privacy Rights — Health Care Records" on page 227.

Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service provider (see "Assignment of Benefits" on page 204). Benefits are paid after the network and/or claims administrator receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the network and/or claims administrator may pay all or part of the benefit to:

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

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

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

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

Right to Recovery

If claims payments are more than the amount payable under the Plans, the network and/or claims administrator may recover the overpayment. The network and/or claims administrator may seek recovery from one or more of the following:

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

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

Subrogation

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

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

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

- Cooperate with the Plans to protect the Plans’ subrogation rights
- Provide the Plans with any relevant information they request
- Obtain consent of the Plans before releasing any party from liability for payment of medical expenses
- Sign and deliver documents regarding the Plans’ subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plans’ subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plans
- The Plans’ claims and lien shall not be reduced by any “make whole” or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plans.

The Plans will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plans will not pay your or others’ legal costs associated with subrogation.

Claim Processing Requirements

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), that became effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Airlines, Inc.-sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Time Frame for Initial Claim Determination

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

- As soon as possible after receipt of a claim initiated for urgent care, but no later than 72 hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification)
- Fifteen days after receipt of a pre-service claim

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

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

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

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the network and/or claims administrator or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the network and/or claims administrator or benefit administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to

provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

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

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

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

Urgent Care Claims

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

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

Concurrent Care Claims

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

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

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination

If You Receive an Adverse Benefit Determination on a Health/Welfare Benefit Plan Claim

The network and/or claims administrator or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- Date of service, the health care provider, the claim amount (if applicable)
- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for internal appeal or external review, and will not trigger the start of an internal appeal or external review
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim

When You are Deemed to Have Exhausted the Internal Claim and Appeal Process

If the network/claims administrator or benefit administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review, you may pursue a civil action under ERISA §502(a), or you may pursue civil action under state law if the adverse benefit determination involved a fully-insured benefit. However, keep in mind that the claim and appeal process won't be deemed exhausted based on *de minimis* violations of law (as long as the Plan Administrator or network/claims administrator that the violation was for good cause, was committed in a good faith exchange of information between you, or was due ot matters beyond the Plan Administrator's or network/claims administrator's control.

You may request from the Plan Administrator or network/claim administrator a written explanation of the violation, and such explanation must be provided to you within 10 days. This explanation should include a specific description of the bases, if any, for its assertion that the violation should not cause the internal claim and appeal process to be deemed exhausted.

If an external reviewer or court rejects your request for immediate review because it finds that the Plan Administrator or network/claim administrator met the standards for exception (*de minimis* violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or network/claims administrator will notify you of your opportunity to file the internal appeal of your claim. The 12-month claim filing limit will begin to run upon your receipt of the Plan Administrator's or network/claims administrator's notice.

If your claim is filed under one of the Plan's fully-insured benefits (an HMO, for example), contact the insurer for information on the State process for immediate review.

Disability Claims (Applies to Short-Term Disability Pay)

All Disability Benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the network and/or claims administrator. After the network and/or claims administrator has reviewed the claim for Disability Benefits and obtained any other information that it deems necessary or relevant, the network and/or claims administrator shall notify you within a reasonable period of time not to exceed 45 days after receipt of the acceptance or denial of the claim. The 45-day period during which a claim for Disability Benefits is reviewed may be extended by the network and/or claims administrator for up to 30 days, provided the network and/or claims administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 45-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 30-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 30-day period provided the network and/or claims administrator notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for Disability Benefits is denied, in whole or in part, the network and/or claims administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

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

Effect of Failure to Submit Required Claim Information

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

All Other Claims

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

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

Effect of Failure to Submit Required Claim Information

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

Claims —For Non-Grandfathered Medical Options (Value Plus, Value and HMO Medical Options)

This information regarding claims is for the above referenced non-grandfathered plans. This contains revised appeal information and requirements.

Confidentiality of Claims

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

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

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see "Notice of Privacy Rights — Health Care Records" on page 227.

Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service provider (see "Assignment of Benefits" on page 204). Benefits are paid after the network and/or claims administrator receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the network and/or claims administrator may pay all or part of the benefit to:

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

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

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

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

Right to Recovery

If claims payments are more than the amount payable under the Plans, the network and/or claims administrator may recover the overpayment. The network and/or claims administrator may seek recovery from one or more of the following:

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

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

Subrogation

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

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

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

- Cooperate with the Plans to protect the Plans’ subrogation rights
- Provide the Plans with any relevant information they request
- Obtain consent of the Plans before releasing any party from liability for payment of medical expenses
- Sign and deliver documents regarding the Plans’ subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plans’ subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plans
- The Plans’ claims and lien shall not be reduced by any “make whole” or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plans.

The Plans will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plans will not pay your or others’ legal costs associated with subrogation.

Claim Processing Requirements

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), became effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Airlines, Inc.-sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Time Frame for Initial Claim Determination

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

- As soon as possible after receipt of a claim initiated for urgent care, but no later than 72 hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification)
- Fifteen days after receipt of a pre-service claim

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

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

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

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the network and/or claims administrator or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the network and/or claims administrator or benefit administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

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

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

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

Urgent Care Claims

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

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

Concurrent Care Claims

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

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

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination

If You Receive an Adverse Benefit Determination on a Health/Welfare Benefit Plan Claim

The network and/or claims administrator or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

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

- If the network/claims administrator or benefit administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review, you may pursue a civil action under ERISA §502(a), or you may pursue civil action under state law if the adverse benefit determination involved a fully-insured benefit. However, keep in mind that the claim and appeal process won't be deemed exhausted based on *de minimis* violations of law (as long as the Plan Administrator or network/claims administrator that the violation was for good cause, was committed in a good faith exchange of information between you, or was due ot matters beyond the Plan Administrator's or network/claims administrator's control.
- You may request from the Plan Administrator or network/claim administrator a written explanation of the violation, and such explanation must be provided to you within 10 days. This explanation should include a specific description of the bases, if any, for its assertion that the violation should not cause the internal claim and appeal process to be deemed exhausted.
- If an external reviewer or court rejects your request for immediate review because it finds that the Plan Administrator or network/claim administrator met the standards for exception (*de minimis* violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or network/claims administrator will notify you of your opportunity to file the internal appeal of your claim. The 12-month claim filing limit will begin to run upon your receipt of the Plan Administrator's or network/claims administrator's notice.
- If your claim is filed under one of the Plan's fully-insured benefits (an HMO, for example), contact the insurer for information on the State process for immediate review.

Disability Claims

All Disability Benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the network and/or claims administrator. After the network and/or claims administrator has reviewed the claim for Disability Benefits and obtained any other information that it deems necessary or relevant, the network and/or claims administrator shall notify you within a reasonable period of time not to exceed 45 days after receipt of the acceptance or denial of the claim. The 45-day period during which a claim for Disability Benefits is reviewed may be extended by the network and/or claims administrator for up to 30 days, provided the network and/or claims administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 45-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 30-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 30-day period provided the network and/or claims administrator notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for Disability Benefits is denied, in whole or in part, the network and/or claims administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial
- Specific references to the Plan provisions on which the denial is based
- A description of any information or material necessary to perfect the claim
- An explanation of why this material is necessary

- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request

Effect of Failure to Submit Required Claim Information

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

All Other Claims

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

- Specific reasons for the denial,
- Specific references to the Plan provisions on which the denial is based,
- A description of any information or material necessary to perfect the claim,
- An explanation of why this material is necessary,

- An explanation of the Plan's appeal and review procedure, including a statement of the Participant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review, and
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request.

Effect of Failure to Submit Required Claim Information

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

Appealing a Denial – Grandfathered Medical Options (Standard Medical Options) and Other Health and Welfare Benefits

This information regarding appeals is for the above referenced grandfathered plans. This contains appeal information and requirements specific to the Standard Medical Options.

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), to be effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Airlines, Inc.-sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Important Information about Health Care Provider's Appeals

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

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

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

Procedures for Appealing an Adverse Benefit Determination

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

This two-tiered appeal process 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.

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

- Employee Term Life Insurance Benefit
- Accidental Death & Dismemberment Insurance Benefits (employee, spouse/Company-recognized Domestic Partner, child and all Company-provided Accident Insurance Benefits)
- Vision Insurance Benefit
- Optional Short-Term Disability Insurance Benefit
- HMOs
- Long-term Care Insurance Plan

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

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the network/claims administrator or benefit administrator. You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the network/claims administrator or benefit administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination. For urgent care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

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

The network/claims administrator or benefit administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For pre-service claims – within 30 days of receipt of your First Level Appeal
- For post-service claims – within 60 days of receipt of your First Level Appeal
- For urgent care claims – within 72 hours of receipt of your First Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If the network/claims administrator or benefit administrator requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (the network/claims administrator or benefit administrator will notify you if this additional time period is needed to complete a full and fair review of your case). For disability claims, this process may also be referred to as a "Second Level Review."
- For all other claims for all benefits other than Medical or Disability, within 60 days of receipt of your First Level Appeal, if the network/claims administrator or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your First Level Appeal (the network/claims administrator or benefits administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal with the PBAC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the PBAC at American Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the PBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the PBAC, please complete an Application for Second Level Appeal, and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal.)

The PBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 30-day time period allotted for completion of both levels of appeal
- For post-service claims, within the 60-day time period allotted for completion of both levels of appeal
- For urgent care claims, within the 72-hour time period allotted for completion of both levels of appeal

Example: A participant appeals an adverse benefit determination (post-service claim). For both levels of appeal – First and Second Levels, the combined time taken by the network/claims administrator or benefit administrator and the PBAC to review and complete the appeals must be no more than 60 days. If the First Level Appeal review is completed by the network/claims administrator or benefit administrator in 15 days, then the PBAC has the remaining 45 days (for a total of 60 days) to complete its review and render its decision.

If the PBAC requires additional time to obtain information to evaluate your Second Level Appeal for Disability, it may have an additional 45 days to complete your Second Level Appeal. The PBAC will notify you if this additional time period is needed to complete a full and fair review of your claim.

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the PBAC. Appointed officers of American Airlines, Inc. are on the PBAC. In some cases, the PBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the network/claims administrator or benefit administrator, if appropriate, will be reviewed by the PBAC or its designee(s).

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person’s subordinate

- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for urgent care, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
  - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

You must use and exhaust Plans' administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plans' prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Appealing a Denial —For Non-Grandfathered Medical Options (Value Plus, Value and HMO Medical Options)

This contains appeal information and requirements specific to the Non-Grandfathered Medical Options.

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), to be effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Airlines, Inc.-sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Important Information about Health Care Provider's Appeals

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

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

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

Procedures for Appealing an Adverse Benefit Determination

American Airlines, Inc., as Sponsor and Administrator for the Company-sponsored Health and Welfare Benefit plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the network and/or claim administrator or benefit administrator that rendered the adverse benefit determination. Second Level Appeals are conducted by the Pension Benefits Administration Committee (PBAC) at American Airlines, Inc. (Appeals may be filed on adverse benefit determinations such as claim denial or reduction in benefits, eligibility/enrollment denial, partial payment or partial denial of benefits, rescission of coverage, application of a benefit penalty, or other such adverse benefit determinations.)

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.

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

- Employee Term Life Insurance Benefit
- Accidental Death & Dismemberment Insurance Benefits (employee, spouse/Domestic Partner, child, VPAI and all Company-provided Accident Insurance Benefits)
- Vision Insurance Benefit
- HMOs
- Long-term Care Insurance Plan

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

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the network and/or claim administrator or benefit administrator. You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the network and/or claim administrator or benefit administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination. For urgent care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

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

The network and/or claim administrator or benefit administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For pre-service claims – within 30 days of receipt of your First Level Appeal
- For post-service claims – within 60 days of receipt of your First Level Appeal
- For urgent care claims – within 72 hours of receipt of your First Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If the network and/or claim administrator or benefit administrator requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (the network and/or claim administrator or benefit administrator will notify you if this additional time period is needed to complete a full and fair review of your case). For disability claims, this process may also be referred to as a "Second Level Review."
- For all other claims for all benefits other than Medical or Disability, within 60 days of receipt of your First Level Appeal, if the network and/or claim administrator or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your First Level Appeal (the network and/or claim administrator or benefits administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal with the PBAC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the PBAC at American Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the PBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the PBAC, please complete an Application for Second Level Appeal, and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal.)

The PBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 30-day time period allotted for completion of both levels of appeal
- For post-service claims, within the 60-day time period allotted for completion of both levels of appeal
- For urgent care claims, within the 72-hour time period allotted for completion of both levels of appeal

Example: A participant appeals an adverse benefit determination (post-service claim). For both levels of appeal – First and Second Levels, the combined time taken by the network and/or claim administrator or benefit administrator and the PBAC to review and complete the appeals must be no more than 60 days. If the First Level Appeal review is completed by the network and/or claim administrator or benefit administrator in 15 days, then the PBAC has the remaining 45 days (for a total of 60 days) to complete its review and render its decision.

If the PBAC requires additional time to obtain information to evaluate your Second Level Appeal for Disability, it may have an additional 45 days to complete your Second Level Appeal. The PBAC will notify you if this additional time period is needed to complete a full and fair review of your claim.

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the PBAC. Appointed officers of American Airlines, Inc. are on the PBAC. In some cases, the PBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the network and/or claim administrator or benefit administrator, if appropriate, will be reviewed by the PBAC or its designee(s).

In the filing of appeals under Company-sponsored health and welfare benefit plans, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony.
- Receive from the Plan Administrator or network/claim administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond t the new rationale

- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the Plan Administrator or network/claim processor has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for urgent care, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
  - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

The External Review Process

After you have exhausted (of have been deemed to have exhausted) your internal appeal rights under the benefit plan(s), you have the right to request an external review of your adverse benefit determination. This external review process is defined by federal law—and American Airlines, Inc.-sponsored, non-grandfathered Medical Benefit Options will comply with the requirements of this external review process.

The external review process is applicable to adverse benefit determinations made under group health plans, in which the adverse benefit determination involved a medical judgement—such as

- adverse determinations based on lack of medical necessity
- adverse determinations based on the assertion that the service or supply at issue was determined to be experimental, investigational, or unproven in nature
- adverse determinations based on the assertion that the service or supply was cosmetic in nature
- adverse determinations based on appropriateness or type of care, appropriateness of place of care, manner of care, level of care, or whether provider network status could have affected availability or efficacy of treatment
- adverse determinations based on the determination of whether care constituted "emergency care", "urgent care"
- adverse determination based on a plan exclusion or limitation of coverage for a particular treatment in the presence of certain medical conditions

- adverse determination based on the determination of whether care was “preventive” in nature and the care was not referenced by the US Preventive Care Task Force, the Advisory Committee on Immunization Practices, or the Centers for Disease Control
- adverse determination that brings into question if the benefit plan is complying with the nonquantitative treatment limitations in the Mental Health Parity and Addiction Equity Act (such as methods and limitations on medical management)

American Airlines, Inc. retains three Independent Review Organizations (IROs), as required by federal law, to conduct external reviews, and these IROs meet federal requirements as to levels of expertise, type and manner of reviews. They will conduct external reviews in compliance with the requirements of federal law.

An external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

You must use and exhaust Plans’ administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plans’ prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Notice of Privacy Rights — Health Care Records

This notice applies to all Plan participants of participating AMR Corporation Subsidiaries. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice is effective as of February 17, 2010, and applies to health information received about you by the health care components of the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (particularly, the Standard Medical Options, the Value Option, the Value Plus Option, the Core Option, the Out-of-Area Option, the HMOs, Dental Benefits, Vision Insurance Benefits, Health Care Flexible Spending Accounts Benefit, Limited Purpose Health Care Flexible Spending Account, Health Savings Account), the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, the Group Life and Health Benefits Plan for Retirees of Participating AMR Corp. Subsidiaries, TransWorld Airlines, Inc. Retiree Health and Life Benefits Plan and any other group health plan for which American Airlines, Inc. (“American”) serves as Plan Administrator (collectively, the “Plan”).

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the “Privacy Regulations”) and as amended by the Genetic Information Nondiscrimination Act (“GINA”) and the American Recovery and Reinvestment Act (“ARRA”). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan’s privacy procedures with respect to your health information that is created or received by the Plan (your “Protected Health Information” or “PHI”). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan’s duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan’s privacy practices.

The following uses and disclosures of your PHI may be made by the Plan:

For Appointment Reminders and Health Plan Operations. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you, such as case management, disease management, wellness programs or employee assistance programs.

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claims for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop-loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by AMR Corporation and its subsidiaries for any of the purposes described above. ARRA requires disclosures for purposes of payment to meet its minimally necessary standard.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances. ARRA requires disclosures for purposes of the Plan's operations to meet its minimally necessary standard. The Plan is prohibited from disclosing any of your PHI that constitutes genetic information (as defined by GINA) for underwriting purposes.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you (for example, if your doctor requests information on what other drugs you are currently receiving).

For Workers' Compensation. The Plan may disclose your PHI as authorized by you or your representative and to the extent necessary to comply with laws relating to Workers' Compensation and similar programs providing benefits for work-related injuries or illnesses if either, (1) the health care provider is a member of the employer's workforce and provides health care to the individual at the request of the employer, the PHI is provided to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace, and the information is required for the employer to comply with OSHA or with laws with similar purposes or (2) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

Pursuant to Your Authorization. Any other use or disclosure of your PHI will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

To the Plan Sponsor. Information may be provided to the Sponsor of the Plan, provided that the Sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to disclose or use your PHI for certain other purposes (for example, if certain types of wounds occur that require reporting or a disclosure to comply with a court order, a warrant, a subpoena, a summons or a grand jury subpoena).

Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your Protected Health Information to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family's or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required

Use and disclosure of your Protected Health Information is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.
- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.

- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. State laws may provide you with additional rights or protections.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. The Plan is required to comply with your request not to disclose to another plan any PHI related to any claim for which you paid in full. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: Managing Director, Human Resources Delivery.

To Access. You have the right to request access to your PHI and to inspect and copy your PHI in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. You may also direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by you.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: Managing Director, Human Resources Delivery at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the following officer: Managing Director, Human Resources Delivery at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. You or your personal representative will be required to complete a written form to request amendment of the PHI in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (such disclosures occurring after January 1, 2014, will be required to be included in the accounting); (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Obtain a Paper Copy of This Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Plan's Privacy Officer by calling the Managing Director, Human Resources Delivery, or by writing to American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

To Request Confidential Communication. You have the right to request confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the following officer: Managing Director, Human Resources Delivery, American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

A Note About Personal Representatives

You may exercise your rights through a personal representative (e.g., having your spouse/Company-recognized Domestic Partner call for you). Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A signed authorization completed by you,
- A court order of appointment of the person as the conservator or guardian of the individual, or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the Secretary of the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

The Plan may use or disclose "summary health information" or a limited data set on and after February 17, 2010 to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a "Limited Data Set" that may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, Mail Drop 5134-HDQ, P.O. Box 619616, DFW Airport, TX 75261-9616, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. You may obtain the address of the appropriate regional office of the Office for Civil Rights from the Privacy Complaint Official. If you would like to receive further information, you should contact the Privacy Official, the Managing Director, Human Resources Delivery at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616, or the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, Mail Drop 5134-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. This notice will first be in effect on February 17, 2010 and shall remain in effect until you are notified of any changes, modifications or amendments.

How AMR Corporation Subsidiaries May Use Your Health Information

American Airlines, Inc. ("American"), administers many aspects of the American Group Health Plans (the "Plans"), which are listed below, on behalf of AMR Corporation and its Subsidiaries, including American Airlines. American, as the plan sponsor and/or plan administrator of the Plans may use and disclose your personal medical information (called "Protected Health Information") created and/or maintained by the Plans that it receives from the Plans as permitted and/or required by, and consistent with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations found at 45 CFR Part 164, Subpart A. This includes, but is not limited to, the right to use and disclose a participant's PHI in connection with payment, treatment and health care operations.

The American Airlines Group Health Plans include the health plan components of:

- The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501)
- The Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries (Plan 515)
- Trans World Airlines, Inc. Retiree Health and Life Benefits Plan (Plan 511)
- Any other Group Health Plan for which American serves as Plan Administrator

This Section 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, 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 that it may be involved in the administration of medical benefits.

This Section Does Not Apply To

By law, the HIPAA Privacy rules, and the information in this section, do not apply to the following benefit plans:

- Disability plans (Short-Term, Optional Short-Term and Long-Term Disability),
- Life Insurance plans, including Accidental Death & Dismemberment (AD&D) Insurance,
- Workers' Compensation plans, which provide benefits for employment-related accidents and injuries, and
- 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 Employee Assistance Program (EAP) in its role in administering employment-related programs, such as drug and alcohol testing, is not subject to the HIPAA Privacy rules.

The Plans will disclose PHI to the employer Plan Sponsor (American Airlines, or other current or former AMR subsidiary) only upon receipt of a certification by the employer that the plan documents have been amended to incorporate all the required provisions as described below. To the extent that PHI is maintained by one of the Plans, American and all other participating current or former subsidiaries of AMR Corporation for which American administers the Plans have agreed to:

- Not use or further disclose the information other than as permitted or required by this Employee 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 employer Plan Sponsor, unless that use or disclosure is permitted or required by law (for example, for Workers Compensation programs) or unless such other benefit is part of an organized health care arrangement with the plan.
- To the extent that the employer Plan Sponsor becomes aware that there is any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures, to report such improper uses or disclosures to the Plan.
- Make available PHI in accordance with individual rights to review their PHI.
- Make available PHI for amendment and consider incorporating any amendments to PHI consistent with the HIPAA rules.
- Upon request and to the extent mandated by applicable law, make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules.
- Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Plan.
- Agree to the same restrictions and conditions that apply to the Plan with respect to such information and enter into Business Associate agreements that comply with the standards for such agreements in the Privacy Regulations.
- Enter into limited data set use agreements when the Plan discloses data de-identified in compliance with the requirements for a limited data set as provided in the Privacy Regulations pursuant to a Limited Data Set use or disclosure agreement that meets the standards of the Privacy Regulations.
- Terminate any Business Associate agreement or Limited Data Set agreement in the event the Plan becomes aware of a pattern of non-compliance with the terms of the agreement.

- Provide the individual who is the subject of the PHI with the opportunity to request restrictions on the PHI's disclosure in accordance with the Plan's policy on requesting restrictions on disclosure of PHI.
- Provide the individual who is the subject of the PHI with the opportunity to request confidential communication of PHI from the Plan to the individual in accordance with the Plan's policies and procedures.
- Incorporate any amendments or corrections to PHI when such amendment is determined to be required by the Plan's policy on amendment of PHI.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plans.
- If feasible, return or destroy all PHI received from the Plans that the employer Plan Sponsor still maintains in any form. The employer Plan Sponsor will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if the return or destruction is not feasible, but the Plans must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- 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 Subsidiaries and the Group Health Plans

The following employees or classes of employees or other persons under the control of American Airlines or another AMR subsidiary shall be given access to PHI for the purposes related to the Plan:

- Health Strategy employees involved in health plan design, vendor selection and administration of the Plans, and including the Plan Managers, and administrative assistants, secretarial and support staff; as well as any Retirement Strategy employees involved in health plan issues.
- PBAC, its delegated authority, and PBAC Advisory Committee members, due to their role in governing health plan matters, including reviewing and approving plan design changes, rendering appeal decisions and other health plan administrative matters.
- Benefits Compliance and the PBAC Appeals group personnel involved in receiving, researching and responding to health plan member appeals filed with the PBAC.
- Employee Services personnel 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 Operation Support personnel, but only those involved in investigating health plan fraud or abuse.
- Executive Compensation employees, including secretarial and support staff, who assist Company executives and certain other employees with health plan enrollment and payment issues on a day-to-day basis.
- Occupational Health Services/Clinical Services employees, including the Corporate Medical Director, EAP Manager, EAP nurses and support staff providing services through the Employee Assistance Program (EAP), including possible involvement in mental health and substance abuse benefits 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, Litigation Attorneys and any other attorneys involved in health plan legal matters, and including paralegals 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.
- Employee Relations personnel, but only those involved in grievance processes or mediation/arbitration processes.
- Internal Audit employees, but only for purposes of auditing administrative processes related to the group health plans, and including the secretarial and support staff for these employees.
- Benefits & Travel Technology personnel who maintain key human resource and benefits systems used to transmit, store or manage PHI, and including the secretarial and support staff for these employees.
- Information Technology Services (ITS) management personnel, including certain team leads and other designated personnel managing IT infrastructure for systems used by HR and Benefits, including administrative staff, key vendor managers and certain management personnel responsible for disaster recovery procedures.
- Privacy Compliance Council and HIPAA Subcommittee members, due to their role in understanding and investigating the flow of PHI for the Group Health Plans, in order to ensure compliance with HIPAA and other privacy rules.
- On a need-to-know basis, appropriate personnel employed by the employer Plan Sponsor as independent contractors who have executed Business Associate agreements with the Plan to provide other necessary administrative services to the Plan that include, but are not limited to:
  - Insurance agents retained to provide consulting services and obtain insurance quotes,
  - Actuaries retained to assess the Plan's ongoing funding obligations,
  - Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities,
  - Consulting firms engaged to design and administer Plan benefits,
  - Financial accounting firms engaged to determine Plan costs, and
  - Claims processing companies engaged to assist the Plan Administrator in the processing of claims made against the Plan.

Access to and use of PHI by such employees and other persons described above is restricted to administration functions for the Plans performed by American or another employer Plan Sponsor, including payment and health care operations.

American and other AMR subsidiaries shall provide an effective mechanism for resolving any issues of non-compliance by such employees or persons. American Airlines' Rules of Conduct as outlined in the Employee Policy Guide, including disciplinary procedures, will apply to such issues of employee non-compliance.

Noncompliance Issues

If the persons described above do not comply with the requirements included in this portion of the Plan, the Plan Sponsor shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions for the individuals involved in the violation, which sanctions are included in the policy on sanctions for violation of the privacy policies and procedures. The Plan's Policy Regarding Sanctions for Violation of the HIPAA Privacy Policies and Procedures shall be followed along with the Group Health Plan's Policy and Procedure on Mitigation of Damages for Violative Disclosure of PHI in the event of any violation of the Plan's HIPAA Privacy Provisions in this Article.

Organized Health Care Arrangement

The Plan is part of an organized health care arrangement with the following other health plans maintained by AMR Corporation and its subsidiaries.

The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries with respect to the benefits and benefit options providing medical benefits, dental benefits, vision benefits, health care flexible spending accounts and the HMOs offered hereunder, the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, the Trans World Airlines, Inc. Retiree Health and Life Benefits Plan, the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries and any other Group Health plan for which American serves as Plan Administrator.

The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement for the purposes described in the regulations and in the section entitled "Notice of Privacy Rights — Health Care Records" on page 227.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of the Plan's benefits that relate to an individual to whom health care is provided. A disclosure for payment will be limited to the minimally necessary information unless the disclosure occurs in the form of the standard for the electronic transactions. An authorization is not required to permit a disclosure or use for payment unless the disclosure involves psychotherapy notes or the use of the information for marketing. Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, co-insurance, deductibles and co-payments as determined for an individual's claim)
- Coordination of benefits
- Adjudication of health benefit claims (including appeals and other payment disputes)
- Subrogation of health benefit claims
- Establishing employee contributions

- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Billing, collection activities and related health care data processing
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance)
- Determining medical necessity, experimental or investigational treatment or other coverage reviews or reviews of appropriateness of care or justification of charges (including hospital bill audits)
- Processing utilization review, including precertification, preauthorization, concurrent review, retrospective review, care coordination or case management
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for such purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan)
- Obtaining reimbursements due to the Plan

Health Care Operations. A disclosure for Health Care Operations will be limited to the amount minimally necessary. Health Care Operations include, but are not limited to, the following activities:

- Quality assessment,
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions,
- Rating providers and plan performance, including accreditation, certification, licensing or credentialing activities,
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance),
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies,
- Business management and general administrative activities of the Plan, including but not limited to:
  - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  - Participant service, including the provision of data analyses for participants or the plan sponsors

- Resolution of internal grievances, and
- The sale, transfer, merger or consolidation of all or part of the Plan with another covered entity, or an entity that following such activity will become a covered entity, and due diligence related to such activity.

Treatment. Disclosures for treatment are not limited by the minimally necessary requirement if the disclosures are made to, or the requests are made by, a health care provider for the treatment of an individual. Treatment means the provision, coordination or management of health care and related services by one or more health care provider(s). Treatment includes:

- The coordination or management of health care by a health care provider and a third party,
- Consultation between health care providers about an individual patient, or
- The referral of a patient from one health care provider to another.

Limited Data Set. The Plan may disclose PHI in the form of a limited data set as provided in 45 CFR §164.514(e) provided that the disclosure is in accordance with such provisions.

Your Rights Under ERISA

Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 pension benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We believe that the Plan that has been developed is only good if you receive the benefits to which you are entitled. We encourage you to come to us if you have any questions or problems. In addition, as already

noted, the Plan documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For general information contact:

HR Services
Mail Drop 5141-HDQ-1
American Airlines, Inc.
P.O. Box 619616
DFW Airport, Texas 75261-9616
1-800-447-2000

Website Address: Jetnet.aa.com. Select the Benefits page. You may chat live with HR Services by clicking on the Chat with HR Services icon on the Benefits page of Jetnet.

For information about your claims, contact the appropriate network/claims administrator or benefits plan administrator at the addresses and phone numbers located in the "Contact Information" in the *Reference Information* section.

Reference Information

This section provides useful reference materials. It includes:

- "Contact Information" on page 241,
- a "Glossary" on page 245, and
- "Archives" on page 257.

Contact Information

The following table lists the names, addresses, phone numbers and Websites (when available) for these important contacts.

For Information About:	Contact:	At:
Health and Welfare Benefits General questions, dependent eligibility, information updates,	HR Services AMR Corporation MD 5141-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	1-800-447-2000 Website**:** http://www.jetnet.aa.com/ Chat live with HR Services: Click on the "Start a Chat" button on the top of this page. Chat hours are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday.
Forms, Guides and Contact Information	Jetnet (Benefits page)	
Medical and Mental Health/Chemical Dependency Coverage		
Standard Medical Option Value Plus Option Value Option Network/claims administrator	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp Provider directory: http://www.myuhc.com/groups/americanairlines
	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908 Website: https://www.jetnet.aa.com/jetnet/go/ssoaetna.asp Provider directory: http://www.aetna.com/docfind/custom/americanairlines
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp Provider directory: http://www.bcbstx.com/americanairlines
Health Maintenance Organizations (HMOs)	See the Health Maintenance Organizations (HMOs) section	Call the number on your HMO ID card

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

For Information About:	Contact:	At:
Coverage for Incapacitated Child (HMOs – contact your elected HMO)	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095
	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908
	Blue Cross and Blue Shield of Texas P.O. Box 833940 Richardson, TX 75083	1-877-235-9258
Retiree Medical Benefits Retiree HMO Option (for Retirees Under Age 65 residing in Puerto Rico only)	TRIPLE S, Inc.	1-787-774-6060 Website: http://www.ssspr.com/
CheckFirst (Predetermination of Benefits) (Except HMOs)		
▪ Standard Medical Option ▪ Value Plus Option ▪ Value Option	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095
	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258
QuickReview (Pre-authorization for Hospitalization)		
▪ Value Plus Option ▪ Value Option	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095
	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258

Forms & guides can be located in the eHR Center of Jetnet at https://www.jetnet.aa.com/jetnet/go/ssoehr.asp?TargetDoc=XML=20

The Benefits Service Center is available at https://www.jetnet.aa.com/jetnet/go/ssomercer.asp

For Information About:	Contact:	At:
Medical Case Management and Wellness		
▪ Nurseline ▪ Informed Care Management ▪ Health Advocate ▪ Lifestyle Coaching ▪ Health Assessment	ActiveHealth Management	1-888-227-6558 Website: https://www.jetnet.aa.com/jetnet/go/ssoactivehealth.asp
Short-Term Case Management	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095
	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258
Prescription Drugs (Except HMOs)		
Mail Service Drug Option (Mail Order Pharmacy Service)	Medco P.O. Box 3938 Spokane, WA 99220-3938	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions-Prior Authorization	Medco 8111 Royal Ridge Parkway, Suite 101 Irving, TX 75063	1-800-988-4125
Prescriptions-Retail	Medco Member Services - Phone Inquiries	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Filing Retail Prescription Claims	Medco P.O. Box 2160 Lee's Summit, MO 64063-2160	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Employee Assistance Program		
Employee Assistance Program	EAP at American Airlines	1-800-555-8810

https://www.jetnet.aa.com/jetnet/go/ssomercer.asp?AppID=CHAT

For Information About:	Contact:	At:
Dental Coverage		
Dental Benefits Network/claims administrator	MetLife AMR Dental Claim Unit P.O. Box 981282 El Paso, TX 79998-1282	1-866-838-1072 Website: https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Provider Listing Participating Dentists	Preferred Dentist Program	1-800-474-7371 Website: https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Vision Insurance		
Vision Insurance Benefit	OptumHealth Vision 2811 Lord Baltimore Drive Baltimore, MD 21244	1-800-217-0094 Website: http://www.myoptumhealthvision.com
Life Insurance		
Life Insurance Benefits	MetLife American Airlines Customer Unit P.O. Box 3016 Utica, NY 13504-3016	1-800-638-6420
Accident Insurance		
▪ Accidental Death & Dismemberment (AD&D) Insurance Benefit ▪ Other Accident Insurance Benefits	Contact HR Services	1-800-447-2000 Chat live with HR Services: Click on the "Start a Chat" button on the top of this page. Chat hours are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday.
Disability Coverage		
Optional Short Term Disability (OSTD) Insurance	MetLife Disability American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590	1-888-533-6287 FAX: 1-800-230-9531 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Flexible Spending Accounts (FSAs)		
▪ Health Care FSA ▪ Dependent Day Care FSA	PayFlex Systems USA, Inc. PO BOX 3039 Omaha, NE 68103-3039	1-800-284-4885 FAX: 1-402-231-4310 Website: https://www.jetnet.aa.com/jetnet/go/SSOHealthHub.asp
Long-Term Care		
Long-Term Care Insurance Benefit	MetLife Long-Term Care 57 Greens Farms Road Westport, CT 06880	1-888-526-8495

For Information About:	Contact:	At:
Continuation of Coverage (COBRA)		
Continuation of Coverage (COBRA Administrator)	Benefit Concepts Inc. P.O. Box 246 Barrington, RI 02806-0246	1-866-629-0274 Website: http://www.benefitconcepts.com/
Other Information		
Pension Benefits Administration Committee (Information about appeals)	PBAC American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	ICS or 1-817-967-1412
Other Options (Not Company-Sponsored) The following program options are offered to eligible employees (and eligible dependents). American Airlines, Inc. does not sponsor these programs. For information about these options, contact the sponsor(s) directly:		
Group Prepaid Legal Services	Hyatt Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2507	1-800-821-6400
Group Homeowners' and/or Automobile Insurance	Metropolitan Property & Casualty Insurance Company 477 Martinsville Road, 4th Floor Liberty Corner, NJ 07938	1-800-438-6388

Glossary

Accidental injury

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

Alternative and/or Complementary medicine

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

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

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

Alternative mental health care centers

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

Ancillary charges

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

Assignment of benefits (medical, dental, vision coverages and other health benefits)

You may authorize the Network/claims administrator to directly reimburse your medical service provider for your eligible expenses by requesting that the provider accepts assignment of benefits. When you request assignment of benefits, you avoid paying the full cost of the medical service up front, filing a claim and waiting for reimbursement. Your medical service provider generally files your medical claim for you if he or she accepts assignment.

However, not all Network/claims administrators will accept assignments for out-of-network providers.

Assignment of benefits (life insurance)

You may make an irrevocable assignment (a permanent, unchangeable transfer) of the value of your life insurance benefit. This action permanently transfers all rights and interest, both present and future, in the benefits under this life insurance. Anyone considering assignment of life insurance should consult a legal or tax advisor before taking such action.

Bereavement counseling

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

Chemical dependency treatment center

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

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

Chiropractic care

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

Co-insurance

A percentage of eligible expenses. You pay a percentage of the cost of eligible expenses and the Medical Benefit Option pays the remaining percentage.

Common accident (for AD&D Insurance)

With respect to Accidental Death and Dismemberment (AD&D) Insurance, this refers to the same accident or separate accidents that occur within one 24-hour period.

Company

Participating AMR Corporation subsidiaries.

Convalescent or skilled nursing facility

A licensed institution that:

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

Conventional Medicine

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

Co-pays

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

Custodial care

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

Deductible

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

Dental

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

Detoxification

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

Developmental therapy

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

Durable medical equipment (DME)

Medical equipment intended for use solely by the participant for the treatment of his or her illness or injury. DME is considered to be lasting and would have a resale value. DME must be usable only by the participant and not the family in general.

The equipment must be medically necessary and cannot be primarily for the comfort and convenience of the patient or family. A statement of medical necessity from the attending physician and a written prescription must accompany the claim. DME includes (but is not limited to): prosthetics, casts, splints, braces, crutches, oxygen administration equipment, wheelchairs, hospital beds and respirators.

Eligible medical expenses or eligible expenses

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

Emergency

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

Enter-on-duty date

The first date that you were on the U.S. payroll of American Airlines, Inc. as a regular employee.

Experimental or investigational service or supply

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

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

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

Explanation of benefits (EOB)

A statement provided by the Network/claims administrator that shows how a service was covered by the Plan, how much is being reimbursed and what portion, if any, is not covered.

Flexible Benefits

The Company-sponsored benefits program for American Airlines, Inc. regular employees in the following workgroups:

- Officer
- Management/Specialist
- Support Staff
- Agent/Representative/Planner
- TWU (retirees represented by the Transport Workers Union, AFL-CIO)

Freestanding surgical facility

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

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

Home health care agency

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

Home health care

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

Hospice care

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

Incapacitated child

A child who is incapable of self-support because of a physical or mental condition and who legally lives with you and wholly depends on you for support.

Individual annual deductible

An annual deductible is the amount of eligible expenses you must pay each year before your medical option coverage will start reimbursing you. After you satisfy the deductible, your selected medical option pays the appropriate percentage of eligible covered medical services.

Infertility treatment or testing

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

Inpatient or hospitalization

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

Life event

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

Loss or impairment of speech or hearing

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

Mammogram or mammography

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

Maximum Out-of-Network Reimbursement Program (MNRP)

(Applies only to out-of-network eligible expenses under the Value Option, Value Plus Option and Retiree Value Plus Option)

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

Medical benefit

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

Medical necessity or medically necessary

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

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

Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National 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, experimental or unproven in nature.

In the case of hospital confinement, the length of confinement and hospital services and supplies are considered medically necessary to the extent the Network/claims administrator determines them to be:

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

Mental health disorder

A mental or emotional disease or disorder.

Multiple surgical procedures

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

Network

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

Nurse

This term includes all of the following professional designations:

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

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

Original Medicare

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

Outpatient

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

Over-the-counter (OTC)

Drugs, products and supplies that do not require a prescription by federal law.

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

- You
- Your spouse
- A parent, child, sister or brother of you or your spouse
- The term physician includes the following licensed individuals:
- Audiologist
- Certified social worker or advanced clinical practitioner
- Chiropractor
- Clinical psychologist
- Doctor of Osteopathy (DO)
- Doctor of Medicine (MD)
- Nurse anesthetist

- Nurse practitioner
- Physical or occupational therapist
- Physician Assistant (PA)
- Speech pathologist or speech language pathologist or therapist

Post-fund, postfunding, postfunded

A mechanism by which Agent/Representative/Planner (who retire on or after January 1, 2011) and Officer, Management/Specialist, and Support Staff retirees pay for the cost of their Retiree Medical Benefit. To post-fund their Retiree Medical Benefit means that these retirees are required to pay ongoing monthly contributions during their retirement in order to obtain and maintain Retiree Medical Benefit coverage.

Prefund, prefunding, prefunded

A mechanism by which Agent/Representative/Planner (who retired on or before December 31, 2010), TWU-represented, and APFA-represented employees gain eligibility for and pay for their Retiree Medical Benefit. To prefund your Retiree Medical Benefit means that you elect to pre-pay contributions during your active working years. When you retire, if you have met the prefunding requirements (and the other requirements for eligibility in the Retiree Medical Benefit), you may enter the Retiree Standard Medical Option at no further contribution cost to you.

Pre-existing condition (or pre-existing condition limitation) (applies to disability coverages)

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 a plan and that will not be covered under that plan for a specified period after enrollment.

Preferred Provider Organization (PPO)

A group of physicians, hospitals and other health care providers who have agreed to provide medical services at negotiated rates. For the Standard Medical Option, the Network/claims administrator's preferred provider organization is a PPO. For the Dental Benefit, the claim processor's Preferred Dentist Program is a PPO.

Prescriptions

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

Primary care physician

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

Primary surgical procedure

The principal surgery prescribed based on the primary diagnosis.

Prior authorization for prescriptions

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

Proof of Good Health or Statement of Health (also referred to as Evidence of Insurability or EOI)

Some benefit plans require you to provide proof of good health when you enroll for coverage at a later date (if you do not enroll when you are first eligible), or when you increase levels of coverage. Proof of good health (or a Statement of Health) is a form you must complete and return to the appropriate benefit Plan Administrator when you enroll in the Long Term Care Insurance Planor increase levels of Life Insurance.

Coverage amounts will not increase nor will you be enrolled in these coverages until the Plan Administrator approves your Statement of Health Form and you pay the initial/additional contribution for coverage.

If a death or accident occurs before your enrollment for coverage or increase in coverage is processed, the amount of Life Insurance and Accidental Death & Dismemberment (AD&D) Insurance coverage that will be payable is your current amount of coverage or default coverage (if you have not enrolled following your initial period of eligibility).

You may obtain a Statement of Health Form from the Plan Administrator for each benefit plan.

Provider

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

Psychiatric day treatment facility

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

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

Psychiatric hospital

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

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

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

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

Qualifying event

A change in your status that causes you to lose eligibility for Medical, Dental, Vision and Health Care Flexible Spending Account coverages and would qualify you to be eligible for COBRA Continuation of Coverage. Qualifying events are defined by COBRA. For examples, see "Continuation of Coverage – COBRA Continuation" in the *Additional Health Benefit Rules* section.

Regular employee

An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, or a Flexible Work Arrangement, depending on the business needs of the organization or the terms of the applicable labor agreement. A regular employee is eligible for the benefits and privileges that apply to his or her workgroup or as outlined in his or her applicable labor agreement.

Reliable Evidence

Reliable Evidence includes:

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

Residential treatment center

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

Restoration of medical maximum benefit under the Standard Medical Options

Each January 1, you are eligible to have part of your medical maximum benefit automatically restored. The amount restored will be the lesser of:

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

Restorative and rehabilitative care

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

School/Educational Institution

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

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

Secondary surgical procedure

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

Special dependent

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

Summary Plan Description

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

Timely pay, timely payment

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

Urgent/immediate care

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

Unproven Service, Supply or Treatment

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

Usual and prevailing fee limits

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

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

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

Information from this FairHealth database is utilized by American’s medical administrators in determining the eligible expense for medical or dental services and supplies provided by non-participating and out-of-network providers.

Usual and prevailing fee limits can also be impacted by the number of services or procedures you receive during one medical treatment. Under the Plan, when reviewing a claim for usual and prevailing fee determination, the network/claim administrator looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (often referred to as “coding fragmentation” or “unbundling”) usually results in higher physician’s charges that if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

Archives

This archives section allows you to access prior versions of the Employee Benefits Guide (EBG).

- Archived July 2011 EBG
- Archived January 2011 EBG
- Archived September 2010 EBG