Retiree Benefits Guide
for TransWorld Airlines, Inc. Retirees

About This Guide

In connection with the bankruptcy proceedings of Trans World Airlines, Inc., American Airlines, Inc. and TWA Airlines LLC agreed with the Official Retirees' Committee to provide TWA retiree medical, dental and life benefits. This Health & Life Benefits Guide for Retirees of TWA (Guide) contains the legal plan documents and the summary plan descriptions (SPDs) for the TransWorld Airlines, Inc. Retiree Health and Life Benefits Plan (TWA Retiree Plan) and the American Airlines, Inc. Retiree Dental Insurance Plan (RDIP) as they pertain to TWA retiree coverages. The TWA Retiree Plan includes the TWA Retiree Medical Benefits and the TWA Retiree Life Insurance Benefit.

The provisions of this Guide apply to eligible retirees of TWA (who were on the United States payroll), spouses, dependents and surviving spouses who were covered under the benefit program for TWA Retirees effective January 1, 2002. American Airlines, Inc. reviews all benefit plans annually, and coverage, as well as contribution/premium amounts, may be adjusted periodically.

In our efforts to provide you with full multimedia access to benefits information, American Airlines, Inc. has created online versions of the plans and SPDs. If there is any discrepancy between the online version and this Guide, then the plan documents contained in this Guide, plus the official notices of changes to the plans will govern.

In the event of a conflict between the plan provisions in this Guide and the provisions contained in any insurance policy(ies), the insurance policy (for fully insured programs) shall govern in all cases.

The Company expects to continue these plans and programs, but reserves the right to alter, amend, modify or terminate any of the plans or programs 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, and you will receive updates and notices of changes.

The Benefits Strategy Committee (BSC), under the authority granted by the Chief Executive Officer of American Airlines, Inc., has the sole authority to create, adopt, amend and/or terminate benefit plans. The Pension Benefits Administration Committee (PBAC), under the sole authority granted to it by the BSC, has the sole authority to make certain amendments to benefit plans. The BSC and PBAC, in consultations with actuaries, consultants, Employee Relations, Human Resources and the Legal Department, have the discretion to adopt such rules, forms, procedures and amendments determined necessary for the administration of employee benefit plans according to their terms, applicable law and regulation, or to further the objectives of the employee welfare plans. The BSC and/or PBAC may act by a majority of its members present during a meeting at which at least half the members are present, or by a unanimous written decision taken without a meeting and filed with the Chair of the PBAC.

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

Table of Contents

Benefits-At-a-Glance

Coverage	Eligibility	Option	See Page
Medical	Eligible retirees and/or spouses under age 65 and their eligible dependent children	**Under Age 65 Option —** A PPO-style option where you receive a higher level of benefit if you use a network provider instead of an out-of-network provider. Coverage is provided for most eligible inpatient, outpatient, physician, prescription drug, and other expenses. The PPO is a network of over 400,000 physicians, hospitals and other medical service providers that have agreed to charge discounted fees for medical services.	9
	Military retirees under age 65, retired military reservists under age 65 and their eligible dependents	**TRICARE Supplement Insurance Option** **IMPORTANT—EFFECTIVE JANUARY 1, 2009, TRICARE SUPPLEMENT INSURANCE IS NO LONGER OFFERED AS A MEDICAL OPTION UNDER THE TWA RETIREE PLAN**	N/A
	Eligible retirees and/or spouses age 65 and over	**Age 65 and Over Option —** Coordinates benefits with Medicare to help pay for eligible expenses not paid by Medicare. Coverage is provided for most eligible inpatient, outpatient, physician, prescription drug and other expenses.	13
Dental	Eligible retirees, spouses and their eligible dependent children	**Retiree Dental Insurance Plan** **IMPORTANT—EFFECTIVE JANUARY 1, 2010, AMERICAN AIRLINES, INC. NO LONGER SPONSORS THE RETIREE DENTAL INSURANCE PLAN. However, you may purchase retiree dental insurance directly from MetLife.**	39
Life	Eligible retirees	**Retiree Life Insurance Benefit —** Provides group term life insurance in an amount based on one or more of these factors: • Your work group at the time you retired from TWA • Your age at retirement • The number of years you've been retired	39
Long-Term Care	Eligible retirees, spouses	**Long-Term Care Insurance Plan —** Provides coverage to help pay for nursing home and home care costs for future chronic illness, disability or effects of aging that prevent you or your covered family member from living independently.	43

Eligibility

TWA Retiree Plan Eligibility

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

Coverage	Under Age 65 Option	Age 65 and Over Option
For You	If you are under age 65, you are eligible to participate as long as you: • Retired from Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express, • Were covered by the TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001, and • You timely pay the required ongoing monthly contributions to maintain coverage	If you are age 65 or over, you are eligible to participate as long as you: • Retired from Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express • Were covered by the TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001 • If you reach age 65 on or after January 1, 2002, were covered by the Under Age 65 Option immediately before reaching age 65, and timely elect to participate, and • You timely pay the required ongoing monthly contributions to maintain coverage
For Your Spouse	If your spouse is under age 65 and is otherwise an eligible dependent, your spouse is eligible to participate as long as your spouse was covered by: • A group medical plan sponsored by either Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express on the day before the date of the retiree's retirement, • The TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001, and • You timely pay the required ongoing monthly contributions to maintain coverage	If your spouse is age 65 or over, your spouse is eligible to participate as long as your spouse: • Was covered by a group medical plan sponsored by either Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express on the day before the date you retired, • Was covered by the TWA Airlines LLC Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001, • If your spouse reaches age 65 on or after January 1, 2002, was covered by the Under Age 65 Option immediately before reaching age 65, and timely elects to participate, and • You timely pay the required ongoing monthly contributions to maintain coverage
For Your Eligible Dependents, Other than Your Spouse	Your eligible dependent children may participate as long as either you or your spouse are enrolled and your eligible dependents: • Were covered by a group medical plan sponsored by either Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program), Ozark Air Lines, Inc. or Trans World Express on the day before the date of the retiree's retirement, • Were covered by the TWA Airlines LLC	Not available

Coverage	Under Age 65 Option	Age 65 and Over Option
	Universal Welfare Benefit Plan (including any HMOs) provided by TWA Airlines LLC on December 31, 2001, and • You timely pay the required ongoing monthly contributions to maintain coverage	

Retiree Dental Plan (RDIP) Eligibility

American Airlines, Inc., sponsor and administrator for the TWA Retiree Plan, no longer sponsors or offers retiree dental coverage under the RDIP. However, you may purchase retiree dental insurance directly from MetLife.

Retiree Life Insurance Benefit Eligibility

You are eligible for TWA Retiree Life Insurance Benefit if you retired from Trans World Airlines, Inc., TWA Airlines LLC (provided you did not elect coverage under American Airlines' retiree benefits program) or Ozark Air Lines, Inc. if you were eligible for retiree basic life insurance and were covered under the TWA Airlines LLC Universal Welfare Benefit Plan on December 31, 2001. Your coverage became effective January 1, 2002. However, your eligible dependents are not covered by TWA Retiree Life Insurance Benefit. Only Company-paid life insurance is extended to eligible retirees.

Retiree Long-Term Care Insurance Plan Eligibility

As a TWA retiree, you are eligible for the Long-Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (LTC Plan). If you enrolled in LTC Plan in November, 2001 (for the 2002 plan year), you did not have to provide proof of good health to the insurer, MetLife. If you declined LTC Plan coverage in November, 2001 and subsequently enrolled in the LTC Plan at a later date, you are required to provide proof of good health satisfactory to MetLife for all covered persons in order to obtain coverage.

Dependent Eligibility

An "eligible dependent" is an individual who is related to you, the TWA retiree, in one of the following ways:

- **Spouse,** if he or she is not covered as an employee or retiree under a medical plan sponsored by American Airlines or a participating AMR Corporation subsidiary (see page 5),
- **Unmarried child under age 19**,
- **Unmarried incapacitated child age 19 or over** (see the definition of “incapacitated child” below), or
- **Unmarried child age 19 through 22 if registered as a full-time student** at a school in a program of study leading to a degree or certification (proof of continuing eligibility will be required from time to time) and the child maintains his or her legal residence with you and is wholly dependent on you for maintenance and support.

Also, your dependent must meet the eligibility requirements set forth on page 2.

“Child” includes your:

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

A child may not be an eligible dependent of more than one retiree or employee (see Coordination of Benefits on page 34).

In order to be eligible for coverage, eligible dependents must have been eligible for and enrolled in the TWA Retiree Plan and/or RDIP on January 1, 2002; otherwise, such dependents cannot be added to your coverage on or after January 1, 2002.

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

Incapacitated Child

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

- He or she was covered under the TWA Retiree Plan and/or RDIP as of January 1, 2002,
- He or she is mentally or physically incapable of self-support before reaching age 19 (or age 23 if registered as a full-time student before reaching age 23),
- You file an application with UnitedHealthcare to continue the child's coverage within 31 days after the date coverage would otherwise end; (UnitedHealthcare must approve the application — available from Employee Services at 1-800-447-2000 — in order for coverage to be continued),
- Except for the maximum age limitation, the child continues to meet the criteria for dependent coverage under this plan, and
- You provide additional medical proof of incapacity as may be required by UnitedHealthcare from time to time. Coverage will be terminated and cannot be reinstated if you do not provide proof or if UnitedHealthcare determines your child is no longer incapacitated and the child does not maintain legal residence with you or is not wholly dependent on you for maintenance and support.

Qualified Medical Child Support Order (QMCSO)

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

Parents and Grandchildren

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

When Children's Eligibility Ends

Each eligible dependent, except for your spouse, is eligible for coverage while either you or your spouse are participating in the TWA Retiree Plan Under Age 65 Option. Your enrolled dependent child’s coverage ends on the earliest of the following:

- The date your enrolled dependent child ceases to meet the eligibility requirements for the TWA Retiree Plan;
- The date you (or you and your covered spouse) reach age 65;
- The date you (or you and your covered spouse) die; or
- The date you (or you and your covered spouse) cease to be eligible for these coverages.

When coverage for your child or incapacitated child ends, he or she may be able to elect continuation of coverage as explained on page 36.

Retirees Married To Employees or Retirees

- **Retirees married to active employees:** If you are married to an active employee of American Airlines or a participating subsidiary of AMR Corporation, you may be covered as your spouse's dependent and begin using your retiree coverage at a later time. In order to defer your TWA Retiree Plan coverage, you must complete the Authorization to Defer TWA Retiree Coverage form and send it to HR Services at the address on the form or in the Contact Information section of this Guide. This form is available on the Retiree Web site. To activate this retiree health coverage, you must contact HR Services at 1-800-447-2000 within 60 days of the date your coverage under the active AA benefit ends. You must have been continuously covered under an AMR plan to activate the TWA Retiree Plan. As your spouse's dependent, the amount of medical maximum that you consume will reduce the amount of medical maximum benefit remaining in this plan.

  If you lose your dependent status (because you divorce or the active employee dies), or when the active employee retires or terminates employment, you may begin TWA Retiree Plan coverage described, provided

you are otherwise eligible (you must have been continuously covered under an AMR benefit). You must contact HR Services at 1-800-447-2000 within 60 days of the loss of coverage to activate your TWA Retiree Health Plan. When both you and your spouse are retired, your coverage is maintained on an individual basis – that is, each of you must maintain your own separate coverage under the TWA Retiree Plan.

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

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

Eligibility During Disability

If you become disabled after your retiree coverage begins, your eligibility is not affected by your disability.

Eligibility After Age 65

When you or your covered spouse reaches age 65, Medicare becomes your primary coverage. If otherwise eligible, you and your spouse will each have a one-time opportunity to elect the TWA Retiree Plan Age 65 and Over Option. The Age 65 and Over Option is secondary to Medicare. However, coverage for your other eligible dependents ends when both you and your spouse reach age 65.

Dependents of Deceased Retirees

Coverage for Your Spouse

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

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

When your spouse's coverage ends, he or she may be eligible to elect COBRA Continuation Coverage, as described on page 36.

Coverage for Your Children

After your death, coverage for your eligible dependents, other than your spouse, ends on the earliest of the following:

- The death of your spouse if he or she is participating in the TWA Retiree Plan,
- Your spouse reaches age 65,
- Your spouse remarries,
- Your child becomes eligible for Medicare, or

- Your child ceases to qualify as an eligible dependent or, if applicable, no longer makes the required contribution

Your child may be eligible to elect COBRA Continuation Coverage as described on page 36.

Enrollment and Life Events

Enrollment

Regardless of your age or the age or your eligible dependents, if you waive your coverage under the TWA Retiree Plan, you will not be given another opportunity to enroll. Once retiree coverage is terminated, it cannot be reinstated at a later date.

Effective January 1, 2009, TRICARE Supplement Insurance is no longer a medical coverage option under the TWA Retiree Plan.

Contributions Toward Coverage

You are required to timely pay the required ongoing monthly contributions in order to maintain your coverage. Contributions may be adjusted periodically, as medical and dental costs increase. If you fail to make timely payment of the required contributions, your coverage may end and you cannot join the TWA Retiree Plan again at a later date.

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

Medical — Coverage for the TWA Retiree Plan Under Age 65 Option is self-funded by a combination of Company contributions and retiree contributions. The TWA Retiree Plan Age 65 and Over Option is self-funded exclusively by retiree contributions. The contribution amount is based on a per-person per-month amount for you and your eligible dependents.

Life Insurance — Currently, TWA Retiree Plan life insurance coverage is fully insured and fully paid by the Company.

When Coverage Begins

If you are eligible for coverage, make a timely election, and pay the required contributions, your coverage becomes effective the first of the month after your retirement date.

Coverage under the Age 65 and Over Option becomes effective on the first of the month you attain age 65.

Coverage for your spouse is effective the day your coverage begins and depends on your spouse's age. Coverage for your eligible dependents, other than your spouse, is effective the day your coverage begins, as long as your dependents remain eligible for coverage under the Under Age 65 Option.

Life Events — Under Age 65 Participants

You can make certain changes to your medical and dental coverage only when you experience a qualifying life event that changes your family status. If these events occur, you may drop dependents from your coverage, provided you are covered by the TWA Retiree Plan at the time any of these events occur. To make the change, call HR Services to process a life event change within 60 days of the qualifying event. If you are not enrolled for coverage at the time of the life event, you cannot elect coverage as a result of such life event. Under the TWA Retiree Plan, you may not enroll new dependents in coverage (unless such enrollment is required by a QMCSO or NMSN).

Any change must be consistent with the life event.

Marital Status Changes

Events that change your marital status:

- Death of your spouse,
- Divorce (including the end of a common-law marriage),
- Annulment, and
- Legal separation

Dependent Status Changes

Events that change the number of your eligible dependents:

- Death, or
- Order of Medical Coverage via QMCSO or NMSN

Other Life Event Changes

Other life event changes include:

- A change in your dependent's status that makes him or her no longer eligible for coverage (i.e., your child gets married, drops out of college, becomes employed, or other similar circumstances).
- If your spouse enrolls in coverage during an open enrollment period at his or her place of employment or due to a qualified change in status, you may change your coverage in a manner consistent with your spouse's change in coverage (i.e., you may delete your spouse's coverage under the TWA Retiree Plan).
- You may add medical or dental overage for you and/or your eligible dependents if you originally declined coverage because you and/or your eligible dependents had COBRA coverage and that COBRA coverage has since been exhausted (nonpayment of premiums is not sufficient for this purpose); or you and/or your eligible dependents had non-COBRA medical coverage and the other coverage has terminated due to loss of eligibility for coverage (such as loss of student-only coverage available through a college) or employer contributions towards the other coverage have terminated.
- If benefits are significantly improved, lowered or lessened by the Company under your current medical or dental coverage, you may drop coverage.
- Issuance of 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, you may add medical or dental coverage for the child in order to provide such coverage.
- Issuance of a court order requiring someone else to provide medical or dental coverage for a child that you were required to cover under a QMCSO, if proof is received that the other coverage is provided, then you may drop coverage for the child.
- If you or your eligible dependents become entitled to and enroll in a governmental plan (such as a state's Child Health Plan, Medicare or Medicaid), educational institution's plan or tribal government plan, you can drop medical and dental coverage for yourself and your dependents.

When Coverage Ends

Coverage ends at the earliest of the following:

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

For more information about continuation of coverage under COBRA, turn to page 36.

TWA Retiree Medical Benefits

Overview

The TWA Retiree Plan includes two medical options:

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

Effective January 1, 2009, TRICARE Supplement Insurance is no longer a medical option under the TWA Retiree Plan.

How the Plan Works

Under Age 65 Option

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

In-network benefits for covered expenses will also apply if:

- You receive medical care in a location where your PPO network is not available, or
- Your home address of record is in an area where no PPO network is available. (Your home address of record is your Alternate Address listed in Jetnet or, if you have no Alternate Address listed in Jetnet, your home address of record is your Primary Address as listed in Jetnet.)

NOTE: All services and supplies must be medically necessary.

UNDER AGE 65 OPTION		
FEATURE	**IN-NETWORK BENEFITS**	**OUT-OF-NETWORK BENEFITS[1]**
Co-insurance Rate for Individual/Family	90%/10%, except 100% after $10 co-pay for physician office visit charge	70%/30%
Deductible for Individual/Family[2]	$200/$600 (3 individuals)	$600/$1,800 (3 individuals)
Deductible Carry Over	None	None
Medical Out-of-Pocket Maximum for Individual/Family (separate from mental health & chemical dependency)	$1,000/$3,000 (3 individuals) applies for calendar year in which limit is met	$3,000/$9,000 (3 individuals) applies for calendar year in which limit is met
Durable Medical Equipment	90%	70%
Diagnostic X-ray & Lab	90%	70%
Anesthesia	90%	70%
Ambulance	90%	70%

[1] Out-of-network benefits are subject to usual and prevailing (U&P) fee limits
[2] Individual/family deductible (separate from the medical deductibles)

FEATURE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS[1]
NOTE: Ancillary services, such as radiology, pathology, anesthesia and ambulance, will be considered at the in-network benefit level if you have utilized an in-network physician or hospital.		
Physician Office Visit Charge	100% after $10 co-pay	70%
Chiropractic Care	90%; limited to 20 visits per year	70%; limited to 20 visits per year
Podiatry	90% $10 co-pay on office visit charge	70%
NOTE: If services other than an office visit are rendered, there may be additional charges (i.e., a patient goes to an in-network physician for an office visit and the physician performs blood tests and a chest X-ray). If the in-network deductible is satisfied ($200), the patient would be responsible for the $10 co-pay for the office visit plus the 10% co-insurance since the diagnostic services would now be reimbursed at 90% of the negotiated rate. Example: Office visit - $50 (negotiated rate) Patient owes $10.00 Lab-$20 @ 10% = + 2.00 X-ray-$75 @ 10% = + 7.50 Total Patient Responsibility $19.50		
NOTE: This plan requires hospital pre-certification through QuickReview before any hospital admission. In the case of an emergency admission, please call within 48 hours or the next business day following that admission.		
Pre-admission Testing	100%	70%
Inpatient Hospital Charges	90%*	70%
Physician Inpatient Hospital Visits; Surgery	90%*	70%
Outpatient Surgery or Accidental Injury (Hospital & Surgeon)	90%*	70%*
Emergency Room Physician; Outpatient Hospital	90%*	70% NOTE: If hospital is in-network, then the physician will also be paid as in-network.

*Subject to the deductible

FEATURE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS[1]
Preventive Health Care (includes annual routine exams, immunizations, pap smears, mammograms, PSA tests and proctosigmoidoscopies)	$10 co-pay for office visits; 90% co-insurance for hospital-based services	50%
Free-standing Surgical Facility	90%	70%
Second Surgical Opinion	100% (when authorized by UHC)	70% (when authorized by UHC)
Supplemental Accident (within 90 days of injury)	100% of first $250 in physician and hospital charges per person per calendar year; 90% of excess	100% of first $250 in physician and hospital charges per person per calendar year; 70% of excess
Physical Therapy & Occupational Therapy	90%	70%
Skilled Nursing Facility	90% (based on semi-private room charge); maximum of 60 days per calendar year	70% (based on semi-private room charge); maximum of 60 days per calendar year

[1] Out-of-network benefits are subject to usual and prevailing (U&P) fee limits

FEATURE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS[1]
Home Health Care	90%; 60 visits maximum per person per calendar year	70%; 60 visits maximum per person per calendar year
Hospice Care	90%; lifetime maximum: $10,000 per person	70%; lifetime maximum: $10,000 per person
Medical Maximum Benefit	$1,000,000 lifetime maximum per person	$1,000,000 lifetime maximum per person
Prescriptions – Retail (For acute care prescriptions only)	For up to a 30-day supply: • Generic: $10 co-pay (or actual cost if less than $10) • Brand (generic not available): 30% co-insurance; co-insurance applies to out-of-pocket maximum • Brand (generic available, but brand requested): $10 plus difference in cost between brand and generic when generic is available and brand is requested Psychotherapeutic prescription drugs are covered the same as any other retail prescription drug purchased at a pharmacy	None

FEATURE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS[1]
Prescriptions - Mail Service (For maintenance prescriptions)	For up to a 90-day supply: • Generic: $25 co-pay (or actual cost if less than $25) • Brand (generic not available): 25% co-insurance up to $150 maximum per prescription or refill; co-insurance applies to out-of-pocket maximum • Brand (generic available, but brand requested): $25 plus difference in cost between brand and generic when generic is available and brand is requested Psychotherapeutic prescription drugs are covered the same as any other retail prescription drug purchased at a pharmacy	None

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

[1] Out-of-network benefits are subject to usual and prevailing (U&P) fee limits

Key Plan Provisions - Under Age 65 Option
The following are key features of the Under Age 65 Option. See Covered Medical Expenses beginning on page 15 for specific covered expenses.

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

Annual out-of-pocket maximum: After you satisfy the annual deductible, the TWA Retiree Plan pays its percentage of your eligible expenses, and you pay a percentage. The portion of eligible expenses you pay is known as your “out-of-pocket” amount, and this amount is applied toward your annual out-of-pocket maximum. After you satisfy your out-of-pocket maximum for eligible medical expenses under the TWA Retiree Plan, it pays 100 percent of further eligible medical expenses for the rest of the calendar year.

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

Medically necessary: Medical care is covered by the plan when it is medically necessary. Please note that just because a physician orders a service does not mean it is medically necessary. See Glossary of Terms on page 64 for more information.

Usual and prevailing fee limits: The amount of benefits paid for out-of-network eligible medical expenses is based on the usual and prevailing fee limits for a particular service or supply in that geographic location. See Glossary of Terms on page 64 for more information.

CheckFirst: You should contact UnitedHealthcare (UHC), the network/claim administrator, and use CheckFirst to determine whether a proposed medical service is covered under the plan and if your provider's fee falls within the usual and prevailing fee limits. See the CheckFirst section of this Guide beginning on page 24 for more information.

QuickReview: If you are under age 65, you are required to request pre-authorization before hospitalization. It is also recommended that you pre-authorize outpatient surgery. The QuickReview program authorizes the medical necessity of your surgery and hospitalization, as well as the length of your hospital stay. Contact UnitedHealthcare (UHC), the network/claim administrator, for pre-authorization. See the QuickReview section of this Guide beginning on page 25 for more information.

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

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

Prescription drug benefits: The TWA Retiree Plan covers prescription drugs purchased at any Medco network pharmacy.

A special mail service program is available which allows you to purchase drugs that you take on an ongoing basis (such as medications to treat chronic illnesses) at a discount. For more information, see Prescription Drugs in Covered Expenses on page 18 or Prescription Drug Benefits on page 26.

How the Plan Works

Age 65 and Over Option (formerly known as the TWA Medicare Supplement Plan)

NOTE: All services and supplies must be medically necessary.

AGE 65 AND OVER OPTION	
FEATURE	**BENEFITS**
Annual Deductible	$750 per individual
Annual Out-of-Pocket Maximum	$2,000 per individual (includes deductible)
Lifetime Maximum	$1,000,000 per individual
Office Visit Illness/Injury	 80%[1]
Preventive Health Care Mammograms, Pap smears, PSA tests and Proctosigmoidoscopies	80%[1]
Independent X-ray and Lab	80%[1]
Emergency Physicians Office Emergency Room/Urgent Care Facility Ambulance	 80%[1] 80%[1] 80%[1]
Hospital Inpatient Physicians Visits Pre-admission Testing	 80%[1] 80%[1] 80%[1]
Outpatient Surgical Facility	80%[1]
Surgery Surgeons Fees Second Opinion Consultation	 80%[1] 80%[1]
Outpatient Rehabilitation Includes Physical, Speech, Occupational Therapy and Chiropractic Care	80%[1] (Chiropractic care limited to 20 visits per year)
Special Services Skilled Nursing Facility Home Health Care Hospice Care	 80%[1] up to 60 days per year 80%[1] up to 60 visits per year 80%[1]$10,000 lifetime maximum for hospice care
Durable Medical Equipment	80%[1]
External Prosthetic Appliances	80%[1]
Mental Health and Chemical Dependency Inpatient Outpatient	 80%[1] 80%[1]
Vision Care	Not covered
Prescription Drug Coverage	80%, coordinating with Medicare Part D as the primary coverage and the TransWorld Airlines, Inc. Retiree Health and Life Benefits Plan as the secondary coverage

[1] Subject to the annual deductible

Once the out-of-pocket maximum is reached, the Age 65 and Over Option pays 100 percent of eligible charges for the remainder of the plan year, except for prescriptions drugs, which will continue to be paid at the specified levels.

Key Plan Provisions – Age 65 and Over Option
The following are key features of the Age 65 and Over Option. See Covered Expenses beginning on page 15 for specific covered expenses.

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

Annual out-of-pocket maximum: After you satisfy the annual deductible, the TWA Retiree Plan pays its percentage of your eligible expenses, and you pay a percentage. The portion of eligible expenses you pay is known as your “out-of-pocket” amount, and this amount is applied toward your annual out-of-pocket maximum. After you satisfy your out-of-pocket maximum for eligible medical expenses under the TWA Retiree Plan, it pays 100 percent of further eligible medical expenses for the rest of the calendar year.

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

When you or your covered eligible dependents exhaust the maximum medical benefit, your (or their) medical coverage terminates, and you (or they) are not eligible for any future increases in the maximum medical benefit. However, if you exhaust your maximum medical benefit, your covered eligible dependents may continue their medical coverage under the TWA Retiree Plan up to their maximum medical benefit as long as they continue to meet the eligibility requirements and timely pay the required contributions for coverage.

If you exhaust the maximum medical benefit under the TWA Retiree Plan, you may still continue the retiree life insurance benefit.

Medically necessary: Medical care is covered by the plan when it is medically necessary. Please note that just because a physician orders a service does not mean it is medically necessary. See Glossary of Terms beginning on page 64 for more information.

CheckFirst: You should use CheckFirst to determine whether a proposed medical service is covered under the plan and if your provider's fee falls within the usual and prevailing fee limits. See the CheckFirst section of this guide beginning on page 24 for more information.

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

Prescription drug benefits: Whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the Age 65 and Over Option (or the Under Age 65 Option, for those who are Medicare-eligible) ends, and your primary prescription drug coverage is Medicare Part D. When this occurs, TWA Retiree Plan coverage becomes secondary and members must first fill a prescription using the PDP and then file with AA/UHC for coordination of benefits. As such, it is very important that you enroll in Medicare Part D coverage immediately – as soon as you become eligible.

Since your coverage under the TWA Retiree Plan becomes secondary coverage, Medicare Part D pays first and your TWA Retiree Plan may pay a portion as your secondary coverage. Keep in mind that if you or your dependents are eligible for Medicare, even if you (or they) do not enroll in all or part of the Medicare program, your benefits under the TWA Retiree Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

For more information, see Prescription Drugs in Covered Expenses on page 18, Prescription Drug Benefits on page 26 and Medicare Part D on page 32.

Covered Expenses for the TWA Retiree Plan (both the Under Age 65 and the Age 65 and Over Options)

Listed below in alphabetical order is a description of eligible medical expenses that are covered under the TWA Retiree Plan when medically necessary. For a list of items that are not covered, turn to page 21.

Acupuncture: Medically necessary treatment (performed by a Certified Acupuncturist) for diagnosed illness or injury, only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury. (Coverage does not include acupuncture treatment for conditions in which the treatment has not been proven safe and effective – such as glaucoma, hypertension, acute low back pain, infectious disease, allergies and the like.)

Allergy Care: Charges for medically necessary physician's office visits, allergy testing, shots and serum. See page 21 for excluded allergy care.

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

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

Ambulance services are only covered in an emergency and only when care is required en route to or from the hospital.

Air ambulance services are covered when medically necessary services cannot be safely and adequately performed in a local facility and the patient's medical condition requires immediate medical attention for which ground ambulance services might compromise the patient's life.

Ancillary Charges: Ancillary charges include charges for hospital services, supplies and operating room use.

Anesthesia Expenses: Anesthetics and administration of anesthetics. Expenses are not covered for an anesthesiologist to remain available when not directly attending to the care of a patient.

Assistant Surgeon: Assistant surgeon's fees are covered only when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst pre-determination procedure described on page 24.

Blood: Coverage includes blood, blood plasma and expanders. Benefits are paid only to the extent there is an actual expense to the participant/covered dependent that he/she is required to pay.

Chiropractic Care: Coverage includes services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license.

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

Eligible expenses include room and board, services and supplies (but not personal items) that are incurred while you:

- Are confined to a convalescent or skilled nursing facility,
- Are under the continuous care of a physician, and
- Require 24-hour nursing care.

Your physician must certify that this confinement is an alternative to a hospital confinement and your stay must be approved by UHC through the QuickReview program if you are under age 65. Your stay is not covered for custodial care.

Cosmetic Surgery: Medically necessary expenses for cosmetic surgery are only covered if they are incurred under either of the following conditions:

- As a result of a non-work related injury, or
- For replacement of diseased tissue surgically removed.

Other cosmetic surgery is not covered under the TWA Retiree Plan.

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

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

Detoxification: Detoxification is covered as a medical condition when alcohol and drug addiction problems are sufficiently severe to require immediate inpatient medical and nursing care services. Participants under age 65 are no longer required to contact QuickReview for precertification (effective January 1, 2010).

Durable Medical Equipment (DME): Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The TWA Retiree Plan may, at its option, approve the purchase of such items instead of rental.

Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to natural growth. Replacement of a DME resulting from normal wear and tear is not covered. Coverage includes only the initial purchase of eyeglasses or contact lenses required because of cataract surgery.

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

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

Hearing Care: Covered expenses include medically necessary hearing exams and up to one basic hearing aid for each ear per year. Cochlear implants, osseointegrated hearing systems (such as “bone-anchored hearing aids” or BAHA), or other surgically implanted hearing systems are covered only if medically necessary.

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

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

Hospice Care: Expenses covered in connection with hospice care include both facility and outpatient care.

Benefits are payable for eligible medical expenses necessary for the care and treatment of a terminally ill participant if they are included in an approved written treatment plan and are provided by a hospice agency or hospice center. If you are under age 65, you must contact UHC for your QuickReview authorization.

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

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

Mammograms: Medically necessary diagnostic mammograms are covered regardless of age. Routine mammograms for female retirees and participating eligible dependents are covered, based on the following guidelines:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared,
- Once every one to two years for women ages 40 to 49, as recommended by your physician, and
- Once every year for women age 50 or over.

Mastectomy: Medically necessary mastectomy is covered. Additionally, certain reconstructive and related services are covered following a medically necessary mastectomy, including:

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

This coverage information is provided in compliance with the Women’s Cancer Rights Act.

Medical Supplies: Covered medical supplies include, but are not limited to:

- Oxygen, blood and plasma,
- Sterile items including sterile surgical trays, gloves and dressings,
- Needles and syringes, and
- Colostomy bags.

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

Multiple Surgical Procedures: Reimbursement for multiple procedures performed at the same time is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage and to be sure the charges are within the usual and prevailing fee limits, use the CheckFirst pre-determination program described on page 24.

Nursing Care: Coverage includes medically necessary private duty care by a licensed nurse if it is of a type or nature not normally furnished by hospital floor nurses.

Oral Surgery: Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process are covered only if it is medically necessary to perform oral surgery in a hospital setting rather than a dentist's office. If medically necessary, this medical coverage will pay room and board, anesthesia and miscellaneous hospital charges. However, oral surgeons' and dentists' fees are not covered under the medical plan except as specified under Dental Care on page 21.

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 is covered. If you are under age 65, you should contact UHC for your QuickReview pre-authorization to ensure the procedure is medically necessary.

Physical or Occupational Therapy: Coverage includes medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a Physician.

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

Pregnancy: Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed or certified by the state in which he or she practices.

You should contact UHC for your QuickReview pre-authorization within the first 16 weeks of pregnancy to pre-authorize your hospitalization and to take advantage of the prenatal program. For more information about this program, turn to page 25.

Delivery may be in a hospital or birthing center. Birthing center charges are covered when the state department of health or other state regulatory authority certifies the center. Prescription prenatal vitamin supplements are covered.

Federal law prohibits the plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery, or from requiring your provider to obtain pre-authorization for a maternity hospital stay of 48 hours or less (96 hours or less for a cesarean section). However, federal law does not require a minimum stay of this length, and you, in consultation with your physician, may decide on a shorter hospital stay.

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

Prescription Drugs: Medically necessary prescription drugs that are approved by the United States Food and Drug Administration (FDA) for treatment of your condition are covered. For more information about the prescription drug programs, see page 26. Prescription drugs related to infertility treatment, weight control, and oral contraceptives are not covered. For other exclusions, turn to page 21.

Medications are also covered for the following special situations:

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

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

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

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

Reconstructive Surgery: Surgery following an illness or injury, including contralateral reconstruction of asymmetry of bilateral body parts, such as ears or breasts (also see information regarding Mastectomy on page 18).

Speech Therapy: Restorative and rehabilitative care and treatment for loss or impairment of speech are covered when the treatment is medically necessary because of an illness (other than a mental, psychoneurotic or personality disorder), injury or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must have been performed before the therapy. For other speech therapy exclusions, turn to page 23.

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

Temporomandibular Joint Dysfunction (TMJD): Eligible expenses under the TWA Retiree Plan include the following, if medically necessary:

- Injection of the joints,
- Bone resection,
- Application of splints, arch bars or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion, and
- Manipulation or heat therapy.

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

Transplants: Expenses for transplants or replacement of tissue or organs are covered if they are medically necessary and not experimental services. Benefits are payable for natural or artificial replacement materials or devices. Donor and recipient coverage is as follows:

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

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

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

Transportation Expenses: Regularly scheduled commercial transportation by train or plane is covered when necessary for your emergency travel to and from the nearest Hospital that can provide inpatient treatment not

available locally. Only one round-trip ticket is covered for any illness or injury and will be covered only if medical attention is required en route. For information on ambulance services, see page 15.

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

Urgent/Immediate Treatment: Charges for services and supplies provided at an urgent or immediate care clinic.

Wigs and Hairpieces: Retirees and eligible dependents are covered up to a $350 lifetime maximum for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. A physician must prescribe the wig for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery or severe burns. This benefit is subject to the usual and prevailing fee limits, deductibles, co-insurance and out-of-pocket limits.

Replacement wigs or hairpieces are not covered, regardless of any change in the patient's physical condition. Hair transplants, styling, shampoo and accessories are also excluded.

Covered Mental Health and Chemical Dependency Care

In addition to the covered expenses described above, the plan covers medically necessary mental health and chemical dependency care. Effective January 1, 2010, benefits available under the plan are calculated at the same benefit levels as are calculated for any other injury or illness.

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

- **Inpatient Mental Health Care:** When you are hospitalized in a psychiatric hospital for a mental health disorder, expenses during the period of hospitalization are covered
- **Alternative Mental Health Care Center:** Treatment in an alternative mental health care center is covered. A day of treatment is defined as not more than eight hours in a 24-hour period. This may also be called alternative hospitalization
- **Outpatient Mental Health Care:** Expenses for outpatient mental health care, including prescription drugs, are covered

Chemical Dependency Care: To be eligible for reimbursement under the TWA Retiree Plan, the chemical dependency treatment must be considered medically necessary. While the Employee Assistance Program (EAP) is available to help you obtain appropriate treatment, you are not required to contact EAP in order to receive benefits under the plan—your contacting EAP is totally voluntary on your part. The telephone numbers for the EAP are listed below, if you would like its help in seeking treatment options.

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

Chemical Dependency Rehabilitation: Covered chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient or a combination, provided by a chemical dependency treatment center. The plan does not cover expenses for a family member to accompany the patient being treated, although many treatment centers include family care at no additional cost.

Detoxification and Rehabilitation: Both detoxification and rehabilitation care are considered for benefits and paid at the same benefit levels as claims for any other illness or injury. You are not required to contact QuickReview before any detoxification or chemical dependency rehabilitation.

Excluded Expenses

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

Allergy Testing: Excluded is specific testing (called provocative neutralization testing or therapy) that involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

Alternative and/or Complementary Medicine: Excluded are evaluation, testing, treatment, therapy, care, and medicines that constitute Alternative or Complimentary Medicine, including but not limited to, herbal, holistic, and homeopathic medicine.

Claim Forms: The TWA Retiree Plan will not pay the cost for anyone to complete your claim forms.

Cosmetic Treatment: Excluded are the following:

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

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

Custodial Care and Custodial Care Items: Excluded are custodial care and items such as incontinence briefs, liners, diapers and other items when used for custodial purposes, unless provided during an inpatient confinement in a hospital or convalescent or skilled nursing facility.

Dental Care: No benefits are payable for routine dental care or treatment of dental disease or defect (other than the limited coverage for dental treatment described on page18).

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

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

Drugs: The following are excluded from coverage:

- Drugs, medicines and supplies that do not require a physician's prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem-strips, lancets and test tape.),
- Drugs which are not required to bear the legend "Caution-Federal Law Prohibits Dispensing Without Prescription,"
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order,
- Contraceptive drugs, patches or implants when used for family planning or birth control. (Even though they are not covered, you may order these drugs through the mail service prescription program and receive a discount.),
- Drugs requiring a prescription under state law, but not federal law,
- Medications or products which promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered),
- Drugs prescribed for cosmetic purposes (such as Minoxidil, Botox injections, etc.),

- Medications used primarily for the purpose of weight control,
- Infertility drugs,
- Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs not approved by the FDA or experimental drugs, even though the individual is charged for such drugs, and
- Any and all medications not approved by the FDA as appropriate treatment for the specific diagnosis.

Ecological and Environmental Medicine: See Alternative and/or Complimentary Medicine.

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

Experimental Treatment: Medical treatment, procedures, drugs, devices or supplies that are generally regarded as experimental or investigational services including, but not limited to, treatment for:

- Premenstrual syndrome, chronic fatigue syndrome and Epstein-Barr syndrome
- Hormone pellet insertion, and
- Plasmapheresis.

See the Experimental, Investigational, or Unproven treatment definitions in the Glossary on page 79.

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

Foot Care: Diagnosis and treatment of weak, strained or flat feet including corrective shoes or devices or the cutting or removal of corns, calluses or toenails. (This exclusion does not apply to the removal of nail roots.)

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

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

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

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

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

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

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

Medical error events: Services or supplies charged by the health care provider that are directly associated with , resulting from, or caused by medical mistakes, medical or surgical error, medical negligence or malpractice, preventable illness, preventable injury, or certain preventable complications arising from medical or surgical treatment, as defined by the Center for Medicare and Medicaid Services and identified as “never events”. For

more information on what comprises these events, go to www.cms.gov > site tools & resources > media release database. There you will find fact sheets and news releases about these "never events."

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

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

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

Nursing Care: Excluded are the following:

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

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

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

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

Sex Changes: Sex change, gender reassignment/revision treatments, or transsexual and related services and supplies are not covered.

Sexual Performance Treatment: Prescription medications (including but not limited to, Viagra, Levitra or Cialis), procedures, devices or other treatments prescribed, administered or recommended to treat erectile dysfunction or other sexual dysfunction, or for the purpose of producing, restoring or enhancing sexual performance/experience.

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

Speech Therapy: Expenses are not covered for losses or impairments caused by mental, psychoneurotic or personality disorders, or for conditions such as learning disabilities, developmental disorders or progressive loss due to old age. Speech therapy of an educational nature is not covered.

Temporomandibular Joint Dysfunction (TMJD): Except as described on page 19, diagnosis or treatment for temporomandibular joint (TMJD) disease or syndrome by a similar name, including adult orthodontia to treat TMJD, is not covered.

Transportation: Transportation by regularly scheduled airline, air ambulance or train for more than one round trip per illness or injury.

Usual and Prevailing: the TWA Retiree Plan does not cover any portion of fees for physicians, hospitals and other providers that exceeds the usual and prevailing fee limits.

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

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

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

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

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

CheckFirst for Pre-Determination of Benefits

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

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

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

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

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

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

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

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

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

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

- **Assistant surgeon:** A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if there is a medical necessity, you must use the CheckFirst pre-determination procedure.

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

QuickReview for Hospital Pre-Authorization

QuickReview is the TWA Retiree Plan's hospital pre-authorization program, administered by UnitedHealthcare (UHC) if you are:

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

UHC will tell you:

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

QuickReview does not determine whether you are eligible for benefits under the TWA Retiree Plan or how much you will be reimbursed. For information on eligibility or coverage, contact CheckFirst as explained on page 24.

Any portion of a stay that has not been approved is considered not medically necessary. The plan does not pay charges for any portion of a stay that is not medically necessary. For example, if UHC determines that five hospital days are medically necessary for your condition and you stay in the hospital seven days, charges for the extra two days are not covered.

You are required to contact UHC in the following situations:

- Before you are admitted to the hospital for an illness, injury, surgical procedure or pregnancy,
- Within 48 hours after an emergency hospital admission (or the next business day if you are admitted on a weekend),
- Before outpatient surgery to ensure that the surgery is considered medically necessary, and
- During the first 16 weeks of pregnancy to participate in the prenatal program.

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

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

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

If your illness or injury prevents you from personally contacting UHC, any of the following should contact UHC on your behalf:

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

UHC authorizes the medically necessary length of your hospital stay. In some cases, UHC may refer you for a consultation before surgery or hospitalization is authorized. To avoid any delays in surgery or hospitalization, notify UHC as far in advance as possible.

Be sure to write down the reference number given to you when you call; you will need that number if you call UHC at a later time.

If you receive pre-authorization of a hospital stay over the phone, ask for written confirmation of the pre-authorization.

After you are admitted to the hospital, UHC provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, UHC consults with your physician and hospital to verify the need for any extension of your stay. Contact UHC again if you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness.

If you are scheduled for outpatient surgery, you should also contact UHC. If you do not call, you may be asked to provide medical documentation to support the medical necessity of your surgery before any claim will be paid.

UHC does not guarantee that benefits will be paid. As the network/claim administrator, UHC, reserves the right to make adjustments upon receipt of the final claim papers if the actual service differs from the pre-authorization information you submitted.

Prescription Drug Benefits

If you are enrolled in the TWA Retiree Plan and are not Medicare-eligible, prescription drugs may be purchased either at retail pharmacies or through mail service. For information on which drugs are covered, see Covered Medical Expenses beginning on page 15. For excluded drugs, see Excluded Expenses beginning on page 21.

Retail Prescription Drug Benefit

As a participant in the TWA Retiree Plan, you may have your prescriptions filled at any pharmacy in the Medco network. Be sure to use your Medco ID card when having your prescriptions filled at a retail pharmacy. If you have lost your ID card, contact HR Services for assistance (see Contacts section on page 86).

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

Prescriptions for short term or acute care illnesses, such as colds, flu or allergies, may be filled at network pharmacies. Prescriptions for maintenance medications or for more than a 30-day supply must be filled using Medco mail service. Psychotherapeutic prescription drugs are covered the same as any other retail prescription drugs.

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

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

Only eligible expenses for covered prescription drugs apply to your deductible or out-of-pocket maximum.

Retirees under age 65 (who are not Medicare-eligible) pay the following costs at the network pharmacy:

- $10 co-pay for generic prescription drugs,
- 30 percent of the cost of a brand name prescription drug when no generic is available, and
- $10 plus the difference in cost between brand name and generic, if a brand name is elected when a generic is available.

Retirees age 65 and over (and those who are Medicare-eligible) will pay the amount specific to the Part D plan that he/she has enrolled in. This amount will vary by PDP. You must file with Medicare Part D first and receive a Medicare Part D Explanation of Benefits (EOB) in order to file a prescription drug claim under the TWA Retiree Plan. Send to UnitedHealthcare (UHC):

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

Upon receipt of your complete claim, UHC will process your claim under the TWA Retiree Plan, coordinating benefits with Medicare Part D. For more information on Coordination of Benefits, see page 32.

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

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

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

If Medco does not have a prior authorization on file for you, the pharmacist will then contact your physician to review the request for approval. Both you and your physician will be sent a letter about the authorization review. If

authorization is approved, Medco will automatically allow refills for the original approved time. When your renewal date approaches, you will be sent a letter notifying you of the upcoming expiration with instructions on how to obtain a new authorization.

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

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

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

Mail Service Prescription Drug Benefit

You and your covered eligible dependents are eligible for mail service prescriptions through Medco. You may use Medco's mail service for prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. Injectables drugs that are FDA-approved for self-administration may also be purchased through Medco's mail service.

Under Medco's mail service, 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 (with no annual deductible) for each prescription or refill. Your co-pays are not eligible for reimbursement under the TWA Retiree Plan. Co-pays, which are subject to change, are as follows:

- Generic drugs: $25 co-pay per prescription (or the cost of the drug if the prescription cost is less than $25) for generic drugs
- Brand name drugs if no generic is available: 25 percent of the cost of the drug up to a $150 maximum. (If a generic drug is available and you choose a brand name drug, you pay the generic co-pay plus the cost difference between the brand and generic drug.)
- Brand name drugs if generic is available and not elected: you pay the $25 generic co-pay plus the cost difference between the brand and generic drug

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

You and your covered eligible dependents may purchase oral contraceptives through the mail service program, but since the TWA Retiree Plan does not cover these, you pay the full cost of the prescription drugs. However, the mail service program offers a significant discount compared to retail prices. You will pay a co-insurance amount of 100 percent of the discounted price for oral contraceptives instead of a co-pay.

Generic Drugs

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

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

Ordering Mail Service Prescriptions

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

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

Refills: To order refills, follow these steps:

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

Ordering On the Internet

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

- Go to www.medco.com, then
- Click on Member Services, then
- Select the service you would like to use:
  - Refill your current prescription,
  - Check the status of your recent order, or
  - Request mail service envelopes and claim forms.

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

IMPORTANT NEWS FOR MEDICARE-ELIGIBLE RETIREES/DEPENDENTS: Whether or not you are enrolled in Medicare Part D, your prescription drug coverage under the TWA Retiree Plan (for those who are Medicare-eligible) becomes secondary coverage. You must first fill your prescription using your Medicare Part D Prescription Drug Plan (PDP) and receive the Medicare Part D Explanation of Benefits (EOB); *then* file your claim with UHC for coordination of benefits. If you or your dependents are eligible for Medicare (including Parts A, B, Medicare Advantage and/or Part D), *even if you do not enroll in all or part of the Medicare program,* your benefits under the TWA Retiree Plan will be calculated as though you are enrolled in and receiving Medicare benefits.

- If you reach age 65 or become Medicare-eligible, but your spouse is under age 65 and not Medicare-eligible, your prescription drug coverage under the TWA Retiree Plan ends when you reach age 65 or become Medicare-eligible) and your spouse retains his/her prescription drug coverage with Medco until he/she reaches age 65 or becomes Medicare-eligible.
- If you are under age 65 and not Medicare-eligible, but your spouse is age 65 or over or is Medicare-eligible), you retain your prescription drug coverage under the TWA Retiree Plan with Medco until you reach age 65 or become Medicare-eligible), and your spouse's TWA Retiree Plan prescription drug coverage ends.
- Your or your spouse's prescription drug coverage with Medco ends because you or your spouse is eligible to enroll in Medicare Part D, and the TWA Retiree Plan will coordinate benefits (as the secondary payor) with Medicare Part D as the primary payor.

Prescription Drug Expenses Apply to Your Medical Maximum Benefit
Medco sends you a statement with each prescription they fill. The statement advises you of your co-pay and the amount the Company paid. The amount the Company paid is applied to your medical maximum benefit, as explained in Key Plan Provisions beginning on page 12 for retirees under age 65 and beginning on page 14 for retirees age 65 and over.

Safe and Appropriate Use of Medications
You and your covered eligible dependents benefit from a comprehensive medication safety review. Optimal Health coordinates this program as part of your Medco prescription drug benefits.

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

How the Plan Works with Medicare

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

You may choose to be covered under Original Medicare or under a Medicare Advantage Health Plan. Original Medicare includes Part A (hospital coverage), Part B (medical coverage) and Part D (prescription drug coverage).

This summary provides some general information about Medicare Parts A and B, Medicare Advantage and Medicare Part D, but does not explain all of the Medicare program's benefits and features. If you have specific questions, contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available at www.medicare.gov (see Contact Information beginning on page 74).

Medicare Part A

Medicare Part A helps pay for:

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

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

Medicare Part B

Medicare Part B helps pay for:

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

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

Medicare Advantage Plans (formerly known as Medicare + Choice Plans)

Medicare Advantage Plans are health plan options that are part of the Medicare program. If you join one of these plans, you generally get all your Medicare-covered health care through that plan. This coverage includes Part A and Part B, and can include prescription drug (Part D) coverage. In most of these plans, generally there are extra benefits and lower co-payments than in the Original Medicare program. However, you may have to see doctors that belong to the plan or go to certain hospitals to get services.

When you choose a Medicare Advantage Plan, your health care is coordinated through a Health Maintenance Organization (HMO), an HMO with a Point-of-Service (POS) option, a Preferred Provider Organization (PPO) or a Provider Sponsored Organization (PSO). Medicare Advantage Plans also include private Fee-for-Service plans and Medical Savings Accounts.

Medicare Advantage Plans provide all of the same benefits as Parts A and B. Some plans may also include additional benefits such as coverage for:

- Prescription drugs,
- Routine physical exams,
- Hearing aids and exams,
- Eye exams and glasses,
- Dental services, and
- Health education and wellness programs.

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

Medicare Part D

Medicare Part D helps pay for prescription drugs. The amount types of drugs covered and the amount paid is dependent on your plan. You may pay a monthly premium for this coverage, just as you do for Medicare Part B. Some Medicare Part D plans have a deductible that you will be required to satisfy before Medicare will pay benefits for your prescription expenses. After this deductible is met, you will still pay a portion of your prescription costs, by paying a co-pay or co-insurance. Depending on the Medicare Part D plan you choose, you may a lesser co-pay or co-insurance for generic drugs than for brand name drugs. Some Medicare Part D plans may offer mail-order purchase of your medications.

Your coverage under the TWA Retiree Plan becomes your secondary coverage, and coordinates benefits with Medicare Part D in the same manner that it coordinates with Medicare Parts A and B (or Medicare Advantage). Keep in mind that if you or your dependents are eligible for Medicare, your benefits under the TWA Retiree Plan will be calculated as though you are enrolled in and receiving Medicare benefits *even if you do not enroll in all or part of the Medicare program.*

This summary provides some general information about Medicare Part D, but does not explain all of the program’s benefits and features. If you have specific questions, contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available at www.medicare.gov, and you should carefully review this information, along with the information you receive from Medicare Part D prescription drug providers, to choose the plan that best meets your needs.

Medicare Assignment

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

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

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

If You Have Other Coverage

Coordination of Benefits

If you or any covered eligible dependents are covered under any other group medical plan, the TWA Retiree Plan will coordinate benefits to avoid duplication of payment for the same expenses (this is referred to as coordination of benefits by nonduplication). The TWA Retiree Plan will take into account all payments you receive under any other plan and will only supplement those payments up to the amount you would have received if the TWA Retiree Plan were your only coverage.

The TWA Retiree Plan does not coordinate benefits with any other medical plan sponsored by any participating AMR subsidiary. If you or a covered eligible dependent is covered by a Company-sponsored plan, the TWA Retiree Plan will not pay any benefits — your only benefit would be that paid by any other Company (AMR)-sponsored plan. While you are covered as your spouse's eligible dependent under a Company-sponsored medical plan, you must suspend participation in the TWA Retiree Plan. If you or a covered eligible dependent is hospitalized when coverage begins, your prior coverage is responsible for medical services until you are released.

If you have no prior coverage, this plan will only pay benefits for the portion of your stay occurring after you became eligible under this plan.

Other Plans
"Other group medical plan" includes:

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

Which Plan is Primary
When a person is covered by more than one plan, one plan is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid. If the TWA Retiree Plan is your primary plan, it pays normal benefits without consideration of amounts payable under any other plan.

The following general rules determine which plan is primary:

- If you are covered by Medicare (any and all parts of Medicare, including Parts A and B, Medicare Advantage and Medicare Part D) – or another government-sponsored or tax-supported program, Medicare is your primary plan unless your spouse is still working and you are covered as a dependent under a plan sponsored by your spouse's employer.
- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.
- The TWA Retiree Plan is primary to CHAMPUS.
- If the coordination of benefits is on behalf of a covered child:
  - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is primary and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless the divorce decree specifies otherwise (see QMCSO in the eligible dependents section of this Guide).
  - For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents are divorced, the plan of the parent with custody is primary unless the divorce decree specifies otherwise (see QMCSO in the Eligible Dependents section of this Guide).

If you or your spouse is eligible for Medicare (including Parts A and B, Medicare Advantage and/or Medicare Part D), *even if you do not enroll in all or part of the Medicare program*, your benefits under the TWA Retiree Plan will be calculated as though you are enrolled and receiving Medicare benefits.

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

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

When Medicare is Primary
If you are eligible for Medicare, it is your primary plan unless your spouse is actively working and covers you as a dependent under the plan sponsored by his/her employer. The TWA Retiree Plan coordinates benefits with Original Medicare (Parts A, B and D) if you are eligible for such coverage. Coordination applies regardless of whether you select Original Medicare or Medicare Advantage.

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

Filing Medical Claims

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

Whenever you file a claim, be sure to keep a copy of the claim and any other information (such as itemized bills) that you include with the claim.

UnitedHealthcare (UHC) is the network/claim administrator for the TWA Retiree Plan. They provide claim processing services, but they do not insure these health benefits. Benefits are paid with retiree contributions, contributions from American Airlines, Inc., and general assets of American Airlines, Inc.

To file claims under the TWA Retiree Plan:

- Complete a Medical Claim Form each time you receive medical services and follow the instructions that accompany the form. If you are not eligible for Medicare and received services from a PPO provider, your provider will file the claim for you. For prescriptions, see Retail Prescription Drug Benefit beginning on page 26.
- Submit originals of all itemized receipts from your physician or other health care provider. A cancelled check or non-itemized billing is not acceptable.
- Submit the Explanation of Benefits (EOB) showing any amounts paid by other coverage you have that pays benefits as your primary coverage before the TWA Retiree Plan. It is especially important that you include any Explanations of Medicare Benefits (EOMBs) if you are eligible for Medicare. (However, if Medicare is your primary plan, see Medicare Crossover for more information about how you should file claims.)
- Mail the completed claim form with the original itemized bills, receipts and EOBs to UHC at the address on the claim form.

You must submit the original itemized bill or receipt provided by your physician, hospital or other medical service provider, so you should make copies for your own records. Photocopies are not accepted. In addition, each bill or receipt must include the following:

- Name of patient,
- Date the treatment or service was provided,
- Diagnosis of the injury or illness for which treatment or service was given,
- Itemized charges for the treatment or service, and
- Name of provider, address and tax ID number.

All medical claims payments are sent to you along with Explanation of Benefits Statements (EOB) explaining the amount paid. Payments may, however, be sent directly to your physician, hospital or other medical provider if

your provider accepts assignments of benefits. In this case, the EOB will be mailed to you and the payment mailed to your provider. To request claim forms, call UHC and leave your request on the automated forms voicemail option. Requests are processed daily on weekdays.

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

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

Retail Prescription Drug Benefit

Retirees under age 65: Pay the co-pay amount at the Medco network pharmacies.

Retirees age 65 and over: You must file with your Medicare Part D Prescription Drug Plan (PDP) first and receive a Medicare Part D Explanation of Benefits (EOB) in order to file a prescription drug claim under the TWA Retiree Plan. Send UHC the following items:

- Your prescription receipt from the pharmacy,
- Your Medicare Part D EOB, and
- Your completed Prescription Claim Form for Medicare Part D expenses (available on Jetnet).

Upon receipt of your complete claim, UHC will process your claim under the TWA Retiree Plan, coordinating benefits with Medicare Part D.

Claim Filing Deadline

Prior to January 1, 2010, you must have submitted *all* health claims (including claims prescription drug expenses), within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred were not considered for payment. Effective January 1, 2010, you must submit all health claims within one year (12 months) of the date the expenses were incurred.

For all claims incurred on or after 1/1/2010, you must submit all health claims within one year (12 months) of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

For all claims incurred on or before 12/31/2009, you must submit all health claims within two years (24 months) 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 United States Department of Health and Human Services (HHS) and the Center for Medicare and Medicaid (CMS) or any similar agency under the HHS may file claims under the Medicare Secondary Payer Statue within 36 months of the date on which the expense was incurred.

Medicare Crossover

When you have both Medicare and the TWA Retiree Plan coverage, you can avoid having to file claims twice by using Medicare Crossover. With Medicare Crossover, when you file your Medicare claim, the information is sent electronically to the TWA Retiree Plan for processing — so you don't need to file a separate claim form for each plan.

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

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

To learn more or to take advantage of this Medicare Crossover Process, access e-HR via Jetnet or contact HR Services (see Contact Information on page 74).

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

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

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

Medicare Crossover is available in all 50 states. If you live in a different state for part of the year, the enrollment form provides space for you to indicate the states in which you expect to have medical expenses. Your Medicare Crossover automatic filing will be set up with the Medicare administrator for the residences you indicate on your enrollment form.

Medicare Crossover applies only to Medicare Parts A and B:

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

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

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

Continuation of Coverage

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 HIPAA certificate of creditable coverage showing how long you (or your dependent) had been covered under the TWA Retiree Plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's pre-existing medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will receive another HIPAA certificate of certificate of creditable coverage within the 24 months after your coverage has ended.

You may also request a HIPAA certificate of creditable coverage within the 24 months after your coverage has ended, or at any time. To request a HIPAA certificate of creditable coverage, contact HR Services (see Contact Information on page 74), either by phone, email, or by mail, and ask for a HIPAA certificate of creditable coverage.

COBRA (Consolidated Omnibus Budget Reconciliation Act) Continuation Coverage
You and your covered eligible dependents have the right to elect to continue group health coverage if it terminates for certain specified reasons. This continuation right is in accordance with the requirements of federal

law (PL 99-272), as amended, and is available in the event your or your covered eligible dependents' coverage terminates due to any of the following qualifying events:

1) Your death,

2) Your divorce or legal separation from your lawful spouse,

3) Your entitlement to Medicare benefits under Title XVIII of the Social Security Act,

4) A dependent child ceasing to meet the plan's definition of an eligible dependent, or

5) In certain instances, the bankruptcy of the Company.

If one of your covered eligible dependents loses coverage due to one of the reasons shown in 2 or 4 above, you or your covered eligible dependent must notify HR Services in writing within 60 days of the later of the event or the loss of coverage, so that appropriate notice of continuation rights and the terms which apply to the continuation can be provided. If you fail to provide written notice within this 60-day time limit, your dependent’s rights to COBRA coverage are waived.

Upon its receipt of notice from you or your authorized representative, the Company has the responsibility to notify Benefit Concepts (the COBRA administrator) of your death, termination of employment or reduction in hours, or Medicare eligibility. Notice must be given to Benefit Concepts within 30 days of the event. When Benefit Concepts is notified that one of these events has happened, it will in turn notify you that you have the right to choose continuation coverage. Under the law, you have until the later of 60 days from:

- The date you would lose coverage because of one of the events described above, or
- Your receipt of election notice from Benefit Concepts, to inform Benefit Concepts that you want to elect continuation coverage.

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

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

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

The law permits the Company to charge any person who elects to continue coverage up to 102 percent of the total contributions for the TWA Retiree Plan coverage. If continuation of coverage is elected, you will receive payment coupons from Benefit Concepts indicating the amount of required contributions and when each payment is due.

Coverage cannot be continued beyond the earliest to occur of:

- The last date for which any required premium with respect to the qualified beneficiary was paid,
- Any date following your or your covered eligible dependent's election to continue coverage in which the person whose coverage is being continued becomes covered under another group health plan or entitled to Medicare benefits, unless a pre-existing condition provision excludes coverage,

- The date which the Company ceases to provide any group health plan (including successor plans) to any retirees or employees, or
- A date which is:
  - 36 months from the qualifying event, if coverage is being continued because your covered eligible dependent lost coverage due to your entitlement to Medicare;), or
  - 36 months from the qualifying event, if coverage is being continued for any other reason;

  unless you retired from the Company and experience a qualifying event that is the bankruptcy of the Company, in which case, you and your covered eligible dependents may be entitled to extended coverage.

If you or your qualified beneficiary was disabled at the time of termination or reduction in hours and continue to be disabled at the time of the qualifying event (determined by Social Security) or if you become disabled (as determined by Social Security) within the first 60 days of the qualifying event, you and your covered eligible dependents are entitled to the later of either:

- 29 months of continuation coverage,
- Coverage until the first of the month that is more than 30 days after you or the qualified beneficiary whose disability resulted in the extension from 18 months to 29 months are determined, pursuant to Title II or XVI of the Social Security Act, as no longer being disabled, or
- The coverage period applicable to you or your covered eligible dependents.

In certain cases, the Company is permitted to charge you up to 150 percent of the applicable total contributions for periods beyond which you or your covered eligible dependents receive continuation coverage beyond the applicable maximum period due to a disability. To maintain the coverage, it is necessary to pay the full cost of continuation of coverage on time, including any additional expenses permitted by law. If continuation of coverage is elected, you will receive payment coupons from Benefit Concepts indicating the amount of required contributions and when each payment is due.

Refund of Premium Payments

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

Retiree Dental Benefits

Effective 11:59 p.m. on December 31, 2009, American Airlines, Inc. no longer sponsors the American Airlines, Inc. Retiree Dental Insurance Plan.

Beginning January 1, 2010, participants receive bills directly from MetLife and send their premiums to MetLife. Retirees will be offered two dental plan options from MetLife.

TWA Retiree Life Insurance Benefits

Overview

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

Term life insurance is coverage that pays a death benefit but has no cash value. MetLife insures TWA Retiree Life.

How the Plan Works

For Retired TWA Pilots

If you worked for Trans World Airlines, Inc. and/or TWA Airlines LLC for less than 10 years, all of your Life Insurance will end on your retirement date.

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

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

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

For Retired TWA Mechanics and Related Employees, TWA Passenger Service Employees and TWA Flight Attendants

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

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

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

For Retired TWA Flight Dispatch Officers

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

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

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

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

For Retired TWA Non-Contract, Non-Management Employees

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

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

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

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

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

For Retired TWA Management Employees

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

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

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

The amount of TWA Retiree Life produced by this schedule will be rounded to the nearer $1,000 and will be based on your annual basic earnings immediately before your retirement.

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

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

Beneficiary Designation

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

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

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

Retiree Life benefits will be retained by MetLife and interest compounded daily until the minor child reaches the legal age.

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

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

If your beneficiary is not living at the time of your death, or if you die without having named a beneficiary of your TWA Retiree Life, the benefits under your coverage are paid to the first class of surviving family members in the order outlined below:

1. Your Spouse;
2. Your Children or stepchildren;
3. Your Parents;
4. Your Brothers and sisters;
5. Your Estate.

Conversion Rights

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

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

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

Verbal Representations

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

Claim Payment

In order to process this benefit, the Company must have an *original certified death certificate*. The original death certificate will not be returned because MetLife will need to retain it for their records. Since most life insurance companies, Social Security Administration, etc. require an original death certificate, your survivors may obtain additional original certified death certificates, either from the funeral home or your city/county records agency.

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

Long Term Care Insurance Plan

Overview

Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (LTCIP), fully insured and administered by MetLife, helps pay nursing home and home care costs if future illness, injury, or the effects of aging prevent you or your covered dependents from living independently

How the LTCIP Works

For Eligible TWA Retirees

LTCIP is not only for you; you may also elect it for your spouse, parents, parents-in-law, grandparents, and grandparents-in-law. Children are not eligible for LTCIP.

Proof of Good Health

You may enroll in LTCIP without providing proof of good health if you enrolled when first eligible (November, 2001, for coverage beginning on January 1, 2002). If you did not enroll for coverage when first eligible, you may add coverage at any time, but will be required to provide proof of good health. Spouses, parents, parents-in-law, grandparents, and grandparents-in-law must provide proof of good health in order to be covered under this benefit. All premiums for LTCIP are paid entirely by employee/retiree contributions.

MetLife insures and administers this LTCIP. Contact MetLife for an enrollment form or for more information about LTCIP.

Your LTCIP becomes effective only after MetLife has approved your enrollment/application and you have paid the initial premium. MetLife will then send you a certificate of insurance/coverage document providing you with specific information and coverage provisions of LTCIP.

Plan Information and Administration

PLAN ADMINISTRATOR	**FOR UNITED STATES POSTAL SERVICE MAILING. . .** American Airlines, Inc. P.O. Box 619616, MD 5141-HDQ1 DFW Airport, Texas 75261-9616 **OR FOR EXPRESS DELIVERY SERVICE. . .** American Airlines, Inc. 4333 Amon Carter Blvd., MD5141-HDQ1 Fort Worth, Texas 76155
NETWORK OR CLAIM ADMINISTRATOR	The network or claim administrators for each plan are listed in the Contact Information section of this Guide.
TRUSTEE	State Street Bank & Trust 200 Newport Avenue North Quincy, Massachusetts 02171
EMPLOYER ID NUMBER	13-1502798
AGENT FOR SERVICE OF LEGAL PROCESS (Service of legal process may also be made on the Plan Administrator)	**FOR UNITED STATES POSTAL SERVICE MAILING. . .** Managing Director, Benefits and Productivity American Airlines, Inc. P.O. Box 619616, MD 5126-HDQ1 DFW Airport, Texas 75261-9616 **OR FOR EXPRESS DELIVERY SERVICE. . .** Managing Director, Benefits and Productivity American Airlines, Inc. 4333 Amon Carter Blvd., MD5126-HDQ1 Fort Worth, Texas 76155
PLAN NAME **PLAN NUMBER**	The TWA Retiree Health and Life Benefits Plan This plan includes: • TWA Retiree Medical Option for Under Age 65 Participants • TWA Retiree Medical Option for Age 65 and Over Participants • TWA Retiree Life Insurance Benefit 511
PLAN NAME **PLAN NUMBER**	Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries 510
PLAN YEAR	January 1 through December 31

Plan Administration and Funding

These plans are administered by American Airlines, Inc. The hospitals, physicians and other service providers in the PPO network (for the TWA Retiree Plan) are completely independent of the Company. Neither the Company nor the network/claim administrators are responsible for the medical services provided.

The coverage for the TWA Retiree Medical Benefit-- Under Age 65 Option is self-funded by a combination of Company contributions, retiree contributions, and general assets of the Company. The coverage for the TWA Retiree Medical Benefit – Age 65 and Over Option is self-funded by retiree contributions.

Both Company and retiree contributions as plan assets are held in a Voluntary Employee Benefit Association (VEBA) trust established under Section 501(c)(9) of the Internal Revenue Code. Self-funded benefits are paid from trust assets. The network/claim administrators are independent companies that provide claim payment services. They do not insure these benefits. Claims are processed by UnitedHealthcare (UHC).

TWA Retiree Life Insurance is fully insured by MetLife, and the Company pays the full premiums for this insurance. Claims are paid and reserves held by MetLife.

Plan Amendments

The Benefits Strategy Committee (BSC), as appointed by the Chief Executive Officer, has the sole authority to adopt new employee benefit plans (Plans) and terminate existing Plans. The Pension Benefits Administration Committee (PBAC), as appointed by the Chief Executive Officer, has the sole authority to interpret, construe and determine claims under the Plans. The PBAC also has the authority to amend the Plans or make recommendations to the BSC 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, regulations, collective bargaining agreements, or to further the objectives of the Plans. The PBAC make take action during a meeting if at least half the members are present, or bay unanimous written decision taken without a meeting and filed with the Chair 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 claim procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information;

- To interpret and construe the terms of the Plans, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plans;

- To decide all questions concerning the Plans, and to determine the eligibility of any person to participate in or receive benefits under the Plans and to determine if any exceptional circumstances exist to justify any extensions;

- To compute the amount of benefits that will be payable to any Participant or other person, organization, or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plans and the applicable requirements of law;

- To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plans;

- To allocate and delegate its responsibilities under the Plans and to designate other persons to carry out any of its responsibilities under the Plans, any such action to be by written instrument and in accordance with ERISA Section 405;

- To delegate its authority to administer Claims for benefits under the Plans by written contract with a licensed third party administrator; and

- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions, and reports that are furnished by accountants, counsel, or other experts employed or engaged by the PBAC.

Claims

Confidentiality of Claims

The Company and its agents (including the network/claim 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 properly administer coverage. The Company treats your medical information as confidential and discloses it only as may be required for the administration of the plan (as described in this paragraph) or as may be required by law. For additional information on HIPAA Privacy and Security, see the section beginning on page 63.

Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your provider (as explained on this page). They will be paid as soon as the network/claim 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/claim administrator may pay all or part of the benefit to:

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

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

Assignment of Benefits

You may request that the network/claim administrator pay your service provider directly by assigning your benefits. You may assign benefits for eligible expenses incurred for hospital care, surgery, or medical treatment for illness or injury. You may only assign benefits to the person or institution that provides the services or supplies for which these benefits are payable.

For information about assigning TWA Retiree Life Insurance benefits, see Assignment of Benefits on page 76.

Right to Recovery

If claim payments are more than the amount payable under these Plans, the network/claim administrator may recover the overpayment. The network/claim administrator may seek recovery from one or more of the following:

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

The network/claim administrator may deduct the amount of any overpayments from any future claims payable to you or your service providers.

Plan Reimbursement

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

As a condition for receiving benefits under these Plans, you:

1. Grant the Plans a first lien against any settlement, verdict or other amounts you receive,
2. Assign to the Plans any medical benefits you are eligible to receive under an automobile policy or other coverage, up to the amount the Plans have paid in benefits,
3. Agree to sign and deliver any documents necessary to help the Plans protect their rights (refusal to sign these documents does not diminish the Plans' reimbursement rights), and
4. Assist the Plans by complying with any reasonable request to help the Plans recover any benefits they have paid, without taking any action that may prejudice the Plans' rights to reimbursement.

Subrogation

Subrogation is third-party liability. It 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.

If someone else caused your injury or illness, these Plans have the right to collect payment from the third party (or their insurance carrier) for the medical treatment of your injury or illness. The Plans subrogate (substitute) their own rights for your rights. This means the Plans will be paid first from any settlement or judgment you receive. The Plans may assert this right independently of you.

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

1. Cooperate with the Plans to protect the Plans' subrogation rights
2. Provide the Plans with any relevant information they request
3. Obtain consent of the Plans before releasing any party from liability for payment of medical expenses, and
4. Sign and deliver documents regarding the Plans' subrogation claims if requested. (Refusal to sign these documents does not diminish the Plans' subrogation rights.)

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

Claim Processing Requirements

Time Frame for Initial Claim Determination
For claims for medical benefits, the processing rules vary by the type of claim. For urgent care claims (see definition on page 84) 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/claim administrator or benefit administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- 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), or
- 15 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/claim 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/claim administrator or benefit administrator with sufficient information to determine whether or not, or to what extent, benefits are covered or payable under the Plan, the network/claim administrator or benefit administrator must notify you within 24 hours of receiving you 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/claim administrator's or benefit administrator's receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the network/claim administrator or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the network/claim administrator or benefit administrator must notify you before the end of the first 15-day 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 you 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/claim administrator or benefit administrator sends you an extension notification until the date you respond to the request for additional information needed to process your claim.

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

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

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

Concurrent Care Claim
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 (as defined in the previous section entitled, "Urgent Care Claims"), 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 (as defined in the previous section entitled, "Urgent 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 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/claim administrator or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination;
- References to the specific Plan provisions on which the benefit determination is based;
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination;
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- If the adverse benefit determination concerns an urgent care claim, a description of the expedited review process applicable to the claim.

Claim Submission and Review Requirements
All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the network/claim administrator or benefit administrator. After the network/claim

administrator or benefit administrator has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the network/claim administrator or benefit 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/claim administrator or benefit administrator for up to 90 days, provided the network/claim administrator or benefit administrator both determines that such 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 time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension, the network/claim administrator or benefit 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/claim administrator or benefit 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 benefits is denied, in whole or in part, the network/claim administrator or benefit administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and 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 procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA, 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/claim administrator or benefit 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/claim administrator's or benefit administrator's request for information, or upon a demonstration to the satisfaction of the network/claim administrator or benefit administrator that under the circumstances, its 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/claim administrator or benefit administrator, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts and circumstances the network/claim administrator or benefit administrator deems relevant.

Appealing a Denial

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 Appeal and Second Level Appeal. First Level Appeals are conducted by the network/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. Urgent care appeals do not go through the two-tiered appeal process—they have only one level of appeal filed directly with the PBAC (more information about urgent care appeals is provided later in this section).

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

- TWA Retiree Plan, Under Age 65 Option
- TWA Retiree Plan, Age 65 and Over Option.

This two-tiered appeal process also applies to adverse benefit determinations made regarding eligibility, enrollment, and administrative issues on any and all benefits or plans offered through the benefit program for TWA Retirees.

With respect to adverse benefit determinations made on fully insured benefits, which include the:

- TWA Retiree Plan, Retiree Life Insurance Benefit, and
- Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries,

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

If you receive an adverse benefit determination and elect to pursue the appeal process, you must request a First Level Appeal from the network/claim administrator or benefit administrator. You or your authorized representative have 180 days following the receipt of a notification of an adverse benefit determination in which to file your First Level Appeal. If you do not file your First Level Appeal (with the network/claim administrator or benefit administrator) within this 180-day time frame, you waive your right to file both the First Level and Second Level Appeals of the determination.

To File a First Level Appeal with the network/claim administrator or benefit administrator, please complete and 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 you with information about what to include with your appeal, and there are specific Applications for use in appealing specific benefits (e.g., medical necessity, administrative issues, ineligible expenses, etc.). You can download and print the appropriate Appeal Form, or you can request an Application from HR Services.

The network/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 15 days of receipt of your First Level Appeal
- For post-service claims, within 30 days of receipt of your First Level Appeal
- For all other claims (other than pre-service, post-service, or urgent care), within 60 days of receipt of your First Level Appeal. If the network/claim administrator or benefit administrator requires additional time to obtain information needed to complete its review of your First Level Appeal, it may have an additional 60 days to complete your First Level Appeal (the network/claim administrator or benefit administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon receipt of a First Level Appeal decision notice that upholds the prior adverse benefit determination — if you still believe you are entitled to the denied/withheld benefit and elect to pursue the appeal process, you must file a Second Level Appeal with the PBAC at American Airlines, Inc. You or your authorized representative have 180 days following receipt of the First Level Appeal decision notice within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the PBAC) within this 180-day time frame, you waive your right to file a 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 you with information about what to include with your appeal, and there are specific Applications for use in appealing specific benefits (e.g., medical necessity, administrative issues, ineligible expenses, etc.). You can download and print the appropriate Appeal Form, or you can request an Application from HR Services.

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
- For all other claims (other than pre-service, post-service, or urgent care), within 60 days of receipt of your First Level Appeal. If the network/claim administrator or benefit administrator requires additional time to obtain information needed to complete its review of your First Level Appeal, it may have an additional 60 days to complete your First Level Appeal (the network/claim administrator or benefit administrator will notify you that this additional time period is needed to complete a full and fair review of your case)

Example: A participant appeals an adverse benefit determination (post-service claim). For both levels of appeal—First and Second Levels—the combined time allotted for both the network/claim administrator or benefit administrator and the PBAC to conduct their reviews and render decisions is 60 days. If the First Level Appeal review is completed by the network/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 Second Level Appeal determination.

Upon its receipt of your Second Level Appeal, the PBAC will review it in accordance with the terms and provisions of the Plans and the guidelines of the PBAC. Appointed officers of American Airlines, Inc. are members of the PBAC. The PBAC may designate another official to determine the outcome of your Second Level Appeal. The PBAC or its delegate will review your appeal, including all evidence you submit, reports from the network/claim administrator or benefit administrator, consultation reports from independent clinical authorities (if applicable), and any other information the PBAC deems necessary to conduct a full and fair review of your appeal.

If you elect to pursue appeals of adverse benefit determinations, it is mandatory that you file both First Level and Second Level Appeals (unless otherwise stated in this Guide) as part of the Plans' administrative remedies, and American Airlines, Inc. encourages you to use the appeal processes to exhaust all avenues in efforts to resolve any benefit issues in the quickest manner possible. ***However, if you elect to pursue an appeal of an urgent care issue, urgent care appeals are required to undergo only one level of appeal — the Second Level Appeal with the PBAC. Urgent care appeals should be filed directly with the PBAC.***

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
    - 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 upon 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 claim and appeal procedures 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 Section 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Compliance with Privacy Regulations

Notice of Privacy Rights — Health Care Records

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice applies to all active and retired Plan participants of participating AMR Corporation subsidiaries.

This Notice is effective as of February 17, 2010, and applies to health information received about you by the health care components of the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (particularly, the Standard Medical Options, the Preferred Provider Option, the Out-of-Area Option, the Reduced Work Schedule and Job Share Options, the Point-of-Service Option, the HMOs, Dental Benefits, Vision Insurance Benefits, Health Care Flexible Spending Accounts Benefit), the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries, the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, **TransWorld Airlines Retiree Health and Life Benefits Plan** and any other group health plan for which American Airlines, Inc. ("American") serves as Plan Administrator (collectively, the "Plan"). You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations") and as amended by the Genetic Information Nondiscrimination Act ("GINA") and the American Recovery and Reinvestment Act ("ARRA").. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claims for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop-loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by AMR Corporation and its subsidiaries for any of the purposes described above. ARRA requires disclosures for purposes of payment to meet its minimally necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you (for example, if your doctor requests information on what other drugs you are currently receiving).

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or

securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances. ARRA requires disclosures for purposes of the Plan's operations to meet its minimally necessary standard. The Plan is prohibited from disclosing any of your PHI that constitutes genetic information (as defined by GINA) for underwriting purposes.

When Required by Law. The Plan may also be required to disclose or use your PHI for certain other purposes (for example, if certain types of wounds occur that require reporting, or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena).

For Workers' Compensation. The Plan may disclose your PHI as authorized by you or your representative and to the extent necessary to comply with laws relating to Workers' Compensation and similar programs providing benefits for work-related injuries or illnesses if either, (1) the health care provider is a member of the employer's workforce and provides health care to the individual at the request of the employer, the PHI is provided to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace, and the information is required for the employer to comply with OSHA or with laws with similar purposes, or (2) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

Pursuant to Your Authorization. Any other use or disclosure of your PHI will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

For Appointment Reminders and Health Plan Operations. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. Information may be provided to the Sponsor of the Plan, provided that the Sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment-related activities.

Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family's or friend's involvement with your care or payment for that care, and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or

domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.

- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.
- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. state laws may provide you with additional rights or protections.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. The Plan is required to comply with your request not to disclose to another plan any PHI related to any claim for which you paid in full. Otherwise, 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, MD 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, MD 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, MD 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

To Request Confidential Communication. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the following officer: Managing Director, Human Resources Delivery, American Airlines, MD 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

A Note About Personal Representatives

You may exercise your rights through a personal representative (e.g., having your spouse call for you). Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public
- a signed authorization completed by you
- a court order of appointment of the person as the conservator or guardian of the individual, or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the Secretary of the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

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.

Disclosures of a Limited Data Set need not be included in any accounting of disclosures by the Plan. 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, MD 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, MD 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, MD 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 and Its Subsidiaries, Including American Airlines, May Use Your Health Information

American Airlines, Inc. ("American"), administers many aspects of the American Group Health Plans (the "Plans"), which are listed below, on behalf of AMR Corporation and its Subsidiaries, including American Airlines and American Eagle. American, as the plan sponsor and/or plan administrator of the Plans may use and disclose your personal medical information (called "Protected Health Information") created and/or maintained by the Plans that it receives from the Plans as permitted and/or required by, and consistent with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations found at 45 CFR Part 164, Subpart A. This includes, but is not limited to, the right to use and disclose a participant's PHI in connection with payment, treatment and health care operations.

The American Airlines Group Health Plans include the health plan components of:

- The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries[1] (Plan 501)
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503)
- The Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries (Plan 5)
- 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 Applies To

The information in this section applies only to health-related benefit plans that provide "medical care," which means the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, transportation primarily for and essential to medical care, and insurance covering medical care. This means that, for the Plans listed above, only the health-related benefits, including medical, dental, vision, prescription drug, mental health, and health care flexible spending account benefits, are subject to the limitations described in this section. The EAP is included only to the extent that it is involved in the administration of medical benefits.

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

This Section Does Not Apply To

By law, the HIPAA Privacy rules, and the information in this section, do *not* apply to the following benefit plans:

- Disability plans (short-term and long-term disability)
- Life insurance plans, including accidental death and dismemberment (AD&D)
- Workers' compensation plans, which provide benefits for employment-related accidents and injuries
- Property and casualty insurance.

In addition, AMR Corporation and its subsidiaries may have personal medical information about you that is used for routine employment activities. Medical information held or used by AMR Corporation and its subsidiaries in its employment records for employment purposes is *not* subject to the HIPAA Privacy rules.

This includes, but is not limited to, medical information, files or records related to compliance with government occupational and safety requirements, the Americans with Disabilities Act (ADA) or other employment law requirements, occupational injury, disability insurance eligibility, sick leave requests or justifications, drug or alcohol screening results, workplace medical surveillance, fitness-for-duty test results, or other medical information needed to meet Federal Aviation Administration (FAA), Department of Transportation (DOT), or other company policy or government requirements. Information used by the EAP in its role in administering employment-related programs, such as drug and alcohol testing, is not subject to the HIPAA Privacy rules.

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 noncompliance 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, and
- Ensure that there is an adequate separation between the Plans and the employer Plan Sponsor as will be set forth below.

Separation of AMR Corporation and Its Subsidiaries, Including American Airlines, and the Group Health Plans

The following employees or classes of employees or other persons under the control of American Airlines or another AMR subsidiary shall be given access to PHI for the purposes related to the Plan:

- Health Strategy employees involved in health plan design, vendor selection, and administration of the Plans, and including the Plan Managers, and administrative assistants, secretarial and support staff; as well as any Retirement Strategy employees involved in health plan issues
- Pension Benefits Administration Committee (PBAC), its delegated authority, and PBAC Advisory Committee members, due to their role in governing health plan matters, including reviewing and approving plan design changes, rendering appeal decisions, and other health plan administrative matters
- Benefits Compliance and the PBAC Appeals group personnel involved in receiving, researching, and responding to health plan member appeals filed with the PBAC
- Employee Services personnel who assist with day-to-day health plan operations, including Vendor Relations personnel; Retirement Counselors, who assist with retiree medical coverage questions; employees involved in receiving, reviewing and processing Qualified Medical Child Support Orders; and all call center personnel, case coordinators and support staff who assist employees by answering questions, researching issues and resolving health plan problems, including those administering the Travel program; Leave of Absence coordinators working with health plan enrollment issues; Survivor Support counselors, who assist with health plan issues for survivors; and administrative assistants, secretarial and support staff for the employees listed:
  - Instructors who train Employee Services personnel, and thus have access to the call center Systems
  - HR Records Room personnel responsible for managing benefit plan record storage
  - Certain Management Advisory Services (MAS) personnel, but only those involved in investigating health plan fraud or abuse
  - Executive Compensation employees, including secretarial and support staff, who assist Company executives and certain other employees with health plan enrollment and payment issues on a day-to-day basis
  - Occupational Health Services/Clinical Services employees, including the Corporate Medical Director, EAP Manager, EAP nurses and support staff providing services through the Employee Assistance Program (EAP), including review and approval of mental health and substance abuse claims under the Plans, but only to the extent of their involvement with the Group Health Plans
  - Legal department employees, including Employment Attorneys, ERISA counsel, Labor Attorneys and Litigation Attorneys, and any other attorneys involved in health plan legal matters, and including 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
  - American Eagle personnel involved in benefit plan administration for that subsidiary
  - Privacy Compliance Council and HIPAA Subcommittee members, due to their role in understanding and investigating the flow of PHI for the Group Health Plans, in order to ensure compliance with HIPAA and other privacy rules; and

- On a need-to-know basis, appropriate personnel employed by the employer Plan Sponsor as independent contractors who have executed Business Associate agreements with the plan to provide other necessary administrative services to the Plan that include, but are not limited to:
  - Insurance agents retained to provide consulting services and obtain insurance quotes
  - Actuaries retained to assess the Plan's ongoing funding obligations
  - Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities
  - Consulting firms engaged to design and administer Plan benefits
  - Financial accounting firms engaged to determine Plan costs; and
  - Claims processing companies engaged to assist the Plan Administrator in the processing of claims made against the Plan.

Access to and use of PHI by such employees and other persons described above is restricted to administration functions for the Plans performed by American or another employer Plan Sponsor, including payment and health care operations.

American and other AMR subsidiaries shall provide an effective mechanism for resolving any issues of non-compliance by such employees or persons. American Airlines' Rules of Conduct as outlined in the Employee Policy Guide, including disciplinary procedures, will apply to such issues of employee noncompliance.

Non-compliance Issues

If the persons described above do not comply with the requirements included in this portion of the Plan, the Plan Sponsor shall provide a mechanism for resolving issues of 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. Individuals involved in a violation may also be subject to sanction by the government agencies enforcing the HIPAA privacy requirements. The Plan's Policy Regarding Sanctions for Violation of the HIPAA Privacy Policies and Procedures shall be followed along with the Group Health Plan's Policy and Procedure on Mitigation of Damages for Violative Disclosure of Protected Health Information in the event of any violation of the Plan's HIPAA Privacy Provisions in this Article.

Organized Health Care Arrangement

The Plan is part of an organized health care arrangement with the following other health plans maintained by AMR Corporation and its subsidiaries.

The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation subsidiaries with respect to the benefits and benefit options providing medical benefits, dental benefits, vision benefits, , health care flexible spending accounts and the HMOs offered hereunder, the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries with respect to the benefits and benefit options providing medical benefits offered thereunder, the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, **the Trans World Airlines, Inc. Retiree Health and Life Benefits Plan**, and any other Group Health plan for which American serves as Plan Administrator.

The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement for the purposes described in the regulations and in the section entitled "Notice of Privacy Rights | Health Care Records" above.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of the Plan's benefits that relate to an individual to whom health care is provided. A disclosure for payment will be limited to the minimally necessary information unless the disclosure occurs in the form of the standard for the electronic transactions. An authorization is not required to permit a disclosure or use for payment unless the disclosure involves psychotherapy notes or the use of the information for marketing. Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, coinsurance, deductibles and copayments 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), and
- Obtaining reimbursements due to the Plan.

Your ERISA Rights

As a participant in the TWA Retiree Plan and/or the Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits 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 or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Where To Receive Help

For general information about your benefits, contact American Airlines, Inc. HR Services at the addresses, phone numbers, and web sites or Chat sites listed in the Contact Information of this Guide.

For information on your claims, contact the network/claim administrator, benefit administrator, at the addresses and phone numbers located in the Contact Information section of this Guide.

Glossary

Accident, Accidental: An unexpected event of outside and unforeseen traumatic force, where both the cause and the result of the event are unforeseen/unexpected.

Adverse Benefit Determination:

1. Denial, reduction, termination of or failure to provide/pay a benefit under the plan
2. Denial, reduction, termination of or failure to provide/pay a benefit based on a claimant's eligibility to participate in the plan
3. Denial, reduction, termination of or failure to provide/pay a benefit based on application of utilization review, and/or
4. Denial, reduction, termination of or failure to provide/pay a benefit based on plan provisions involving experimental/investigational treatment or medical necessity.

Alternative and/or Complementary Medicine: 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 Institutes of Health or similar organizations recognized by the National Institutes 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, to diagnose or treat a patient. Examples include fees for X-rays, lab tests, medicines, operating rooms and medical supplies.

Assignment of Benefits: You may authorize the network/claim administrator to directly reimburse your medical service provider for your eligible medical expenses by requesting that the provider accept assignment of benefits. When you request assignment of benefits, you avoid paying the full cost of the medical service up front, filing a claim and waiting for reimbursement. Your medical service provider generally files your medical claim for you if he or she accepts assignment.

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

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.

Child: See page 3.

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

Claim Involving Urgent Care (also referred to as "Urgent Care Claim"): Urgent care claims are those that, unless the special urgent care deadlines for response to a claim are followed, either:

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

Co-insurance: You pay a percentage of eligible medical expenses and the TWA Retiree Plan pays the remaining percentage. For example, after you satisfy your deductible under the Age 65 and Over Option, you pay 20 percent co-insurance for most covered expenses and the TWA Retiree Plan pays 80 percent.

Company: American Airlines or a participating AMR Corporation subsidiary.

Concurrent Care Claim: Claims involving an ongoing course of treatment over a period of time. Examples of a concurrent care claim are claims for physical or occupational therapy, courses of chemotherapy or other oncological treatment, courses of chiropractic adjustment/treatment, etc.

Convalescent or Skilled Nursing Facility: A licensed institution that:

1. Mainly provides Inpatient care and treatment for persons who are recuperating from illness or injury
2. Provides care supervised by a physician
3. Provides 24-hour nursing care by nurses who are supervised by a full-time registered nurse
4. Keeps a daily clinical record of each patient
5. Is not a place primarily for the aged or persons who are chemically dependent, and
6. 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.

Company: Participating AMR Corporation subsidiary(ies)

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

Covered Expenses, Covered Medical Expenses: The terms covered expenses, covered medical expenses, means the usual and prevailing fee charge incurred, but only those incurred after you and your covered eligible

dependents become covered, for services and supplies that are recommended by a physician and are medically necessary for the care and treatment of the injury, sickness or pregnancy.

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

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

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

Dental necessity/dentally necessary: Dental treatment that follows generally accepted dental practices, is required for sound dental health, and is prescribed by a qualified dental professional. For example, necessary dental treatment includes fillings and crowns for decayed teeth. It does not include treatment primarily for cosmetic purposes.

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

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.

Detoxification: Twenty-four hour medically directed evaluation, care, and treatment of drug-and alcohol-addicted patients in an inpatient setting. The services are delivered under a defined set of physician-approved policies and procedures or clinical protocols.

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

Eligible Dependent: See page 3.

Eligible Medical Expenses, Eligible Expenses: The TWA Retiree Plan covers the portion of regular, medically necessary services, supplies, care and treatment of non-occupational injuries or illnesses up to the usual and prevailing fee limits, when ordered by a licensed physician acting within the scope of his or her license.

Emergency: An illness or injury 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 attack.

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

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

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

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, or
- 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.

When used herein, reliable evidence refers to "Reliable Evidence" as defined on page 84.

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

Explanation of Medicare Benefits (EOMB): A statement provided by your Medicare claim administrator or carrier that shows how a service was covered by Medicare, how much is being reimbursed, and what portion (if any) is not covered.

Free-standing Surgical Facility: An institution primarily engaged in medical care or treatment at the patient's expense and that is:

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

Group Health Plan: An employee welfare benefit plan (maintained by an employer or employee organization) providing, through insurance or otherwise:

- Medical, surgical or hospital care or benefits,
- Dental care benefits, and/or
- Benefits in event of sickness, accident, death or unemployment.

Health Care Professional: State-licensed physician or other health care professional licensed to perform specified health services consistent with state law in which he or she is licenses, and who practices within the scope of his or her license. Also see the terms Physician and Nurse.

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. A team of trained medical personnel, homemakers and counselors provides care. The hospice must meet the licensing requirements of the state or locality in which it operates.

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

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

Hospitalization or Hospital Stay: See the term Inpatient.

Illness: Disease, pregnancy, syndrome, disorder, infirmity, medical condition, or malformation that results in compromise of the normal state of health, as diagnosed by a Physician.

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

Injury: Accidental bodily injury in which both the cause and the result are accidental, and will include all injuries received by an individual in any one accident. Also see the term Accident.

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.

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

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

When you have exhausted your maximum medical benefit your retiree medical coverage terminates, and you do not receive the annual restoration of benefits. You are not eligible for any future increases in the maximum medical benefit.

Even if you have exhausted your maximum medical benefit, your covered eligible dependents may continue their existing medical coverage under the benefit or plan up to their maximum medical benefit (as long as they meet the eligibility requirements).

If you and your covered eligible dependents exhaust the maximum medical benefit, you may continue other coverages/benefits in the retiree benefit or plan, e.g., Retiree Life Insurance, Retiree Dental Insurance. The medical coverage is the only coverage that terminates for the affected individual.

Mammogram or Mammography: 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.

Medical Necessity or Medically Necessary: A medical or dental service or supply required for the diagnosis or treatment of a non-occupational accidental injury, illness, or pregnancy. The TWA Retiree Plan determines medical necessity based on and consistent with standards approved by the claims administrator's medical personnel. To be medically necessary, a service, supply or hospital confinement must meet **all** of the following criteria:

1. Ordered by a physician (although a physician's order alone does not make a service medically necessary)
2. Appropriate (commonly and customarily recognized throughout the physician's profession) and required for the treatment and diagnosis of the illness, injury or pregnancy
3. Unavailable in a less intensive or more appropriate place of service, diagnosis or treatment that could have been used instead of the service, supply or treatment given, and either:
    a. Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications, or
    b. 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 for an illness or injury must meet the above conditions to be considered medically necessary. A service is not considered medically necessary if it is educational, experimental or unproven in nature.

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

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

A determination that a service or supply is not medically necessary may apply to all or part of the service or supply.

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

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

Multiple Surgical Procedures: Surgical procedures performed at the same time as the primary surgical procedure, which are medically necessary but are not the primary reason for surgery. Multiple surgical procedures may be performed through the same incision, may be bilateral, and are performed during the same operative session.

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

Nurse: A practitioner of the healing arts who is licensed by the state, practices within the scope of his or her license, and maintains one or more of the following professional designations:

- Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.), or

- Licensed Vocational Nurse (L.V.N.).

Also see the terms Health Care Professional and Physician.

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

Over-the-Counter: Drugs, products and supplies that do not require a prescription by federal law.

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

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

The term physician includes, but is not limited to, the following licensed individuals, listed alphabetically:

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

Also see the terms Health Care Professional and Nurse.

Post-service Claim: Any claim that, under the terms of the plan, does not require approval in advance of obtaining medical care in order to receive benefit. A claim for benefits in which the care, service, or supply has already been rendered.

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

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

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

Pre-service Claim: Any claim that, under the terms of the plan, requires approval in advance of obtaining medical care in order to receive benefit, and in which the care, service, or supply has not yet been rendered.

Primary Surgical Procedure: The surgical procedure performed based upon 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 and plan criteria for coverage.

Proof of Good Health, Statement of Health: Some plans, benefits, or options 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 Plan.

You will not be enrolled in the Long Term Care Insurance Plan until MetLife approves your Proof of Good Health or Statement of Health form and you pay the initial premium.

You may obtain a Statement of Health or Proof of Good Health from MetLife or you may download and print the Statement of Health.

Provider: The licensed individual or institution that provides medical services or supplies. Providers include physicians, hospitals, pharmacies, surgical facilities, dentists, and other covered medical/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, and
- Have a structured program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the program's treatment format.

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

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

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

- Nursing care,
- Rest care,
- Convalescent care,
- Care of the aged,
- Custodial care, or
- Educational care.

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 of 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 work group or is outlined in his or her applicable labor agreement.

Relevant: Document, record or other information that:

- Was relied upon in making the benefit determination
- Was submitted, considered or generated in the course of benefit determination, whether or not it was relied upon in making the benefit determination
- Is in compliance with administrative processes and safeguards designed to ensure and verify that benefit determinations have been made in accordance with plan provisions and that those provisions have been applied consistently and uniformly.

Reliable Evidence: Reliable evidence includes:

- Published reports and articles in the authoritative medical and scientific literature (including, but not limited to: AMA Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopeia Dispensing Information and National Institutes of Health),
- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment or procedure, and
- Written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

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

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

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

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

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

Secondary Surgical Procedure: A surgical procedure performed at the same time as the primary surgical procedure, which is medically necessary, but was not included as part of the primary surgical procedure.

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

Spouse: Your legally married spouse or common law spouse.

Summary Plan Description: Document(s) providing the plan participant information about a benefit plan, including, but not limited to, plan eligibility requirements, enrollment procedures, descriptions of covered and excluded or limited expenses, claim filing instructions, claim and appeal procedures, etc. The document(s) meet the requirements of the United States Department of Labor regulations for Summary Plan Description. 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.

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 safe and effective by Reliable Evidence.

"Reliable Evidence" is defined in this Glossary and when used in this Guide, refers to "Reliable Evidence" as defined herein.

Urgent/Immediate Treatment: Medical treatment 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 or immediate treatment include, but are not limited to, high fevers, flu, cuts that may require stitches, and sprains.

Usual and Prevailing Fee Limits:

The maximum amount that the Plan will consider as an eligible expense for medical or dental services and supplies. The following are 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, and
- 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, in its sole discretion, has retained the network/claim administrator to determine usual and prevailing fees. These usual and prevailing fees are based on the network/claim administrator's database of prevailing health care charges, or if that data is not applicable, the usual and prevailing fees are based on a relative unit value methodology.

Under the relative unit value method, every procedure is assigned a specific unit value based on a professional reference standard. Unit values are assigned by this reference according to the relative complexity of a procedure. The unit value is then multiplied by a dollar value per unit, in accordance with professional fee data taken from the geographic area where the medical services were rendered. (This dollar value is referred to as the "area conversion factor," and is determined by statistical calculations that take into account all charges from this multiplication (unit value times area conversion factor) is the maximum charge allowed under the Plan.

The usual and prevailing fee limits can also be impacted by number of services or procedures you receive during one medical treatment. Under the Plan, when the claims processor reviews a claim for usual and prevailing fees, it looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code.

Coding individual services and procedures by providers (called "coding fragmentation" or "unbundling") usually results in higher physician charges than 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.

For example, the appendix is often removed by the surgeon during a hysterectomy. The appropriate code for the hysterectomy procedure includes removal of the appendix. However, some physicians will bill separately for a hysterectomy and an appendectomy as if these procedures had been separately performed at different times. Recognizing this, when multiple surgical procedures are performed at the same time, the Plan pays benefits up to the usual and prevailing fee limit of the appropriate combined code rather than calculating and awarding benefits for each surgical procedure separately.

Contact Information

The following table lists the names, addresses, phone numbers and Web sites (when available) for these important contacts relating to the TransWorld Airlines, Inc. Retiree Health and Life Benefits Plan (TWA Retiree Plan), and the Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (LTCIP).

For Information About:	Contact:	At:
TWA Retiree Health and Welfare Benefits General questions, information updates and request forms	**American Airlines HR Services** (USPS Mail) P.O. Box 9741 Providence, RI 02940-9741 **OR** **American Airlines HR Services** (Express Delivery) One Investors Way Norwood, MA 02062	**(800) 447-2000** **(888) 891-3625** (fax) **Web site:** www.jetnet.aa.com; then click on e-HR; then click on HR Assistant to Chat with HR Services
TWA Retiree Guide Replacement Copies To purchase replacement copies of this Health and Life Benefits Guide for Retirees of TWA *(request must be made in writing and mailed or faxed)*	**American Airlines HR Services** (USPS Mail) P.O. Box 9741 Providence, RI 02940-9741 OR **American Airlines HR Services** (Express Delivery) One Investors Way Norwood, MA 02062	**(800) 447-2000** **(888) 891-3625** (fax) **Web site:** www.jetnet.aa.com; then click on e-HR; then click on HR Assistant to Chat with HR Services
American Airlines, Inc. HR Delivery, Managing Director	**American Airlines, Inc.** Managing Director, HR Delivery P.O. Box 619616 MD 5144-HDQ1 DFW Airport, TX 75261-9616	
American Airlines, Inc. **HIPAA Privacy Complaints**	**HIPAA Compliance Subcommittee** Privacy Complaint Official American Airlines, Inc. c/o PBAC Appeals Group P.O. Box 619616 MD 5134-HDQ1 DFW Airport, TX 75261-9616	
Medical Coverage		
TWA Retiree Plan First Level Appeals *Appeals should be filed with the proper appeal form available under Forms and Guides in e-HR*	**UnitedHealthcare (UHC)** First Level Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432	**(801) 938-2100** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
TWA Retiree Plan Medical Benefits UnitedHealthcare Network Provider Listing	**UnitedHealthcare (UHC)**	**(800) 638-9599** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssouhc.asp

For Information About:	Contact:	At:
		Provider directories: www.provider.uhc.com/american
TWA Retiree Plan Medical Benefits • Network/claim administrator for: Under Age 65 Option Age 65 and Over Option • Customer Service	**UnitedHealthcare (UHC)** AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**(800) 638-9599** **Web site:** www.myuhc.com **Provider directories:** www.provider.uhc.com/american **Web site:** https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
TWA Retiree Plan Medical Benefits Billing and Eligibility for Coverage	**PayFlex** P.O. Box 2239 Omaha, NE 68103-2239	**(800) 359-3921** **Web site:** https://www.jetnet.aa.com/jetnet/go/SSOHealthHub.asp
TWA Retiree Plan Medical Benefits Mental Health Care	**United Behavioral Health** AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**(888) 444-8624**
TWA Retiree Plan, Medical Benefits Maximum Medical Benefit Requests	**UnitedHealthcare (UHC)** AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**(800) 638-9599**
TWA Retiree Plan, Medical Benefits Coverage for Incapacitated Child and Special Dependents, (Under Age 65 Option Only)	**UnitedHealthcare (UHC)** Statement of Health Underwriting 1900 East Golf Road, Suite 400 Schaumburg, IL 60173	**(800) 865-6098**
CheckFirst (Predetermination of Benefits)		
TWA Retiree Plan Medical Benefits	**UnitedHealthcare (UHC)** AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**(800) 638-9599** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
QuickReview (Pre-authorization for Hospitalization)		
Retiree Medical Benefit (Under Age 65 Option Only)	**UnitedHealthcare (UHC)** AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**(800) 638-9599** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
Prescription Drugs		
Prescriptions – Mail Order (Under Age 65 Option Only)	**Medco** P.O. Box 650022 Dallas, TX 75265-2200	**(800) 988-4125** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions - Prior Authorization (Under Age 65 Option Only)	**Medco** 8111 Royal Ridge Parkway, Suite 101 Irving, TX 75063	**(800) 988-4125** **Web site**: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions - Retail (Under Age 65 Option Only)	**Medco** Member Services	**(800) 988-4125** **Web site:**

For Information About:	Contact:	At:
		https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Filing Retail Prescription Claims (Under Age 65 Option Only)	**Medco** P.O. Box 14711 Lexington, KY 40512	**(800) 988-4125** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions • Age 65 and Over Option • Medicare Part D • Medicare Part D Prescription Drug Provider	• **UnitedHealthcare (UHC)** • **Medicare** • **Contact the Prescription Drug Provider with whom you secured your Medicare Part D Coverage**	• **(800) 638-9599** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssouhc.asp • **(800) 633-4227)** **Web site:** http://www.medicare.gov
Life Insurance		
TWA Retiree Life Insurance Benefit	**MetLife** American Airlines Customer Unit P.O. Box 6100 Scranton, PA 18505	**(800) 638-6420** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssometlife.asp **(877) 275-6387** (Conversion Options Information)
TWA Retiree Life Insurance Benefit Conversion Options Information	**MetLife**	**(877) 275-6387**
Continuation of Coverage (COBRA)		
Continuation of Coverage (COBRA Administrator) Mail Payments	**Benefits Concepts, Inc.** P.O. Box 9222 Chelsea, MA 02150-9922	**(866) 629-0274** **(401) 427-8721** (fax) **Web site:** http://avantserve.com
Continuation of Coverage (COBRA Administrator) Eligibility, General Correspondence	**Benefits Concepts, Inc.** P.O. Box 246 Barrington, RI 02806-0246	**(866) 629-0274** **(401) 427-8721** (fax) **Web site:** http://avantserve.com
Employee Assistance Program		
Employee Assistance Program – For approval of admission to a chemical dependency rehabilitation program, contact the EAP office	**American Airlines** **Employee Assistance Program**	**(800) 555-8810**
Long Term Care Insurance Plan		
Long Term Care Insurance Plan	**MetLife** 57 Greens Farm Road Westport, CT 06880	**(800) 438-6388** **Web site:** https://www.jetnet.aa.com/jetnet/go/ssometlife.asp

For Information About:	Contact:	At:
Other Information		
Pension Benefits Administration Committee Second Level Appeals to the PBAC	**PBAC** American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	**ICS or (817) 967-1412**
Survivor Support Services	**American Airlines HR Services** (USPS Mail) P.O. Box 9741 Providence, RI 02940-9741 OR **American Airlines HR Services** (Express Delivery) One Investors Way Norwood, MA 02062	**(800) 447-2000** **Web site:** www.jetnet.aa.com; then click on e-HR; then click on HR Assistant to Chat with HR Services
Travel Services	**Dial-AA-Flight** **General Reservations** **A9 Emergency Travel**	
AA Federal Credit Union • Toll-free nationwide phone • Dallas-Fort Worth area phone	**AA Federal Credit Union**	**• (800) 533-0035** **• (817) 963-6000** **Web site: Error! Hyperlink reference not valid.**
C.R. Smith Museum • Update Member Information • Tours	**C.R. Smith Museum**	**• (817) 963-5995** **• (817) 967-1560** (Tours) **Web site:** www.crsmithmuseum.org
Medicare, Social Security Administration		
For eligibility, enrollment premiums and lost Medicare cards	**Social Security Administration**	**(800) 772-1213** **Web site;** www.ssa.gov
For publications, policies, and Medicare Health Plans in your area	**Medicare**	**(800) 638-6833** **Web site:** www.medicare.gov
United States Department of Labor		
For general inquiries, correspondence, complaints	**Division of Technical Assistance and Inquiries** Employee Benefits Security Administration U.S. Department of Labor Frances Perkins Building 200 Constitution Avenue, NW Washington, DC 20210	**Web site:** www.dol.gov