Benefits Guide

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

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

The benefits described in this Guide include:

Medical Options, specifically

- STANDARD Medical Option with Health Reimbursement Account
- VALUE Medical Option with Health Incentive Account
- CORE Medical Option with Health Savings Account
- OUT-OF-AREA Medical Option with Health Reimbursement Account
- HMOs

Dental Coverage

Vision Coverage

Flexible Spending Accounts

- Health Care Flexible Spending Account
- Limited Purpose Flexible Spending Account
- Dependent Care Flexible Spending Account

Life Insurance & Accident Insurance

Disability Benefits

Employee Assistance Program

Additional Important Information

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

About this Guide section

General Eligibility section

General Enrollment section

Life Events section

Additional Health Benefit Rules section

Plan Administration section

Reference Information section, including a Contacts list, the Glossary, and the Archives of older versions of the Guide.

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About This Guide

This Employee Benefits Guide is for:

- Agents/Representatives/Planners (ARP); including Home-Based Representatives or Level 84 Premium Services Representatives (HBR).
- Officers, Management/Specialists, Support Staff (OMSS)
- Transport Workers Union-represented employees (TWU)

Includes Company-sponsored health and welfare benefit plans established under and operated pursuant to the Employee Retirement Income Security Act (ERISA) and other applicable federal laws. These health and welfare benefit plans are organized in a §125 cafeteria plan arrangement, as described and controlled by Internal Revenue Code, US Treasury regulations, and US Department of Labor regulations.

This Guide contains the legal plan documents and the summary plan descriptions (SPDs) for the following plans of the benefits program (collectively the "Plans"):

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (the "Group Life and Health Plan"), the American, Inc.
- Long-Term Disability Plan
- Long-Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries.

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

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

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

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

American, Inc., a sponsor and administrator of the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries, believes that the medical coverages in this plan meet the requirements to be deemed non-grandfathered health plan(s), under the Patient Protection and Affordable Care Act (PPACA). The following chart specifies which medical benefit options in this plan are grandfathered, and which are not:

Medical Option	Grandfathered or Non-Grandfathered
Standard Medical Option	Non-Grandfathered
Core Medical Option	Non-Grandfathered
Value Medical Option	Non-Grandfathered
Out-of-Area Medical Option	Non-Grandfathered
HMO Medical Options	May be either, depending upon the HMO; contact your specific HMO for this information

Questions about non-grandfathered Medical Options can be addressed to:

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

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections apply to non-grandfathered health plans.

Voluntary Offerings Provided by American Benefits Consulting (ABC)

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

How do I determine my eligibility?

This section outlines general eligibility requirements.

- Employee Eligibility
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  - Eligibility During Leaves of Absence and Disability
  - Eligibility After Age 65
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Determination of Eligibility

You are eligible for the STANDARD Medical Option, CORE Medical Option, VALUE Medical Option or an HMO only if you reside where your Network/Claims Administrator or HMO offers a network. Your eligibility is determined by the ZIP code of your alternate address on record.

If you do not live in an area where with an administrator or HMO, then the Company will advise you on the eligibility for Out-Of-Area Medical Option.

You are allowed to list two addresses:
1. A permanent address (for tax purposes or for your permanent residence)
2. An alternate address (for a P.O. Box or street address other than your permanent residence).

If you do not have an alternate address listed in the Update My Information page of Jetnet, your benefit eligibility is based on your permanent address.

Benefits Effective Date

If you are an Agent/Rep/Planner, Home-Based Representative, Premium Services Representative, Support Staff, or TWU-represented employee, you are eligible for coverage for yourself and your eligible dependents after you fulfill a one-month waiting period.

If you are an Officer or Management/Specialist employee, you are eligible for coverage for yourself and your eligible dependents on your hire date.

If you are not at work on the date coverage would otherwise begin, coverage is effective on the date you are actively at work, unless you are not actively at work due to a health condition; then coverage is effective on the date coverage would otherwise begin.

After you receive your enrollment information, you may enroll on the Benefits Service Center. If you do not enroll for coverage when you are first solicited for benefits, you will receive "default coverage."

You are ineligible to participate in the benefits program if your employment relationship with the Company is defined under "Ineligibility."

Employee Eligibility

Proof of Eligibility

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

Whether you:

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

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

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

The following coverage requires proof of good health:

- **As a new employee:** Employee Voluntary Term Life Insurance (in amounts greater than the 1× basic coverage)
- **As an existing employee:** Employee Voluntary Term Life Insurance (if you waived coverage when first eligible or wish to increase coverage), Optional Short Term Disability Insurance and/or Long Term Disability (if you waived coverage when first eligible) (Long Term Disability does not apply to TWU-Represented employees)
- **As a new or existing employee:** Spouse Term Life Insurance (all levels of coverage)

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

Eligibility During Leaves of Absence and Disability

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

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

HR Services will send you a letter acknowledging your leave, instructing you where to find important information regarding your benefits while on your leave of absence and to access the Benefits Service Center to process the going leave of absence Life Event, and asking you to decide if you will or will not continue your benefits while on leave.

Once you record your Life Event and benefit elections on the Benefits Service Center, it will display a confirmation statement showing your choices, the monthly cost of benefits, covered dependents, etc.

If you have not received the HR Services' letter within 10 days of being placed on a leave, immediately contact HR Services by clicking on the "Start a Chat" button at the top of this page to be sure you can continue coverage during the leave.

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

Family Medical Leave of Absence (FMLA) or Military Leave

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

During the first 12 months of an unpaid sick or injury-on-duty leave of absence you may keep the same health and welfare benefits you had by continuing to pay your share of the cost.

If your disability continues beyond 12 months, you will be solicited for COBRA continuation coverage for up to a period of 36 months. If you are eligible to retire you can elect retiree medical coverage up to age 65.

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

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

Eligibility After Age 65

When you reach age 65 (or your spouse reaches age 65), you (or your spouse) must notify the Company in writing if you want Medicare to be your only coverage.

If you elect Medicare as your only coverage: your Company-sponsored active medical coverage will terminate, including coverage for your dependents.

If your spouse elects Medicare as his or her only coverage, only your spouse's Company-sponsored active coverage will terminate.

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

Dependent Eligibility by Benefit

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

Medical Coverage

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

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

Dental and Vision Coverage

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

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

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

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

- Incapacitated child age 19 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.
- Your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild (including the child of a Company-recognized Domestic Partner) who is:

  - Under age 19 unmarried and supported by you; or
  - Under age 23 and who is:
    - A full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
    - Unmarried;
    - Supported by you; and
    - Not employed on a full-time basis.
- The term Child does not include any person who:
  - Is in the military of any country or subdivision of any country; or
  - Is insured/covered under a employer group plan as an employee.

For Texas residents “child” means the following for Life Insurance ONLY:

- Your natural child, adopted child or stepchild (including the child of a Company-recognized Domestic Partner) who is under age 25 and unmarried. The term also includes your grandchild who is under age 25, unmarried and who was able to be claimed by you as a dependent for Federal Income Tax purposes at the time you applied for Life Insurance.
- A child will be considered your adopted child during the period you are party to a suit in which you are seeking the adoption of the child.

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

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

Dependent Eligibility Requirements

Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered spouse, Company-recognized Domestic Partner, or common law spouse as defined by the Plan
- For Medical coverage: Stepchild
- For Medical and Dental coverage: Stepchild, if the child lives with you, and you (the employee) either jointly or individually claim the stepchild as a dependent on your federal income tax return

Special Dependent, if you meet all of the following requirements:

- You must have legal custody and legal guardianship of the child.
- The child must maintain legal residence with you and be wholly dependent on you for maintenance and support.
- You must submit a Statement of Dependent Eligibility for Special Dependent Form to HR Services and HR Services must approve the form. (Complete and return the form to HR Services, along with copies of the official court documents awarding you custodianship or guardianship of the child.)You must receive confirmation from HR Services notifying you of its determination.
- HR Services will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 60 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by HR Services. If you submit the request after the 60-day time frame, the child will not be added to your coverage.

You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a National Medical Support Notice issued by a state agency (see "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" under "Qualified Medical Child Support Orders (QMCSO) Procedures" in the *Additional Health Benefit Rules* section.

Coverage for an Incapacitated Child — Medical Coverage Only

***Below you will find the critical steps that you, as the employee, are responsible for requesting incapacitated status for your disabled child. ***

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

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

Dependents of Deceased Employees

If you have elected medical coverage for your spouse and children and you die as an active employee, your dependents' medical coverage will continue for 90 days at no contribution cost. Your covered dependents are also eligible to continue medical coverage and certain other benefit Options for up to 36 months under COBRA Continuation Coverage at the full COBRA rate (see "Continuation of Coverage – COBRA Continuation" in the Additional Health Benefit Rules section. The 90 days of coverage are part of the 36 months of COBRA coverage. If you are over age 55 but not yet 65 at the time of death and were working as an active employee, your surviving spouse is eligible for Retiree Medical Benefits . This applies to your spouse, common law spouse, or Company-recognized Domestic Partner under age 65 at the time of your death. Your covered dependents can elect to continue dental and vision insurance benefits under COBRA at the full COBRA rate if they had dental and/or vision benefits at the time of your death. To continue dental and/or vision coverage, your dependents must pay contributions effective from the date of your death.

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

Spouse (SP)

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

Opposite-Sex Spouse

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

Same-Sex Spouse

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

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

Common Law Spouse

Common law spouses are eligible for enrollment in Plan benefits only if your common law marriage is recognized and deemed (certified) legal by the individual state where the employee resides, and only if the employee and spouse have fulfilled the state's requirements for common law marriage. To enroll your common law spouse for benefits, you must complete and return a Common Law Marriage Recognition Request and provide proof of common law marriage, as specified on the form. You and your common law spouse must not be married to, or have a DOMESTIC PARTNER (DP), common law, or other spouse-like relationship with any other person(s) at the same time you are in a common law marriage to each other. Requirements for your common law spouse to be eligible for coverage under the Plan(s) are:

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

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

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

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

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

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

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

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

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

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

Employees Married to Other Employees

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

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

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

- Accident Insurance Benefits
- Employee Term Life Insurance Benefits
- Retiree Medical Benefits (when available)
- Health Reimbursement and Health Incentive Accounts

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

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

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

Spouse not eligible for full benefits: During the one-month waiting period required for some workgroups to be eligible for benefits, the new employee may be covered as the spouse of the active employee who already has benefits. If your spouse, common law spouse, or Company-recognized Domestic Partner is working as a Home-Based Representatives or Level 84 Premiums Service Representative employee, he or she may waive medical, dental and/or vision coverage and be covered as a dependent under your coverage.

Retirees married to active employees: Retirees married to active employees are eligible for coverage as dependents of active employees. The benefits available and benefit limits, if any, are defined by the active employee's coverage. When the actively working spouse retires, each retiree is covered under his or her own retiree health benefit, if applicable. Please refer to the Retiree Health and Life Benefits Guide for Retirees of Participating AMR Corporation Subsidiaries (Retiree Benefits Guide or RBG for information specific to each workgroup.

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

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

The actively working spouse may elect to:

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

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

Optional coverage's the person elected as an active employee end, unless payment for these coverage's is continued while on leave.

Proof of good health may be required to re-enroll or increase optional coverage's upon the employee's return to work.

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

Other Information

Eligible dependent children:

- Children cannot be covered under both parents' health benefits.
- If one spouse is covered under the Benefits, the children are covered under the parent with Benefits
- If both spouses are covered under the Benefits Program, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year.

The parent(s) covered under the Benefit program can contact HR Services to elect otherwise. See "Dependent Eligibility Requirements" for additional information.

Contributions: Both you and your spouse may elect to be covered independently under the benefits plans or Options for which you are each eligible. If married employees choose to be covered under one employee, the contributions for the employee covering both will reflect either Employee plus Spouse/Domestic Partner, Employee plus Child(ren) or Employee plus Family, whichever is applicable. This applies to contributions for the Medical and Vision Benefits.

Contributions for benefits that still must be maintained independently, such as Life Insurance (see the Life Insurance section), will be applied appropriately and payroll-deducted from each employee's paycheck.

Family deductibles: If the parents choose different Options, the family deductible applies to the employee covering the children and the individual deductible applies separately to the other parent.

HMO participation: Company-recognized Domestic Partners may be eligible for coverage under your HMO, subject to the HMO's eligibility rules. If your Company-recognized Domestic Partner can be covered under your HMO, you will be able to choose coverage for him or her when you enroll. The decision to offer coverage to Company-recognized Domestic Partners is made by individual HMO plan provisions, not by American. Home-Based Representatives and Level 84 Premium Service Guest Representatives and their dependents are not eligible to enroll in an HMO.

Accident coverage: Both you and your spouse or Company-recognized Domestic Partner must enroll for yourselves (for married employees without children) — you cannot be covered both as an employee and as a dependent. For married employees with dependents, you cannot be covered as an employee and as a dependent; therefore, only the parent who elects medical coverage for the dependent children may elect family accident coverage, and the spouse, Company-recognized Domestic Partner, must waive coverage. If your spouse, Company-recognized Domestic Partner works for an AMR subsidiary that does not offer accident coverage, you may elect Voluntary Personal Accident Insurance Benefit for him or her (see the Accident Insurance Benefits section).

Flexible Spending Accounts: Contributions to the Health Care Flexible Spending Account and/or the Limited Purpose Spending Account (see the Health Care Flexible Spending Account section) and Dependent Care Flexible Spending Account (see the Dependent Care Flexible Spending Account section) may be made by one or both spouses. Either of you may submit claims to the account. However, if only one spouse is making contributions to the account, claims must be submitted under that person's Social Security number. If you both make contributions to the Dependent Care Flexible Spending Account, you may only contribute the maximum amount the law permits for a couple filing a joint tax return. For the Health Care Flexible Spending Account or Limited Purpose Spending Account, you may both make contributions up the maximum allowed by American. You may not file claims for expenses incurred by a Company-recognized Domestic Partner who is an employee of AMERICAN (or his or her dependents) under your Flexible Spending Accounts according to federal law. Company-recognized Domestic Partners who are both AMERICAN employees may each have his or her own Flexible Spending Account.

Health Savings Account: You may not file claims for expenses incurred by a Company-recognized Domestic Partner who is an employee of American (or his or her dependents) under your Health Savings Account according to federal law.

Retiree Medical Benefits: If you are both eligible for benefits, you must each maintain your Retiree Medical Benefits as individuals. By maintaining your Retiree Medical Benefits separately, the death of your spouse or a divorce would not jeopardize your eligibility for Retiree Medical Benefits.

Ineligibility

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

A leased employee, as defined in section 414(n) of the Internal Revenue Code.

This includes any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service, or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker; this term includes any of the following former classifications:

- **Temporary employee**
  - If a temporary worker becomes a regular employee, and meets all of the other requirements to participate in the Benefits Program without a break in service, the time worked as a full-time temporary worker will be credited solely toward the eligibility requirement for life and health coverage. Under no circumstances will time worked as a temporary worker entitle the individual to retroactive group health and welfare benefits.
- **Provisional employee**
- **Associate employee**
- **Independent contractor**

Any person:

- Who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion)
- Who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate
- Whose compensation is reported to the Internal Revenue Service on a form other than a Form W-2, regardless of whether such person was treated as an employee for federal income tax purposes
- Parents or grandchildren. Neither your parents nor grandchildren are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchild's legal guardian).

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

What benefits could I be eligible for?

- Medical Benefit Options
  - Self-Funded Medical Benefit Options Overview
  - Standard Medical Option with HRA
  - Value Medical Option with HIA
  - Core Medical Option with HSA
  - Out-of-Area(OOA) with HRA
  - Health Maintenance Organizations (HMOs)
- Dental Benefits
- Vision Benefits
- Flexible Spending Accounts
  - Health Care Flexible Spending Account (HCFSA)
  - Limited Purpose Flexible Spending Account (LPFSA)
  - Dependent Care Flexible Spending Account (DCFSA)
- Life Insurance Benefits
  - Basic Term Life
  - Voluntary Term Life
  - Spouse and Child Term Life
- Accidental Insurance Benefits
  - Accidental Death and Dismemberment (AD&D)
  - Other Accident Insurance
- Disability Benefits
  - Optional Short-Term (OSTD)
  - Long-Term Disability
- EAP

Medical Benefit Options Overview

This section includes:

- Medical Benefit Options
  - Network/Claims Administrators
  - Administrator's Discretion
- Medical Benefit Options Comparison
- Mid-Year Medical Benefit Option Change: Impact on Deductibles and Out-of-Pocket Maximums
- Mental Health and Chemical Dependency Care
- Gender Reassignment Benefit (GRB)
  - GRB Coverage
  - Surgical Benefit.
  - Travel Reimbursement
  - Preauthorization for the GRB
- Wellness Resources
  - Additional Medical Case Management with Your Network/Claims Administrator
- Covered Expenses
- Excluded Expenses
- CheckFirst (Predetermination of Benefits)
- QuickReview (Pre-Authorization)
- When to Request Approval from Your Network/Claims Administrator

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

These are the available Medical Benefit Options: STANDARD Medical Option, CORE Medical Option, VALUE Medical Option, OUT-OF-AREA Medical Option and HMO Medical Option (if available in your area).

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

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

Medical Benefit Options

You may choose one of the following Plan Options:

- **The STANDARD Medical Option.** The STANDARD Medical Option is self-funded by the Company. Aetna, Blue Cross and Blue Shield of Texas and UnitedHealthcare (UHC) administer this Option. Reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- **The VALUE Medical Option.** The VALUE Medical Option is self-funded by the Company. Aetna, Blue Cross and Blue Shield of Texas and UnitedHealthcare (UHC) administer this Option. Reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- **The CORE Medical Option.** The CORE Medical Option is self-funded by the Company. Aetna, Blue Cross and Blue Shield of Texas and UnitedHealthcare (UHC) administer this Option. Reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- **The OUT-OF-AREA (OOA) Medical Option**. The OOA Option is self-funded by the Company. UnitedHealthcare (UHC) administers this Option. Reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company. If you do not live within any network service area, the Company will offer enrollment in the OOA Option.
- **Health Maintenance Organization (HMO) Medical Option.** HMOs are insured Options whose covered services are paid by the HMO. The Company pays a flat monthly premium and the HMO pays for all covered services. HMOs are offered in many locations, but their coverage and features vary by location. If you live in a location where an HMO is offered, it will be indicated as an Option in the Benefits Service Center when you enroll online. You must go to each HMOs website to read and understand the details of their benefit coverage. See Contact Section in this document for the list of available HMOs for 2014.

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

You may choose from the following coverage levels:

- Employee
- Employee + Spouse/Company-recognized Domestic Partner
- Employee + Child(ren)
- Employee + Family

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

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

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

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

You can only enroll in a medical Option during Annual Benefits Enrollment or if you experience a recognized Life Event during the year (see the Life Events section).

Network/Claims Administrators

The Plan's self-funded Medical Options, STANDARD, VALUE and CORE are administered by three Network/Claims Administrators:

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

The OUT-OF-AREA Medical Option is administered by UnitedHealthcare.

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

Each state has a designated preferred Network/Claims Administrator. Your preferred administrator is determined by the ZIP code of your alternate address on record. If you do not have an alternate address listed in the Update MY Information page of Jetnet, your Network/Claims Administrator is based on your permanent address.

See the sections STANDARD Medical Option, CORE Medical Option, VALUE Medical Option and OUT-OF-AREA Medical Option for more information on Network/Claims Administrators and your medical Option.

Administrator's Discretion

The Plan Administrator may, at its sole discretion, pay benefits for services and supplies not specifically stated under the Plans.

Medical Benefit Options Comparison

The table in this section provides a summary of features under the STANDARD Medical Option, CORE Medical Option, VALUE Medical Option and OUT-OF-AREA Medical Option. Benefits are available for eligible expenses that are medically necessary. Reimbursement for in-network services are based on network-contracted rates while out-of-network services must be within the usual and prevailing (U&P) fee limits. See the Glossary section for a definition of U&P.

For the OUT-OF-AREA Option, benefits are available for eligible expenses that are medically necessary and must be within the usual and prevailing (U&P) fee limits. See the Glossary section for the definition of U&P.

The table shows the amount or percentage you pay for eligible expenses. You also pay any amounts not covered by the Options. You also must satisfy your selected Medical Option's calendar year deductible amount before benefits are payable for medical services subject to co-insurance. There are certain covered expenses that do not require satisfaction of the deductible and these are referenced in the following chart.

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

- For the STANDARD Medical Option, VALUE Medical Option and OUT-OF-AREA Medical Options copayments and coinsurance apply to the annual out-of-pocket maximum. The out-of-pocket maximum does not include deductibles, amounts not covered, or amounts exceeding the U&P fee limits.
- For the CORE Medical Option the out-of-pocket maximum does include the deductible and co-insurance.
- Retail pharmacy and mail order prescription drug co-insurance amounts apply to the out-of-pocket maximum for all Medical Benefit Options. For the Standard, Value and OOA Options any applicable co-payments apply to the out-of-pocket maximum.
- Your eligibility for the OUT-OF-AREA Medical Option is determined by your five-digit ZIP code, whether or not your residence is outside the network access area. Employees living outside the access area are eligible for the OUT-OF-AREA Medical Option. At the time you enroll, the Company will determine whether or not you are eligible for the OUT-OF-AREA Medical Option.

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

Due the Patient Protection and Affordable Care Act (PPACA), with amendments made by the Health Care and Education Reconciliation Act (HCERA), signed into law March 23, 2010, the government has published recommendations of what services should be covered as preventive care. [http://www.uspreventiveservicestaskforce.org] *However, some of these services may not be covered by your Option.* Contact your Network/Claims Administrator for more information about covered services.

All services must be medically necessary. Medical necessity is determined by the Network/Claims Administrator.

Important Facts For You To Know About The Medical Benefit Options Comparison Chart…	
Co-Insurance	This is the percentage of covered expense that you're required to pay. When you see a percentage referenced in the Medical Benefit Options Comparison chart, it is the co-insurance that is your financial responsibility.
Co-Payment, Co-Pay	This is the flat dollar amount of covered expense that you're required to pay. When you see a flat dollar amount in the Medical Benefit Options comparison chart ($100 or less, and associated with physician's visits, maternity care, emergency room expense, etc.), it is the co-pay that is your financial responsibility.
Deductible	For most covered expenses, you must meet your elected Medical Benefit Option's annual (calendar year) deductible amount before you start receiving benefits. Certain covered expenses, however, may be payable even if you haven't yet met your deductible for the calendar year. The Medical Benefit Options Comparison chart references those particular expenses that are payable whether or not you've met your deductible. Unless the covered expenses in the chart specifically state that benefits are payable even if you haven't met your deductible for the calendar year, you should know that you have to meet your deductible before benefits can be paid. Only covered expenses can be used to meet your deductible amount.
HIA - Health Incentive Account (applies to the VALUE Medical Option only)	If you participate in the Healthmatters Rewards wellness program, dollars that you earn will be deposited into your HIA. You can use these funds to help offset out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. If you do not earn Healthmatters Rewards, you will not have an HIA. Funds must be in the account before you can use them.
HAS - Health Savings Account (applies to the CORE Medical Option only)	This account allows you to deposit funds that you may use to help pay your health care costs. If you want to make pre-tax contributions, you must establish your HSA through WageWorks. If you establish your HSA through any other financial institution, your contributions will be after-tax. If you participate in the Healthmatters Rewards wellness program, dollars that you earn will be deposited into your HSA. You can use these funds to help offset out-of-pocket expenses (deductible, co-pay, co-insurance). Funds must be in the account before you can use them. See the CORE Medical Option section for more information.
HRA - Health Reimbursement Account (applies to the STANDARD and OUT-OF-AREA Medical Options only)	This account Is funded if you participate in the Healthmatters Rewards wellness program. Dollars that you earn will be deposited into your HRA. You can use these funds to help offset out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. Funds must be in the account before you can use them.

Important Facts For You To Know About The Medical Benefit Options Comparison Chart…	
Flexible Spending Accounts HCFSA – Health Care Flexible Spending Account	Health Care Flexible Spending Account (For STANDARD, VALUE and OUT-OF-AREA Medical Options only) You can deposit pre-tax dollars into your HCFSA and can use those funds to pay out-of-pocket expenses (deductible, co-pay, co-insurance). The entire amount of your election is available as soon as you make the first deposit into the account. See the Flexible Spending Account section for more information.
LPFSA- Limited Purpose Flexible Spending Account	Limited Purpose Flexible Spending Account (For CORE Medical Option only) You can deposit pre-tax dollars into your LPFSA and can use those funds to pay for dental and vision out-of-pocket expenses (deductible, co-pay, co-insurance). The entire amount of your election is available as soon as you make the first deposit into the account. See the Flexible Spending Account section for more information.
Medical Necessity	ALL of the medical services and supplies described in the Medical Benefit Options Comparison chart must be covered by the Plan and be medically necessary in order to be determined to be covered expenses. If those services and supplies are not medically necessary, they cannot be covered by the Plan.
Out-Of-Pocket/Out-Of-Pocket Maximum	This is the portion of covered expenses (that you have to pay) that must accumulate until it reaches the dollar limit where the Plan begins paying 100% of any further covered expenses for the remainder of the calendar year. Out-of-Pocket maximum never includes expenses that are excluded from coverage, and expenses that exceed the usual and prevailing allowances. For the CORE Medical Option, these expenses include the deductible and your co-insurance. In-network and out-of-network out-of-pocket maximums are accumulated separately. For the STANDARD, VALUE, and OUT-OF-AREA Medical Options, these expenses include your co-pays and co-insurance, but DO NOT INCLUDE your deductible. In-network and out-of-network out-of-pocket maximums are accumulated separately.

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Annual (Calendar Year) Deductibles, Out-of-Pocket Limits, and Maximum Medical Benefit							
HSA- Health Savings Account	Not Available		You can contribute up to: Employee: $3,050 ($3,300 w/ earned Healthmatters rewards) Employee + Child(ren): $6,300 ($6,550 w/ earned Healthmatters rewards) Employee + Covered Spouse/Domestic Partner Family: $6,050 ($6,550 w/ earned HM rewards) Employee + Family: $6,050 ($6,550 w/ earned Healthmatters rewards)		Not Available		Not Available
Your elected employee contributions can be used to pay medical expenses that the CORE Medical Option cannot pay. IRS sets the annual maximum amounts you can contribute and the expenses that are payable/not payable from the HSA. You can earn employer contributions by earning Healthmatters rewards. If you elect your HSA with WageWorks the contributions can be deducted pre-tax from your paychecks, or you can establish it with an external financial institution. (these must be after tax contributions) See the EBG in the CORE Medical Option section for details on how this account works. Note that the HSA maximum contribution referenced above takes into account Healthmatters Rewards that you are eligible to earn in 2014.							
HRA - Health Reimbursement Account	You can earn Healthmatters Rewards up to: Employee: $250 + Spouse/Domestic Partner: $250		Not Available		Not Available		You can earn Healthmatters Rewards up to: Employee: $250 + Spouse/ Domestic Partner: $250
HIA - Health Incentive Account	Not Available		Not Available		You can earn Healthmatters Rewards up to: Employee: $250 + Spouse/Domestic Partner: $250		Not Available

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
HCFSA - Health Care Flexible Spending Account	Up to $2500		Not Available		Up to $2500		Up to $2500
FACTS ABOUT THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) You have your elected amount (up to $2,500) deducted on a pre-tax basis from your paychecks during the calendar year to help pay for expenses your medical, dental, and vision coverage's don't pay (examples are deductibles, coinsurance, copays, amounts exceeding your medical, dental, vision coverage limits, etc.). IRS sets the annual maximum amounts you can contribute, and dictates what types of expenses are payable/not payable from an FSA. See your EBG in the Flexible Spending Account section for details on how this account works.							
Limited Purpose Flexible Spending Account (LPFSA)—	Not Available		Up to $2,500		Not Available		Not Available
FACTS ABOUT THE LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (FSA) You can make pre-tax deductions to your LPFSA (up to $2,500) to help pay for dental and vision care expenses not reimbursed by your medical, dental, and/or vision coverage's (examples are deductibles, coinsurance, copays, amounts exceeding your dental and vision coverage limits, vision correction surgery, dental implants, etc.). The IRS sets the annual maximum amounts you can contribute, and dictates what types of expenses are payable/not payable from an LPFSA. See the EBG under "Health Care Flexible Spending Accounts" for details on how this account works.							
Individual annual deductible	$750	$3,000	$2,000	$4,000	$300	$1,500	$750
FACTS ABOUT THE INDIVIDUAL ANNUAL DEDUCTIBLE • For most covered expenses, the deductible must be met before benefits are payable. Deductible is satisfied with covered expenses that the Medical Option otherwise pays at a *percentage (coinsurance)* of the covered expense. You must pay all of the covered expenses yourself until the amount you've paid equals the deductible amount shown for the calendar year under your elected Medical Option—only then will the Medical Option begin to pay its percentage of the covered expenses. If the Medical Option requires you to pay a *flat dollar amount (copay)* of the covered expense (for physician visits, emergency room, prescription drugs, maternity care), that dollar amount you must pay does NOT count toward your satisfaction of the deductible for the calendar year. You do not have to satisfy your deductible in order to purchase prescription drugs under STANDARD, VALUE and OOA Options. • For some of the Medical Options, some types of *in-network* expenses (such as preventive care, certain physician visits, and certain prescription drugs) are paid by the Medical Option *even if you've not yet satisfied your deductible. These types of expenses are referenced in the chart below.*							

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Family annual deductible	$2,250	$9,000	$4,000	$8,000	$900	$4,500	$2,250
FACTS ABOUT THE FAMILY ANNUAL DEDUCTIBLE For most covered expenses where the Medical Option requires that you pay a *percentage (coinsurance)* of the covered expense. • You must pay all you and your covered dependents' covered expenses yourself until the amount you've paid equals the individual deductible for a covered person or three members of your family have met their individual deductibles. Once three members of your family have met their individual deductibles, the family deductible is deemed satisfied and then the Medical Option will begin to pay its percentage of the covered expense. • You do not have to meet the family deductible under Standard, Value or OOA in order for your Medical Option to begin paying its percentage for a family member that has met his/her individual deductible. • If the Medical Option requires you and your covered dependents to pay a *flat dollar amount (copay)* of the covered expense (for physician visits, emergency room, prescription drugs, maternity care), the dollar amount you must pay will NOT count toward your satisfaction of the deductible. • Some types of *in-network* expenses (such as preventive care, certain physician visits, and certain prescription drugs) are paid by the Medical Option *even if you've not yet satisfied your deductible. These types of expenses are referenced in the chart below.* • **CORE Medical Option:** If more than one person is covered under the CORE Medical Option, the Family deductible must be met before the CORE Medical Option starts to pay benefits. Covered expenses from any and all covered persons can be used to meet the family annual deductible.							
Individual annual out-of-pocket maximum	$2,000 per covered person for covered expenses that require you to pay co-insurance	$6,000	$6,000	$12,000	$2,000 per covered person for covered expenses that require you to pay co-insurance	$6,000	$2,000 per covered person for covered expenses that require you to pay co-insurance
FACTS ABOUT THE INDIVIDUAL OUT-OF-POCKET MAXIMUM • Only each covered individual's portion of covered expenses can be used to meet his/her individual annual out-of-pocket maximum (the point where the coverage will pay 100% of the covered expense for the remainder of the calendar year). • **STANDARD, VALUE and OUT-OF-AREA Medical Options:** Copays and coinsurance counts toward the individual annual out-of-pocket maximum (the limit where this coverage pays benefits at 100% for the remainder of the calendar year). The deductible DOES NOT COUNT toward the annual out-of-pocket maximum. • **CORE Medical Option:** Covered expenses you must pay to satisfy your annual deductible ***ARE USED*** to meet the individual annual out-of-pocket maximum (the limit where this coverage pays benefits at 100% for the remainder of the calendar year). If more than one person is covered, the family out-of-pocket maximum must be							

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
satisfied before expenses are payable at 100%.							
Family out-of-pocket maximum	$5,000	$15,000	$12,000	$24,000	$5,000	$15,000	$5,000
FACTS ABOUT THE FAMILY OUT-OF-POCKET MAXIMUM • **STANDARD, VALUE, and OUT-OF-AREA Medical Options:** Co-pays and coinsurance count toward the family out-of-pocket maximum (the point where this coverage pays benefits at 100% of the covered expense for the remainder of the calendar year for all covered family members). The deductible DOES NOT COUNT toward the annual out-of-pocket maximum. • **CORE Medical Option:** You and your covered dependents' deductibles and covered medical expenses that require you to pay a *percentage* of the cost *(co-insurance)* ARE counted toward the satisfaction of this maximum (the point where the coverage will pay 100% of the covered expenses for the remainder of the calendar year). If more than one person is covered, the family out-of-pocket maximum must be satisfied before expenses are payable at 100%.							
Individual medical maximum benefit	Unlimited for all self-funded Medical Benefit Options						
Preventive Care							
Annual routine physical exams	No cost to you	40%	No cost to you	50%	No cost to you	40%	No cost to you
Well-child care	No cost to you	40%	No cost to you	50%	No cost to you	40%	No cost to you
Medical Care							
Physician's office visit (including X-ray and lab work)	$30 per visit	40%	30%	50%	$20 per visit	40%	20%,
Specialist's office visit	20%	40%	30%	50%	$40 per visit	40%	20%
Retail Clinic visit ie. clinics inside of CVS, Walgreens, Wal-mart, etc.	20%	40%	30%	50%	$40 per visit	40%	20%
Urgent care clinic	20%	40%	30%	50%	$40 per visit	40%	20%

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Gynecological care *(see* **Mammograms** *for coverage information on routine screening or diagnostic mammograms, and see* **Pregnancy** *for coverage information on pregnancy and maternity care)*	No cost to you for annual preventive exam $30 per visit to an OB/GYN diagnostic	40% for treatment of illness/ injury and preventive exam	No cost to you for annual preventive exam 30% for treatment of illness/ injury	50% for treatment of illness/injury and preventive exam	No cost to you for annual preventive exam $20 per visit to an OB/GYN diagnostic	40% for treatment of illness/ injury and preventive exam	No cost to you for annual preventive exam 20% for treatment of illness/injury
Preventive Pap tests: routine screening	No cost to you	40%	No cost to you	50%	No cost to you	40%	No cost to you
Diagnostic Pap tests: test performed for a problem	No cost to you if performed in the doctor's office. Otherwise 20%	40%	30%	50%	No cost to you if performed in the doctor's office. Otherwise 20%	40%	20%
Preventive Mammogram: routine screening done according to national age specific guidelines and regardless of where the service is performed	No cost to you	40%	No cost to you	50%	No cost to you	40%	No cost to you
Diagnostic Mammograms: test performed for a problem	No cost if part of office visit or at an independent facility. 20% if performed in outpatient hospital	40%	30%	50%	No cost to you if part of office visit or at an independent facility. 20% if performed in outpatient hospital	40%	20%

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Pregnancy and Maternity Care: OB-GYN's Charges Only. *Includes prenatal and postnatal care, and delivery charges*	Routine prenatal care, no cost to you. All other services, 20%	40%	Routine prenatal care, no cost to you. All other services3 0%	50%	Routine prenatal care, no cost to you. All other doctor's services, $150 per pregnanc y	40%	Routine prenatal care, no cost to you. All other services, 20%
Pregnancy and Maternity Care: *Hospital and Other Ancillary Charges Only. Includes labor/delivery and postnatal expenses*	20%	40%	30%	50%	20%	40%	20%
Second surgical opinions No cost if ordered by the Plan or claim administrator	20% if elected by participant	40% if elected by participa nt	30% if elected by participant	50% if elected by participant	$40 per visit if elected by participant	40% if elected by participant	20% if elected by participant
Chiropractic care Maximum 20 visits per calendar year per covered family member for both in-network and out-of-network visits combined. Maintenance care is not covered	20%	40%	30%	50%	$40 per visit	40%	20%
Speech, physical, occupational, restorative and rehabilitative therapy, if medically necessary *Therapies for developmental disorders are not covered*	20%	40%	30%	50%	$40 per visit	40%	20%

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Allergy Care							
Physician's office visit for allergy care	If PCP: $30 per visit If Specialist: 20%	40%	30%	50%	If PCP – $20 per visit If Specialist – $40 per visit	40%	20%
Allergy testing, shots or serum	20% No cost for Allergy testing performed in the doctor's office	40%	30%	50%	No cost to you if administered in physician's office. $20 per visit if PCP office visit is charged. If Specialist – $40 per visit	40%	20%
Outpatient Services							
Diagnostic X-ray and lab	No cost to you if performed at doctor's office or non-hospital imaging center/lab 20% if at hospital	40%	30%	50%	No cost to you if performed doctor's office or non-hospital imaging center/lab ; 20% if at hospital	40%	20%
Outpatient surgery in physician's office Pre-authorization is recommended to ensure medical necessity; see "CheckFirst"	PCP – $30 per visit. If Specialist – 20%	40%	30%	50%	PCP – $20 per visit. If Specialist – $40 per visit	40%	20%

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Outpatient surgery in a hospital or freestanding surgical facility Pre-authorization is recommended to ensure medical necessity; see CheckFirst	20%	40%	30%	50%	20%	40%	20%
Pre-admission testing	No cost if performed at lab or in doctor's office; 20% if at hospital	40%	30%	50%	No cost if performed at lab or in doctor's office; 20% if at hospital	40%	20%
Hospital Services							
Inpatient room and board	20%	40%	30%	50%	20%	40%	20%
Intensive care unit and special care unit	20%	40%	30%	50%	20%	40%	20%
Ancillary services, including radiology, pathology, operating room and supplies	20%	40%	30%	50%	20%	40%	20%
Newborn nursery care	20%	40%	30%	50%	20%	40%	20%

FACTS ABOUT NEWBORN NURSERY CARE

• This care is considered under the baby's coverage, not the mother's; therefore, the baby must be enrolled in coverage for his/her newborn claims to be covered.

• Within 60 days of the birth, you must process a Life Event change online through Benefits Service Center to enroll your baby in your health coverage. If you do not, you must wait until the next Annual Benefits Enrollment period to enroll your baby.

• Payment of maternity claims does not automatically enroll your baby.

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Surgery and related expenses (such as anesthesia and medically necessary assistant surgeon)	20%	40%	30%	50%	20%	40%	20%
Blood transfusions	20%	40%	30%	50%	No cost to you if performed in doctor's office; 20% if at hospital	40%	20%
Organ transplants	20%	40%	30%	50%	20%	40%	20%
Emergency ambulance	20%	20%	30%	30%	No cost to you	No cost to you	20%
Emergency room	$100 copay PLUS 20% on full amount allowed on the bill	$100 copay, PLUS 20% on full amount allowed on the bill Non Emergency - $100 copay PLUS 40% on full amount allowed	30%	50%	$100 copay, PLUS 20% on full amount allowed on the bill	$100 copay, PLUS 20% on full allowed amount of the bill Non Emergency- $100 copay PLUS 40% on full amount allowed	$100 copay, PLUS 20% on full allowed amount of the bill
FACTS ABOUT EMERGENCY ROOM CLAIMS **STANDARD, VALUE, and OUT-OF-AREA Medical Options:** If you're admitted to the hospital as an inpatient directly from the emergency room, the $100 copay is waived, and you are only required to pay any amount needed to meet your deductible and your percentage of the covered expense							

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Out-of-Hospital Care							
Convalescent and skilled nursing facilities following hospitalization Within 15 days of hospitalization. Maximum of 60 days per illness/injury for in-network and out-of-network facilities combined	20%	40%	30%	50%	20%	40%	20%
Home health care	20%	40%	30%	50%	No cost to you when approved by your network adminis-trator	40%	20%
Hospice care	20%	40%	30%	50%	20%	40%	20%
Other Services							
Tubal ligation (Reversals are not covered)	No cost to you	40%	No cost to you	50%	No cost to you	40%	No cost to you
Vasectomy (Reversals are not covered)	If PCP - $30; If Specialist - 20%	40%	30%	50%	If PCP - $20; If Specialist - $40; otherwise, 20%	40%	20%
Infertility treatment, including in-vitro fertilization	Not covered by any of the self-funded Medical Benefit Options						
Radiation therapy and chemotherapy	20%	40%	30%	50%	No cost to you if in physician's office; otherwise, 20%	40%	20%
Kidney dialysis	20%	40%	30%	50%	No cost to	40%	20%

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
(If the dialysis continues more than 12 months, participant must apply for Medicare)					you if in physician' s office; otherwise, 20%		
Supplies, equipment and durable medical equipment (DME)	20%	40%	30%	50%	20%	40%	20%
FACTS ABOUT SUPPLIES, EQUIPMENT, DME Your cost is the percentage shown above, regardless of where the device is purchased, and is *in addition to* any physician's visit costs you're required to pay.							
Mental Health Benefits - No Treatment Limits(benefits are the same as for any other illness or injury) **EAP approval IS NOT REQUIRED for any cases NOT resulting from regulatory or Company policy violations** **EAP approval IS REQUIRED for all cases resulting from regulatory or Company policy violations.**							
Inpatient mental health care	20%	40%	30%	50%	20%	40%	20%
Alternative mental health care center — residential treatment	20%	40%	30%	50%	20%	40%	20%
Alternative mental health care center – intensive outpatient and partial hospitalization	20%	40%	30%	50%	20%	40%	20%
Outpatient mental health care	$30 per visit for PCP 20% for Specialist and outpatient hospital	40%	30%	50%	$20 per visit for PCP; $40 per visit for Specialist; 20% outpatient hospital	40%	20%

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Marriage/ relationship/ family counseling	Not covered by any of the self-funded Medical Benefit Options						
Chemical Dependency Benefits - No Treatment Limits (benefits are the same as for any other illness or injury) EAP approval IS NOT REQUIRED for any cases NOT resulting from regulatory or Company policy violations EAP approval IS REQUIRED for all cases resulting from regulatory or Company policy violations.							
Detoxification	20%	40%	30%	50%	20%	40%	20%
Inpatient chemical dependency rehabilitation	20%	40%	30%	50%	20%	40%	20%
Outpatient chemical dependency rehabilitation	$30 per visit if PCP; 20% if Specialist or outpatient facility	50%	30%	50%	$20 per visit PCP; $40 per visit Specialist; 20% outpatient facility	40%	20%
Gender Reassignment Benefit (Cumulative maximum benefit for surgery is $75,000. The cumulative maximum benefit for travel is $10,000)							
Surgery One bilateral mastectomy or bilateral augmentation mammoplasty AND One genital revision surgery	20%	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Travel Expenses For yourself and one caregiver to travel to the network facility and for time while you're hospitalized/ receiving medically necessary outpatient care following surgery	No cost to you, up to $10,000	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Non-Surgical	Covered as any other	Not	Not	Not	Not	Not	Not Covered

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Treatments Physician's visits Specialist visits Outpatient mental health care X-rays and lab work Retail prescription drugs Mail order prescription drugs	illness or injury under the Plan; see the sections of this chart (named to the left under the "Features" column for details on how these covered expenses are paid	Covered	Covered	Covered	Covered	Covered	
Prescription Medication							
RETAIL Pharmacy (typically a 30-day supply)	**Generic:** ▪ 20% ▪ $10min ▪ $40 max **Preferred Brand:** ▪ 30% ▪ $30 min ▪ $100 max **Non-Pref Brand:** ▪ 50% ▪ $45 min ▪ $150 max	**Generic:** ▪ 20% ▪ $10 min ▪ $40 max **Preferred Brand:** ▪ 30% ▪ $30 min ▪ $100 max **Non-Pref Brand:** ▪ 50% ▪ $45 min ▪ $150 max	30% after deductible New preventive list for 2014		**Generic:** ▪ $10 per Rx **Preferred Brand:** ▪ 30% ▪ $20 min ▪ $75 max **Non-Pref Brand:** ▪ 50% ▪ $35 min ▪ $90 max	**Generic:** ▪ $10 per Rx **Preferred Brand:** ▪ 30% ▪ $20 min ▪ $75 max **Non-Pref Brand:** ▪ 50% ▪ $35 min ▪ $90 max	**Generic:** ▪ 20% ▪ $10 min ▪ $40 max **Preferred Brand:** ▪ 30% ▪ $30 min ▪ $100 max **Non-Pref Brand:** ▪ 50% ▪ $45 min ▪ $150 max
	Prescriptions are not subject to deductible		Preventive medications are not subject to deductible		Prescriptions are not subject to deductible		

FACTS ABOUT THE RETAIL PRESCRIPTION COVERAGE

• **Generic vs Preferred or Non-Preferred for STANDARD, VALUE, and OUT-OF-AREA Medical Options:** If you select a non-Preferred brand medication when a generic equivalent is available, you'll pay the generic copay or co-insurance PLUS the difference between the generic and non-Preferred brand costs, maximums do not apply.

• **Retail Refill Allowance for all Medical Benefit Options:** This allowance refers to maintenance medications—beginning with your fourth purchase (or earlier), you should switch your prescriptions to Express Scripts Mail Order. This coverage allows retail coverage at the stated percentages for the first three fills of each maintenance prescription drug. If you continue to fill your maintenance prescriptions at retail pharmacies

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
beyond this three fill allowance, you'll have to pay 50% of the cost with no maximum. See the "Prescription Drug Benefits" section under your *Medical Benefit Option* section for your elected Medical Benefit Option. • If you fill your prescriptions at an out-of-network retail pharmacy, your benefit will be based on the Express Scripts in-network discounted rate, which means the amount you'll have to pay for your prescription will be greater than if you used an in-network retail pharmacy.							
MAIL ORDER through Mail Order (typically a 90 day supply)	**Generic:** ▪ 20% ▪ $5 min ▪ $80 max **Preferred Brand:** ▪ 30% ▪ $60 min ▪ $200 max **Non-Preferred Brand** ▪ 50% ▪ $90 min ▪ $300 max	Not covered	30% after the deductible	Not covered	**Generic:** ▪ 20% ▪ $0 min ▪ $80 max **Preferred Brand:** ▪ 30% ▪ $40 min ▪ $150 max **Non-Preferred Brand** ▪ 50% ▪ $70 min ▪ $180 max	Not covered	**Generic:** ▪ 20% ▪ $5 min ▪ $80 max **Preferred Brand:** ▪ 30% ▪ $60 min ▪ $200 max **Non-Preferred Brand** ▪ 50% ▪ $90 min ▪ $300 max
FACTS ABOUT MAIL ORDER PRESCRIPTION COVERAGE: • **Generic vs Non-Preferred for STANDARD, VALUE, and OUT-OF-AREA Medical Options:** If you select a r non-Preferred brand medication when a generic equivalent is available, you'll pay the generic co-pay/coinsurance PLUS the difference between the generic and non-Preferred brand costs (maximums do not apply). • For mail order prescriptions, you *must* purchase through ESI Mail Order; otherwise, you'll have to pay 100% of the cost yourself and the plan will not pay any of the cost.							
Specialty Medications	For certain specialty medications, you *must* obtain them from Accredo (Express Scripts specialty mail order pharmacy) or an in-network retail pharmacy; otherwise, you'll have to pay 100% of the cost yourself and the plan will not pay any of the cost. Contact Express Scripts to find out if your specialty medication is only covered under the prescription drug benefit.						
Oral contraceptives	Oral contraceptives, transdermal and intravaginal contraceptives are covered at 100% by ESI Mail Order only. This includes both generic and brand name (Preferred or non-Preferred) contraceptives. If you purchase at a retail pharmacy, the plan will not pay any of the cost. If you purchase a brand name contraceptive at Mail Order when a generic equivalent is available, you will be responsible for the cost difference between generic and brand.						
Fertility (infertility) medications	Medications used to treat infertility or to promote fertility are not covered by any of the self-funded Medical Benefit Options.						

Features	Standard Medical Option		Core Medical Option		Value Medical Option		OOA Medical Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Over-the-counter medication (OTC)	Over-the-counter medications are not covered under the Medical Options. See the "Prescription Drug Benefits" section under your *Medical Benefit Option* section for information about certain coverage allowances.						
Other Information							
Pre-determination of benefits	Recommended before hospitalization and surgery for all the self-funded Medical Benefit Options						
Hospital pre-authorization	Required for hospitalization and recommended before outpatient surgery						

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

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

- move from one American Airlines workgroup to another, or
- move from American Airlines to another AMR Corporation Subsidiary, or
- relocate and your Medical Option is no longer available in your new location, or
- retire, or
- you or your dependents move from Active coverage to COBRA coverage.

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

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

If…	Your Deductible and Out-of-Pocket Maximum…
You transfer/relocate and you have to select a new Medical Benefit Option because your existing Medical Benefit Option is not offered in your transfer/relocation area	**will not** carry over
You move between AMR Corporation Subsidiaries	**will not** carry over
You retire and move from Active coverage to Retiree coverage	**will not** carry over
You or your dependent(s) move from Active to COBRA continuation coverage	**will** carry over

In the event you experience a mid-year change, you must contact People Services to determine if your deductibles and out-of-pocket maximums will carryover and if you need to provide information to your Network/Claims Administrator.

Mental Health and Chemical Dependency Care

Regardless of the Medical Benefit Option you elect, each Network/Claims Administrator uses its own mental health care management vendor:

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

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

Inpatient mental health care: When you use in-network providers under the Medical Benefit Options for hospitalization for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses (see "Covered Expenses" in this section).

Alternative mental health care center – residential treatment: Under the STANDARD Medical Option, such treatment is covered at 80% (after deductible is met) when you use in-network providers and at 60% when you use out-of-network providers.

- Under the VALUE Medical Option, such treatment is covered at 80% (after deductible is met) when you use in-network providers and at 60% when you use out-of-network providers.
- Under the CORE Medical Option, such treatment is covered at 70% when you use in-network providers and at 50% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Option, such treatment is covered at 80%.

Alternative mental health care center – intensive outpatient and partial hospitalization: Under the STANDARD Medical Option, such treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers.

- Under the VALUE Medical Option, such treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers.
- Under the CORE Medical Option, such treatment is covered at 70% when you use in-network providers and at 50% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Option, such treatment is covered at 80%.

Outpatient mental health care (physician's office): Under the STANDARD Medical Option, such treatment is covered at 80% after the deductible is met when you use in-network providers and at 60% when you use out-of-network providers.

- Under the VALUE Medical Option, a $40 per visit co-pay applies when you use in-network providers and the service is covered at 60% when you use out-of-network providers.
- Under the CORE Medical Option, such treatment is covered at 70% when you use in-network providers and at 50% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Option, such treatment is covered at 80%.

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

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

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

- Under the STANDARD Medical Option, inpatient and outpatient treatment is covered at 80%.
- Under the VALUE Medical Option, inpatient treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers. For outpatient treatment through an in-network provider under the VALUE Medical Option, the co-pay is $20 per PCP visit and $40 per specialist visit. Outpatient treatment is covered at 60% when you use out-of-network providers.
- Under the CORE Medical Option, inpatient treatment is covered at 70% when you use in-network providers and at 50% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Option, inpatient and outpatient treatment is covered at 20% when you use in-network providers.

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

- Under the VALUE Medical Option, such treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers.
- Under the CORE Medical Option, such treatment is covered at 70% when you use in-network providers and 50% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Option, such treatment is covered at 20% when you use in-network providers.

Gender Reassignment Benefit (GRB)

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

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

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

The GRB is offered under the STANDARD Medical Option only:

Coverage for surgical benefits under the GRB is limited to $75,000, regardless of your Network/Claims Administrator, even if you change administrators. This $75,000 GRB is available to the employee or retiree only one time during the entire time the employee or retiree is covered under the Plan.

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

The GRB is not offered out-of-network

GRB Coverage

The Plan pays the following benefits:

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

Surgical Benefit

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

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

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

Travel Reimbursement

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

Preauthorization for the GRB

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

See “CheckFirst (Predetermination of Benefits)” and “QuickReview (Pre-Authorization)”

Wellness Resources

Wellness programs and resources are available to American Airlines employees. Eligibility, including family member participation, varies by program. See http://www.my.aa.com/en/Healthmatters for more information.

These programs and services are not part of the American-sponsored health and welfare plans. They are offered at no cost to participants, and participation is completely voluntary and confidential.

Additional Medical Case Management with Your Network/Claims Administrator

In addition to the programs listed in the Wellness Resources section, participants in the self-funded Medical Benefit Options also have access to medical case management through their Network/Claims Administrator. Medical case management offers access to health professionals who can answer your health questions, refer you to health resources for information and help you navigate the health care system.

Contact your Network/Claims Administrator at the member services website or call (see “Contact Information” in the *Reference Information* section).

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

Covered Expenses

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

Quick Tip

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

For a list of items that are excluded from coverage, see “Excluded Expenses”.

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

Allergy care: Charges for medically necessary physician’s office visits, allergy testing, shots and serum are covered. See “Excluded Expenses” for allergy care not covered.

Ambulance: Medically necessary professional ambulance services and air ambulance once per illness or injury to and from:

- The nearest hospital qualified to provide necessary treatment in the event of an emergency
- The nearest hospital or convalescent inpatient care
- An in-network hospital, if you are covered under any Medical Option and your Network/Claims Administrator authorizes the transfer

Ambulance services are only covered in an emergency and only when care is required en route to or from the hospital. Air ambulance services are covered when medically necessary services cannot be safely and adequately performed in a local facility and the patient’s medical condition requires immediate medical attention for which ground ambulance services might compromise the patient’s life.

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

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

Assistant surgeon: Only covered when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst pre-determination procedure.

Blood: Coverage includes blood, blood plasma and expanders. Benefits are paid only to the extent that there is an actual expense to the participant.

Chiropractic care: Coverage includes medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered. You are limited to 20 visits per year for combined in-network and out-of-network chiropractic care.

Convalescent or skilled nursing facilities: To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital for a covered inpatient hospital confinement and be recommended by your physician for the condition that caused the hospitalization. Eligible expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement and your Network/Claims Administrator must approve your stay. Maximum benefit is 60 days per illness or injury for network and out-of-network facilities. Custodial care is not covered.

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

- As a result of a non-work related injury.
- For replacement of diseased tissue surgically removed.
- Other cosmetic surgery is not covered because it is not medically necessary.

Dental expenses for medically necessary dental examination, diagnosis, care and treatment of one or more teeth, the tissue around them, the alveolar process or the gums, only when care is rendered for:

Accidental injury(ies) to sound natural teeth, in which both the cause and the result are accidental, due to an outside and unforeseen traumatic force,

Fractures and/or dislocations of the jaw, or

Cutting procedures in the mouth (this does not include extractions, dental implants, repair or care of the teeth and gums, etc., unless required as the result of accidental injury, as stated in the first bullet above)

Detoxification: Detoxification is covered as any other medical condition. Contact your Network/Claims Administrator for authorization.

Dietician services: Dietician services are covered under the STANDARD Medical Option, CORE Medical Option, VALUE Medical Option or OUT-OF-AREA Medical Option.

Durable medical equipment (DME): Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its Option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME and/or components (such as batteries or software) resulting from normal wear and tear is not covered. Examples of DME are items such as CPAP or BiPAP machines, wheelchairs, hospital beds, nebulizers, oxygen concentrators, TENS units, passive range of motion devices, joint cooling devices, bone stimulators, etc.

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

Emergency room: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. You must call your Network/Claims Administrator for QuickReview approval within 48 hours of an emergency resulting in admission to the hospital.

Eyeglasses or contact lenses: If cataract surgery is performed, coverage is available for the first pair of eyeglasses or contact lenses required after cataract surgery. For all other vision care, see the Vision Insurance Benefit section.

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

Gender reassignment/sex changes: Covered under the Gender Reassignment Benefit (GRB) under the STANDARD Medical Option. It is not covered under VALUE Medical Option, CORE Medical Option or OUT-OF-AREA Medical Option.

Hearing care: Covered expenses include medically necessary hearing exams performed by an audiologist or physician and medically necessary hearing aids. Replacement hearing aids are allowed once every 36 months and the maximum allowable for replacement is $3,500 per hearing aid. Cochlear implants and/or osseointegrated hearing systems are covered only if medically necessary.

Hemodialysis: Coverage provided for medically necessary hemodialysis.

Home health care: Home health care, when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. Custodial care is not covered. You should call your Network/Claims Administrator to initiate the QuickReview process to be sure home health care is considered medically necessary.

Hospice care: Eligible expenses medically necessary for the care and treatment of a terminally ill covered person. Expenses in connection with hospice care include both facility and outpatient care. Hospice care is covered when approved by your Network/Claims Administrator. You should contact your Network/Claims Administrator to initiate the QuickReview process.

Inpatient room and board expenses: Eligible expenses are based on the negotiated rates with that particular in-network hospital. For out-of-network, eligible expenses are determined based on the most common semiprivate room rate in that geographic area.

Intensive care, coronary care or special care units (including isolation units): Coverage includes room and board and medically necessary services and supplies.

IUD: Insertion or removal of an IUD. Covered if performed in an in-network physician's office (covered as outpatient surgery). Service not covered out-of-network.

Laboratory or pathology expenses: Coverage is provided for medically necessary diagnostic laboratory tests. In-network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility. If you use an in-network, non-hospital facility (doctor's office, lab, etc.), then these services are covered at 100%.

Mammograms (diagnostic - required as part of a work-up for symptoms or a problem): Diagnostic mammograms are covered, regardless of age under all Medical Options both in-network and out-of-network.

Mammograms (routine screening or preventive): In-network, routine screening mammograms are covered under all Medical Options at 100%.

Out-of-network, routine screening mammograms are covered:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared,
- Once every year from ages 40 and up as recommended by your physician.

Mastectomy: Medically necessary mastectomy and certain reconstructive and related services after a mastectomy are covered. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:

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

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

- Oxygen, blood and plasma
- Sterile items including sterile surgical trays, gloves and dressings
- Needles and syringes
- Colostomy bags
- Diabetic supplies, including needles, chem-strips, lancets and test tape covered under the prescription drug benefit
- Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered

Multiple surgical procedures: Reimbursement for multiple surgical procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. In-network surgeries are based on the network provider's contractor rates. Out-of-network surgeries are based on Usual and Prevailing (U&P) fee limits. To determine the amount of coverage, and to be sure the charges are within the usual and prevailing fee limits, contact your Network/Claims Administrator to use the CheckFirst pre-determination program.

Newborn nursery care: The hospital expenses for a newborn baby are considered under the baby's coverage, not the mother's. The hospital expenses for a newborn baby are covered, provided you timely process a Life Event. To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. If you miss the 60-day deadline you will not be able to add your baby to your coverage until the next Annual Benefits Enrollment period, even if you already have other children enrolled in coverage. The filing or payment of a maternity claim does not automatically enroll the baby.

Oral surgery: Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process, only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the Medical Option will pay room and board, anesthesia and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the Medical Options. However, they may be covered under the Dental Benefit.

Outpatient surgery: Charges for services and supplies for a medically necessary surgical procedure performed on an outpatient basis at a hospital, freestanding surgical facility or physician's office. You should pre-authorize the surgery through your Network/Claims Administrator to initiate the QuickReview process to ensure the procedure is medically necessary.

Physical or occupational therapy: Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a physician. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered.

Physician's services: Office visits and other medical care, treatment, surgical procedures and post-operative care for medically necessary diagnosis or treatment of an illness or injury. The Medical Benefit Options cover office visits for certain preventive care, as explained under Preventive Care.

Pregnancy: Charges in connection with pregnancy, only for female employees and female spouses/Company-recognized Domestic Partners. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed or certified by the state in which he or she practices.

- Within the first 12 weeks of pregnancy, you should call ActiveHealth Management to participate in the MaternityMatters pregnancy program if you are enrolled in the self-funded plans. This is offered at no cost to employees and their covered dependents.
- Routine prenatal expenses are covered at 100% in-network. Labor, delivery and post-natal expenses are covered by the applicable co-insurance percentage.
- Employees enrolled in an HMO should contact their HMO.
- Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority.
- Prescription prenatal vitamin supplements are covered by Medical Benefit Options.
- Federal law prohibits the Plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery, or from requiring your provider to obtain pre-authorization for a longer stay. However, federal law does not require you to stay any certain length of time. If, after consulting with your physician, you decide on a shorter stay, benefits will be based on your actual length of stay.
- Charges in connection with pregnancy for covered dependent children are covered only if due to certain complications of pregnancy, for example: ectopic pregnancy, hemorrhage, toxemia, placental detachment and sepsis.

Prescription drugs: Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition.

- This includes Preventive OTC covered with a prescription if required by ACA.
- Prescriptions for the treatment of obesity or weight control are covered only for the diagnosis of morbid obesity. Oral contraceptives, transdermal, and intravaginal contraceptives are covered by mail order only.
- Medications provided, administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit with the exception of certain specialty medications that are only covered under the prescription drug benefit.
- Medications that are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy are covered as part of the facility's ancillary charges.
- Medications that are administered as part of home health care.
- Diabetic supplies, including insulin, needles, chem-strips, lancets and test tape. These diabetic supplies are covered at 100% if purchased from ESI or a network pharmacy under your prescription drug benefit.
- Medications or products used for smoking or tobacco as determined by the participation in the Healthmatters smoking cessation program

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

Preventive care: Covers preventive care, including well-child care, immunizations, routine screening mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages. Non-routine tests for certification, sports or insurance are not covered unless medically necessary.

Private duty nursing care: Coverage includes medically necessary care by a licensed nurse in a home setting.

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

Radiology (X-ray): Examination and treatment by X-ray or other radioactive substances, imaging/scanning (MRI, PET, CAT and ultrasound), diagnostic laboratory tests and routine mammography screenings for women (see "Mammograms" in this section for guidelines).

In-network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility. If you use an in-network, non-hospital facility (doctor's office, imaging center, etc.), then these services are covered at 100%.

Reconstructive surgery: Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:

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

Retail Clinic Visits: If you go to an in-network retail clinic (such as Minute Clinic in CVS stores, Healthcare Clinics in Walgreens stores, the Clinic at WalMart, etc.) and you are enrolled in the the Standard/OOA medical Otion for health care services, the eligible expense is subject to the deductible and co-insurance, and is not paid as a co-payment.

Speech therapy: Restorative and rehabilitative care and treatment for loss or impairment of speech when the treatment is medically necessary because of an illness (other than a mental, psychoneurotic or personality disorder), injury or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered.

Surgery: When medically necessary and performed in a hospital, freestanding surgical facility or physician's office. (See "CheckFirst (Predetermination of Benefits)" for details about hospital pre-authorization and pre-determination of benefits.)

Temporomandibular joint dysfunction (TMJD): Eligible expenses under the medical benefits include only the following, if medically necessary:

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

- Temporomandibular joint replacement, ONLY if ALL of the following conditions are met:
  - It is the treatment of last resort ("salvage" treatment)
  - It has been documented by clinical records that all other medically appropriate lesser treatments have been performed and have failed (and the failure is not due to patient non-compliance)
  - The prosthetic implant system being used is a total implant system manufactured by either TMJ Concepts, Inc. or Walter Lorenz Surgical, Inc.
  - The patient meets all generally accepted medical/surgical criteria for total replacement of the TMJ
  - The TMJ replacement is not used on an experimental or investigational basis

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

Transplants: Expenses for transplants or replacement of tissue or organs if they are medically necessary and not experimental, investigational or unproven services. Benefits are payable for natural or artificial replacement materials or devices.

Donor and recipient coverage is as follows:

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

The following transplants are covered if they are medically necessary for the diagnosed condition and are not experimental, investigational, unproven or otherwise excluded from coverage under the Medical Options, as determined in the sole discretion of the Plan Administrator and its delegate, the claims processor:	
Artery or vein	Kidney
Bone	Kidney and pancreas
Bone marrow or hematopoietic stem cell	Liver
Cornea	Liver and kidney
Heart	Liver and intestine
Heart and lung	Lung
Heart valve replacements	Pancreas
Implantable prosthetic lenses in connection with cataract surgery	Pancreatic islet cell (allogenic or autologous)
Intestine	Prosthetic bypass or replacement vessels
	Skin
This is not an all-inclusive list. It is subject to change. Contact your Network/Claims Administrator for more information.	

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

Transportation expenses: Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip is covered for any illness or injury and will be covered only if medical attention is required en route.

For information on ambulance services, see “Ambulance” in this section.

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

Urgent/immediate care: Charges for services and supplies provided at an Urgent Treatment Clinic are covered. In order to receive the in-network benefit level, you should contact your network provider or your Network/Claims Administrator if you go to an out-of-network provider within 48 hours to ensure that you receive the in-network level of benefits.

Well-child care: Initial hospitalization following birth, immunizations, and well-child care visits.

Wigs and hairpieces: Eligible expense for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery or severe burns. Only one wig or hairpiece benefit is covered under the Plan for the entire time the individual is covered. This benefit is subject to the usual and prevailing fee limits, deductibles, co-pays, co-insurance and out-of-pocket limits of the selected Medical Option. The maximum benefit available for wigs and hairpieces is $350. Replacement wigs or hairpieces are not covered, regardless of any change in the patient’s physical condition. Hair transplants, styling, shampoo and accessories are also excluded.

Excluded Expenses

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

Allergy testing: Specific testing (called provocative neutralization testing or therapy), which involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

Alternative and/or Complementary medicine: Evaluation, testing, treatment, therapy, care and medicines that constitute alternative or Complementary medicine, including but not limited to herbal, holistic and homeopathic medicine.

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

Care not medically necessary: All services and supplies considered not medically necessary.

Cosmetic treatment: Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction and sclerotherapy for varicose veins or spider veins).

Cosmetic surgery: Unless medically necessary and required as a result of accidental injury or surgical removal of diseased tissue.

Counseling: All forms of marriage and family counseling.

Custodial care: Custodial care is not covered.

Custodial care items: Custodial care items such as incontinence briefs, liners, diapers and other items when used for custodial purposes are not covered, unless provided during an inpatient confinement in a hospital or convalescent or skilled nursing facility.

Developmental therapy for children: Charges for all types of developmental therapy.

Dietician services: Dietician services are excluded if you use an out-of-network provider. Contact your in-network provider to determine the services that are covered.

Ecological and environmental medicine: See “Alternative and/or Complementary Medicine” in this section.

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

Experimental, Investigational or Unproven treatment: Medical treatment, procedures, drugs, devices or supplies that are generally regarded as experimental, investigational or unproven, including, but not limited to:

- Treatment for Epstein-Barr Syndrome
- Hormone pellet implantation
- Plasmapheresis

See the Experimental, Investigational or Unproven Treatment definition in the Glossary under the *Reference Information* section.

Eye care: Eye exams, refractions, eyeglasses or the fitting of eyeglasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training and vision therapy.

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

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

Gender reassignment/sex changes: Covered under the STANDARD Medical Option only. Any expenses received from an out-of-network provider will not be payable. There is no coverage under the GRB for spouses, Company-recognized Domestic Partners or any other eligible dependents.

Government-paid care: Care, treatment, services or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

Infertility treatment: Expenses or charges for infertility treatment or testing and charges for treatment or testing for hormonal imbalances that cause male or female infertility, regardless of the primary reason for hormonal therapy.

- Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction and infertility drugs such as, for example, Clomid or Pergonal, are also excluded.
- Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.

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

Massage therapy: All forms of massage and soft-tissue therapy, regardless of who performs the service.

Medical records: Charges for requests or production of medical records.

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

Nursing care:

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

Organ donation: Expenses incurred as an organ donor, when the recipient is not covered under the Plan. For additional information, see "Transplant" under "Covered Expenses".

Prescription Drugs:

- Drugs that are not required to bear the legend "Caution-Federal Law Prohibits Dispensing Without Prescription"
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
- Contraceptive drugs, patches or implants purchased from retail pharmacies (these are available through mail order only)
- Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy); however the Plan does provide coverage for Folic Acid and pediatric multivitamins with Fluoride in accordance with the Affordable Care Act.
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Drugs used to treat infertility or to promote fertility
- Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs not approved by the Food and Drug Administration (FDA) or experimental drugs, even though the individual is charged for such drugs
- Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis
- Medications or products used for smoking or tobacco use cessation. The only exception is through the participation in smoking cessation program through Healthmatters.

Pregnancy for dependents: Prenatal care and delivery charges are excluded for covered dependent children unless the charges are due to certain complications. Examples of covered complications include ectopic pregnancy, hemorrhage, toxemia, placental detachment and sepsis. (dependents of employees residing Massachusetts, see "Notice for Employees Who Work in (Are Based in) Massachusetts" in the *Standard Medical Option* section)

Preventive care: Not all preventive care may be covered. Consult your Network/Claims Administrator to learn what preventive care is not covered.

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

Sleep disorders: Treatment of sleep disorders, unless it is considered medically necessary.

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

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

TMJD: Except as described in "Covered Expenses", diagnosis or treatment of any kind for temporomandibular joint disease or disorder (TMJD), or syndrome by a similar name, including orthodontia, crowns, bridges or orthodontic procedures to treat TMJD.

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

Usual and prevailing: Any portion of fees for physicians, hospitals and other providers that exceeds the usual and prevailing fee limits. This applies to out-of-network expenses under all Medical Options and all expenses incurred under OOA.

War-related: Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.

Weight reduction: Hospitalization, surgery, treatment and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact your Network/Claims Administrator (or HMO if applicable) to determine if treatment is covered.

Wellness items: Items that promote well-being and are not medical in nature and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas and health club memberships).

Also excluded are:

- Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning
- Services related to vocation, including but not limited to: physical or FAA exams, performance testing and work hardening programs

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

CheckFirst (Predetermination of Benefits)

Check First allows you to find out if:

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

If you are receiving discounted provider's fees, or if are using in-network providers, the provider's fees are not subject to usual and prevailing fee limits. However, you may want to contact your Network/Claims Administrator at the appropriate CheckFirst number for your Medical Option to determine if the proposed services are covered under your selected Medical Option.

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

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

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

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

Multiple surgical procedures: If you are having multiple surgical procedures performed at the same time, any procedure that is not the primary reason for surgery is covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgeon. You must use CheckFirst to find out how the Plan reimburses the cost for any additional procedures.

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

QuickReview (Pre-Authorization)

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

When to Request Approval from Your Network/Claims Administrator

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

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

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

If you are using in-network providers, your provider will call for you. If you are using out-of-network providers, you must call yourself (or a family member can call on your behalf).

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

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

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

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

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

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

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

Standard Medical Option

This section includes:

- How the Standard Medical Option Works
  - Network/Claims Administrator
  - In-Network Services
  - Out-of-Network Services
  - Other Information
  - Features of the Standard Medical Option
- Covered and Excluded Expenses
- Filing Claims
- Claims Filing Deadline
- Prescription Drug Benefits
- Retail Drug Coverage
  - Filling Prescriptions and Filing Claims
  - Filing Claims for Prescriptions
    - Retail Refill Allowance — Long-Term Medications
  - Retail Prescription Clinical Programs
  - Generic Drugs .
  - Prior Authorization
  - Specialty Pharmacy Services
  - ESI Mail Order
  - Mail Order Prescription Clinical Programs
  - Generic Drugs
  - Ordering Prescriptions by Mail
  - Internet Refill Option
  - Other Refill Options
  - Claims Filing Deadline
  - Reimbursement of Co-insurance
- Health Reimbursement Account
- Notice for Employees Who Work in (Are Based in) Massachusetts

The STANDARD Medical Option is non-grandfathered, effective January 1, 2013.

If you are eligible to enroll in this option, you can cover yourself, your spouse/Company-recognized Domestic Partner and/or your dependent children.

Your Network/Claims Administrator

The STANDARD Medical Option is administered by three network/claims administrators:

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

Access to each administrator's network is determined by your alternate address. If you do not have an alternate address on file, your state will be determined by your permanent address. Go to the "Update MY Information" page of Jetnet to verify your address on record.

If you relocate to a new state, your medical plan Option election and contribution rates remain the same for the remainder of the plan year. Your elected Network/Claims Administrator does not change based on your relocation.

You must wait until the next Annual Benefits Enrollment period to change your medical option election and your Network/Claims Administrator, unless you experience a relocation Life Event. See "Life Events" in the Life Events: Making Changes During the Year section for more information.

Network/Claims Administrator- Buy-up Option

When you enroll for the STANDARD Medical Option, you have a choice among the three Network/Claims Administrators- the preferred, Tier 1 and Tier 2 administrator. When you elect an administrator that is not the preferred for your state it is referred to as the "Buy-up Option".

The administrator with the lowest employee contribution costs will be the preferred Network/ Claims Administrator for your state. You can choose a non-preferred Network/Claims Administrator — called Tier 1 or Tier 2 — but you will pay more in employee contributions. *The only difference in the choice of administrators is the network of physicians. The benefit coverage is the same.*

The preferred, Tier 1 and Tier 2 Network/Claims Administrators will vary from state to state. For example, Aetna may be a preferred Network/Claims Administrator in one state and a Tier 1 or Tier 2 Network/Claims Administrator in another.

Tier 1 and Tier 2 Network/Claims Administrators reflect monthly contributions that are 25% and 50% higher than the cost of the preferred Network/Claims Administrator, as this chart demonstrates:

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

*Preferred rate increases are subject to change.

The map of the Network/Claims Administrators by state can be found on my.aa.com

How the Standard Medical Option Works

The STANDARD Medical Option offers a network of preferred physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. You may use any qualified licensed physician you wish. If you use an in-network provider, the STANDARD Medical Option will pay your expenses at a higher level of benefit. When you use an in-network provider, you pay only a co-pay or deductible and co-insurance for most services. If you choose to use an out-of-network provider, the charges will be subject to usual and prevailing fee limits and the STANDARD Medical Option will pay your expenses at a lower level of benefit.

Go online or call your Network/Claims Administrator for more information and to access a list of in-network providers. See "Negotiated Rates" in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

Benefit Overview				
Standard Medical Option	Annual Deductible		Annual Out-of-Pocket Maximum	
	Individual	Family	Individual	Family
In-Network	$750	$2,250	$2,000	$5,000
Out-of-Network	$3,000	$9,000	$6,000	$15,000

In-Network Services

In-network providers who contract with your Network/Claims Administrator agree to provide services and supplies at contracted rates. At the in-network benefit level, you pay a fixed co-pay or co-insurance amount and a $750 per person annual deductible.

Each covered person, which includes you and any covered dependents, must first satisfy an annual in-network deductible before the Option begins paying a percentage of eligible medical expenses that are subject to co-insurance (this does not include prescription drugs, annual physical or PCP visits).

After the annual in-network deductible of $750 has been satisfied, the STANDARD Medical Option pays 80% of in-network eligible expenses. You pay 20% co-insurance for in-network services and co-pays where applicable.

After you or your covered dependents meet the individual annual out-of-pocket maximum of $2,000 for services that require you to pay 20% co-insurance, further eligible expenses are covered at 100% for the remainder of the year for that individual.

You can receive in-network benefits for specialist care without a referral from a primary care physician (PCP), but you are encouraged to have a PCP to coordinate in-network services for you.

- You pay $30 co-pay per PCP visit.
- You must meet your deductible and/or pay 20% co-insurance when you see an in-network specialist or visit a retail/urgent care clinic.

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

Out-of-Network Services (OON)

If you go to a provider who is not part of the network, you are covered for eligible medically necessary services; however, coverage reimbursement is at a lower level (out-of-network benefit level).

Each covered person, which includes you and any covered dependents, must first satisfy an annual out-of-network deductible of $3,000 before the Option begins paying a percentage of eligible expenses. After you meet the annual out-of-network deductible, the STANDARD Medical Option pays 60% of out-of-network eligible expenses. You pay 40% co-insurance for out-of-network services.

Additionally, you must pay any amount of the provider's billed fee that exceeds the usual and prevailing (U&P) fee limits. U&P for OON services is 80th percentile of Fair Health.

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

- If the claim is for care in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the STANDARD Medical Option will allow the out-of-network provider's full billed charge as an eligible expense.
- If the claim is for care in a "network gap" (where the nearest source of appropriate medical treatment is greater than the Network/Claims Administrator's network gap mile limit), and the covered person has received prior approval from the Network/Claims Administrator, the STANDARD Medical Option will allow the out-of-network provider's full billed charge as an eligible expense.
- If the claim is for services for which no usual and prevailing fee data exist, the STANDARD Medical Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.

Other Information

After you have enrolled, you will receive a medical ID card from your Network/Claims Administrator. The ID card includes important phone numbers and your member ID. You should present the card at the time of medical service for you and your covered dependents. Members will receive an Express Scripts ID card for prescription drug services.

Special Features of the Standard Medical Option

Primary Care Physicians (PCP): Your PCP is your partner in the services you receive under the STANDARD Medical Option. He or she:

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

PCPs may specialize in pediatrics, family practice, general practice, gynecology or internal medicine. You are encouraged to establish a relationship with a PCP.

Preventive care: You and each covered family member are eligible to receive 100% coverage for in-network annual routine physical exams, preventive care, routine screenings and immunizations.

No claims to file: In most cases, when you use network providers, the provider files your claims for you.

Co-pays and co-insurance: Co-pays and co-insurance are the amounts you pay for eligible covered medical services depending on where you receive these services.

Co-pays: For in-network services such as office visits to your in-network PCP, including any tests or treatment received during the office visit, you pay a fixed dollar co-pay amount, as described in the Medical Benefit Options Comparison table.

Co-insurance: For in-network services other than preventive care, PCP office visits, and pharmacy expenses, you pay 20% co-insurance (a percentage of the cost) after you satisfy the annual $750 per person annual in-network deductible. The exception is diagnostic testing (e.g., lab work, X-rays, MRI, CT scan, etc.) that is performed in the doctor's office or at an in-network, non-hospital imaging center/lab. These expenses are covered at 100%. For all eligible out-of-network services you pay 40% out-of-network co-insurance after you satisfy the annual $3,000 per person out-of-network deductible.

Individual in-network annual out-of-pocket maximum: After you satisfy the annual individual in-network out-of-pocket maximum of $2,000, the Medical Option pays 100% of in-network eligible expenses for the rest of the calendar year, with the exception of certain prescription drug expenses.

- The in-network deductible does not apply to the in-network out-of-pocket maximum.
- Beginning January 1, 2014, co-pays for in-network services do apply to the out-of-pocket maximum. Once the OOP max is met, co-pays are waived.

Negotiated Rates: The Medical Option offers a network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. The negotiated rates save you and the Company money when you or your covered dependent needs medical care and chooses an in-network provider.

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

Hospital-based services include: hospital facility charges, freestanding surgical facilities, physician charges, room and board, diagnostic testing, X-ray and lab fees, anesthesia, dialysis, chemotherapy and MRIs.

Emergency care: If you have a medical emergency, go directly to an emergency facility. Benefits are paid at the in-network level regardless if your provider is in-network or out-of-network. You should arrange any follow-up treatment through your PCP. Call your Network/Claims Administrator as soon as possible. If you go to an out-of-network emergency room for a non-emergency medical issue, your claim will be processed at the out-of-network benefit level.

Urgent/immediate care: If you are in your network service area and need urgent or immediate care, but you do not have an actual emergency, contact your PCP first. He or she will direct you to the appropriate place for treatment.

- In order to receive the in-network benefit level, you should contact your network provider or your Network/Claims Administrator before seeking care at an urgent or immediate care treatment clinic, or if you are traveling and need urgent or immediate medical care. If your Network/Claims Administrator's offices are closed, seek treatment and then call your Network/Claims Administrator within 48 hours to ensure that you receive the in-network level of benefits.
- See the definition of urgent/immediate care in the "Glossary" in the *Reference Information* section).

Specialist care: To receive the in-network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use an in-network specialist, and services must be eligible under the terms of the Plan.

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

Diagnostic testing: Diagnostic testing (e.g., lab work, X-rays, MRI, CT scan, etc.) that is performed in a network physician's office (PCP or specialist) or at a network non-hospital imaging center or lab is covered at a 100% if medically necessary.

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

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

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

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

Network/Claims Administrator: Your Network/Claims Administrator establishes standards for participating providers, including physicians, hospitals and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges and medical outcomes. They also periodically monitor whether participating providers continue to meet network standards. Your Network/Claims Administrator also processes claims, negotiates fees and contracts with care providers. **Please note that if BCBS TX is your Network/Claims Administrator and you live in or seek care in California, you will need to use providers in the BlueCross network to receive the in-network level of benefits.**

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

Leaving the service area (moving your home address or relocating): If you move to an area where the Medical Option is available, you remain enrolled in the Medical Option and retain your current Network/Claims Administrator.

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

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

Covered and Excluded Expenses

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

Filing Claims

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

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

Each bill or receipt submitted to your Network/Claims Administrator must include the following:

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

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

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

If you have questions about your coverage or your claim under the STANDARD Medical Option, contact your Network/Claims Administrator (see "Contact Information" in the *Reference Information* section).

Claims Filing Deadline

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

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

Prescription Drug Benefits

Prescription drug coverage is based upon a formulary. The amount of co-insurance you pay under the STANDARD Medical Option is based upon whether the medication is a generic drug, a preferred brand drug (formerly known as a "formulary drug") or a non-preferred brand drug (formerly known as a "non-formulary drug").

- Generic drugs are drugs that are chemically and therapeutically equivalent to the corresponding brand name drug, but cost less.
- Preferred brand name drugs are Express Scripts' formulary drugs.
- Non-preferred are brand names that are Express Scripts' non-formulary. They have preferred alternatives (either generic or brand) that are in the Express Scripts formulary.

Express Scripts (ESI) (formerly known as Express Scripts) is the prescription drug vendor for the STANDARD Medical Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the ESI Mail Order Prescription Drug Benefit. Express Scripts has a broad network of pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the Express Scripts website or call them at 1-800-988-4125.

Retail Drug Coverage

Always try to have your prescriptions filled at a network pharmacy or through ESI Mail Order. You must present your Express Scripts prescription drug card *every time* you purchase prescription drugs in order to receive the discounted medication rates and to have your pharmacy claim processed at the time of purchase. If you do not present your Express Scripts prescription drug card at the time of purchase, you will have to pay the full cost. By showing your Express Scripts ID card, the pharmacy will process your claim at the time of purchase and you will only pay your co-insurance portion. Showing your Express Scripts ID card also allows your out-of-pocket pharmacy expense to be applied toward satisfaction of your annual out-of-pocket maximum. Co-insurance, which is subject to change, is currently:

- **Generic Drugs:** 20% co-insurance per prescription or refill for generic drugs. The minimum amount you will pay is $10 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $40.
- **Preferred Brand Drugs:** 30% co-insurance per prescription or refill for formulary/brand name drugs. The minimum amount you will pay is $30 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $100.
- **Non-preferred Brand Drugs:** 50% co-insurance per prescription or refill for non-formulary/brand name drugs. The minimum amount you will pay is $45 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $150.

If you select a brand name drug when a generic is available, you will pay the generic co-insurance plus the cost difference between generic and brand name prices. Maximums do not apply. Once you have met your annual out-of-pocket maximum, you will continue to pay the cost difference between generic and brand name prices.

Note: You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted price and to have your pharmacy claim processed at the time of purchase.

Filling Prescriptions and Filing Claims

Follow these steps to fill prescriptions:

Network pharmacies:

- Present your Express Scripts ID card at the in-network pharmacy
- Pay your portion of the cost for the prescription

Out-of-network pharmacies:

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

1. At the time of purchase, you will pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
2. File a claim for reimbursement of your covered expenses through Express Scripts. See *Filing Claims for Prescriptions* for more information on how to file a claim.

Standard Option OON Rx Reimbursement Example	
Cost of Non-preferred prescription at pharmacy	$250
Express Scripts discount price	$150
You Pay	$75 (50% co-insurance of $150), plus $100 (the difference between the pharmacy cost and the Express Scripts discount price)
Your Total	$175

Note: If you purchase prescription drugs at an out-of-network pharmacy, you will be reimbursed based on the Express Scripts discount price, **not** the actual retail cost of the medication.

Filing Claims for Prescriptions

If you are enrolled in the STANDARD Medical Option and you participate in the Health Care Flexible Spending Account (HCFSA), your eligible retail drug out-of-pocket expense is reimbursable under your HCFSA (see "Covered Expenses" in the *Health Care Flexible Spending Account* section). If you have funds in your Health Reimbursement Account (HRA), you can use those funds to pay eligible retail drug out-of-pocket expenses once your HCFSA funds have been exhausted.

If you have questions concerning your prescription drug coverage, call the Express Scripts Member Services number on your Express Scripts ID card. (Your ID card may still reflect "ESI")

Retail Refill Allowance — Long-Term Medications

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

Beginning with your fourth purchase of a Long-Term Medication, you should utilize ESI Mail Order for these refills. You can purchase up to a 90-day supply of your Long-Term Medications,

which can ultimately save you money on your prescription costs. See *ESI Mail Order* in this section for more information.

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

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

Retail Prescription Clinical Programs

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

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

Generic Drugs

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

Prior Authorization

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

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

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

Ask your physician to contact Express Scripts or to complete Express Scripts' prior authorization form with the following information:

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

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

Specialty Pharmacy Services

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

Accredo Health Group, a subsidiary of Express Scripts, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications. Express Scripts also has specialty pharmacists trained in specific medical conditions (e.g., diabetes, cardiovascular, cancer, etc.). If you would like to talk to a pharmacist, call the Member Services phone number on your pharmacy ID card.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at an in-network retail pharmacy or one of Accredo's Health Group pharmacies (mail order) through Express Scripts:

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

This is not an all-inclusive listing. Please note that other conditions are added as appropriate and as required.

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

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

Express Scripts Mail Order

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

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

- **Generic Drugs:** 20% co-insurance per prescription or refill for generic drugs. The minimum amount you will pay is $5 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $80.
- **Preferred Brand Drugs:** 30% co-insurance per prescription or refill for formulary/brand name drugs. The minimum amount you will pay is $60 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $200.
- **Non-preferred Brand Drugs:** 50% co-insurance per prescription or refill for non-formulary/brand name drugs. The minimum amount you will pay is $90 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $300.

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

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100% under the STANDARD Medical Option through ESI Mail Order only. If you purchase contraceptives from a retail pharmacy, no benefits are payable. If you purchase a brand name contraceptive that has a generic equivalent, you are responsible for the cost difference between brand and generic.

Mail Order Prescription Clinical Programs

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

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

Generic Drugs

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

Ordering Prescriptions by Mail

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

- Complete the Mail Order Form.
- Complete the Health, Allergy, and Medical Questionnaire (found on the Express Scripts website). The questionnaire will not be necessary on refills or future orders unless your health changes significantly.
- Include the original written prescription signed by your physician.
- Indicate your method of payment on the form.
- A major credit or debit card, or
- Personal check or money order.

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

- Mail your order to the address on the Mail Order Form.
- Generally, your order is shipped within three working days of receipt. All orders are sent by UPS or first class mail. UPS delivers to rural route boxes but not to P.O. Boxes. If you have only a P.O. Box address, your order is sent by first class mail.
- Once you have established mail order service, your physician can fax new prescriptions directly to Express Scripts.

Internet Refill Option

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

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

Other Refill Options

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

- Call 1-800-988-4125 to request a refill. You will be asked for your Express Scripts ID number, current mailing address and Express Scripts Health Rx Services prescription number.
- Complete and mail in your Mail Order Form. Attach your ESI Mail Order refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order. You can also use the form that was delivered with your prescription.

Claims Filing Deadline

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

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

Reimbursement of Co-insurance

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

If you have exhausted your HCFSA, and have funds in your Health Reimbursement Account (HRA), you can receive reimbursement for your co-insurance.

HRA - Health Reimbursement Account

If you participate in the Healthmatters wellness program, dollars that you earn for completing certain activities will be deposited into your HRA. You can use these funds to help offset eligible medical and prescription out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. Funds must be in the account before you can use them.

Notice for Employees Who Work in (Are Based in) Massachusetts

(Notice of MCC certification for the Standard/Preferred Medical Benefit Option ONLY. All other self-funded Medical Benefit Options are NOT MCC certified.)

In order for a Medical Benefit Option to be certified as Minimum Creditable Coverage (MCC) in the state of Massachusetts, it must meet all the terms of essential benefits required by Massachusetts state law. The law considers it an essential benefit that plans offer the same coverage to a participant's covered dependents as is offered to the participant. Our Medical Benefit Options meet the criteria ***with the exception of providing maternity benefits to covered dependent children of the participant.***

In order for our plan to meet the criteria of MCC, we will provide maternity coverage to covered dependent child(ren) of the Massachusetts-based participant under the Standard Medical Option only - specifically, the Standard Medical Option that is administered by the state Preferred Network/Claims Administrator (known herein as "Standard/Preferred"). You and all your covered dependents must be enrolled in Standard/Preferred to obtain coverage for your covered dependent child's(ren's) maternity expenses, whether enrollment is during the annual enrollment period or as a result of a Life Event.

If you and your covered dependents are enrolled in another Medical Benefit Option and you want to provide maternity coverage for your covered dependent child(ren), register a Life Event with HR Services requesting enrollment in the Standard/Preferred. Your Medical Benefit Option election will change to Standard/Preferred for yourself, your spouse or DOMESTIC PARTNER (DP), and all your covered dependents. You will be required to pay the applicable monthly contributions for Standard/Preferred, back to the start of your covered dependent's pregnancy/maternity, coverage will be effective on this same date, and you and your covered dependents will remain in the Standard/Preferred for the remainder of the plan year (unless you experience another Life Event that would allow you to change your Medical Benefit Option). Additionally, your changing to the Standard/Preferred will require you and your covered dependents to satisfy new deductible and out-of-pocket limits, as your deductibles and out-of-pocket limits do not transfer when you select Standard/Preferred. To enroll in or to change you coverage to Standard/Preferred, contact HR Services at 800-447-2000.

Value Medical Option

This section includes:

The VALUE Medical Option is non-grandfathered, effective January 1, 2013.

If you are eligible to enroll in this option, you can cover yourself, your spouse/Company-recognized Domestic Partner and/or your dependent children.

Your Network/Claims Administrator

The VALUE Medical Option is administered by three Network/Claims Administrators:

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

Access to each administrator's network is determined by your alternate address. If you do not have an alternate address on file, your state will be determined by your permanent address. Go to the "Update My Information" page of Jetnet to verify your address on record.

If you relocate to a new state, your medical plan Option election and contribution rates remain the same for the remainder of the plan year. Your elected Network/Claims Administrator does not change based on your relocation.

You must wait until the next Annual Benefits Enrollment period to change your medical option election and your Network/Claims Administrator, unless you experience a relocation Life Event. See "Life Events" in the Life Events: Making Changes During the Year section for more information.

Network/Claims Administrator- Buy-up Option

When you enroll for the VALUE Medical Option, you have a choice among the three Network/Claims Administrators- the preferred, Tier 1 and Tier 2 administrator. When you elect an administrator that is not the preferred for your state it is referred to as the "Buy-up Option".

The administrator with the lowest employee contribution costs will be the preferred Network/Claims Administrator for your state. You can choose a non-preferred Network/Claims Administrator — called Tier 1 or Tier 2 — but you will pay more in employee contributions. *The only difference in the choice of administrators is the network of physicians. The benefit coverage is the same.*

The preferred, Tier 1 and Tier 2 Network/Claims Administrators will vary from state to state. For example, Aetna may be a preferred Network/Claims Administrator in one state and a Tier 1 or Tier 2 Network/Claims Administrator in another.

Tier 1 and Tier 2 Network/Claims Administrators reflect monthly contributions that are 25% and 50% higher than the cost of the preferred Network/Claims Administrator, as this chart demonstrates:

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

*Preferred rate increases are subject to change.

The map of the Network/Claims Administrators by state can be found on my.aa.com

How the Value Medical Option Works

The VALUE Medical Option offers a network of preferred physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. You may use any qualified licensed physician you wish. If you use an in-network provider, the VALUE Medical Option will pay your expenses at a higher level of benefit. When you use an in-network provider, you pay only a co-pay or deductible and co-insurance for most services. If you choose to use an out-of-network provider, the charges will be subject to usual and prevailing fee limits and the VALUE Medical Option will pay your expenses at a lower level of benefit.

Go online or call your Network/Claims Administrator for more information and to access a list of in-network providers. See "Negotiated Rates" in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

Benefit Overview				
VALUE Medical Option	Annual Deductible		Annual Out-of-Pocket Maximum	
	Individual	Family	Individual	Family
In-Network	$300	$900	$2,000	$5,000
Out-of-Network	$1,500	$4,500	$6,000	$15,000

In-Network Services

In-network providers who contract with your Network/Claims Administrator agree to provide services and supplies at contracted rates. At the in-network benefit level, you pay a fixed co-pay or co-insurance amount and a $300 per person annual deductible.

Each covered person, which includes you and any covered dependents, must first satisfy an annual in-network deductible before the Option begins paying a percentage of eligible medical expenses that are subject to co-insurance (this does not include prescription drugs).

After the annual in-network deductible of $300 has been satisfied, the VALUE Medical Option pays 80% of in-network eligible expenses. You pay 20% co-insurance for in-network services and co-pays where applicable.

After you and your covered dependents each meet the individual annual out-of-pocket maximum of $2,000 for services that require you to pay 20% co-insurance, further eligible expenses are covered at 100% for the remainder of the year. (This does not include prescription drugs)

You can receive in-network benefits for specialist care without a referral from a primary care physician (PCP), but you are encouraged to have a PCP to coordinate in-network services for you.

- You pay $20 co-pay per PCP visit.
- You pay $40 co-pay per Specialist visit.

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

Out-of-Network Services (OON)

If you go to a provider who is not part of the network, you are covered for eligible medically necessary services; however, coverage reimbursement is at a lower level (out-of-network benefit level).

Each covered person, which includes you and any covered dependents, must first satisfy an annual out-of-network deductible of $1,500 before the Option begins paying a percentage of eligible expenses. After you meet the annual out-of-network deductible, the VALUE Medical Option pays 60% of out-of-network eligible expenses. You pay 40% co-insurance for out-of-network services.

Additionally, you must pay any amount of the provider's billed fee that exceeds the usual and prevailing (U&P) fee limits. U&P for OON services is 80th percentile of Fair Health.

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

- If the claim is for care in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the VALUE Medical Option will allow the out-of-network provider's full billed charge as an eligible expense.
- If the claim is for care in a "network gap" (where the nearest source of appropriate medical treatment is greater than the Network/Claims Administrator's network gap mile limit), and the covered person has received prior approval from the Network/Claims Administrator, the VALUE Medical Option will allow the out-of-network provider's full billed charge as an eligible expense.
- If the claim is for services for which no usual and prevailing fee data exist, the VALUE Medical Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.

Other Information

After you have enrolled, you will receive a medical ID card from your Network/Claims Administrator. The ID card includes important phone numbers and your member ID. You should present the card at the time of medical service for you and your covered dependents. Members will receive an Express Scripts ID card for prescription drug services.

Special Features of the VALUE Medical Option

Primary Care Physicians (PCP): Your PCP is your partner in the services you receive under the VALUE Medical Option. He or she:

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

PCPs may specialize in pediatrics, family practice, general practice, gynecology or internal medicine. You are encouraged to establish a relationship with a PCP.

Preventive care: You and each covered family member are eligible to receive 100% coverage for in-network annual routine physical exams, preventive care, routine screenings and immunizations.

No claims to file: In most cases, when you use network providers, the provider files your claims for you.

Co-pays and co-insurance: Co-pays and co-insurance are the amounts you pay for eligible covered medical services depending on where you receive these services.

Co-pays: For in-network services such as office visits to your in-network PCP, including any tests or treatment received during the office visit, you pay a fixed dollar co-pay amount, as described in the Medical Benefit Options Comparison table.

Co-insurance: For in-network services other than preventive care, PCP/Specialist office visits, retail/urgent care clinics and pharmacy expenses, you pay 20% co-insurance (a percentage of the cost) after you satisfy the annual $ 300 per person annual in-network deductible. The exception is diagnostic testing (e.g., lab work, X-rays, MRI, CT scan, etc.) that is performed in the doctor's office or at an in-network, non-hospital imaging center/lab. These expenses are covered at 100%. For all eligible out-of-network services you pay 40% out-of-network co-insurance after you satisfy the annual $1,500 per person out-of-network deductible.

Individual in-network annual out-of-pocket maximum: After you satisfy the annual individual in-network out-of-pocket maximum of $2,000, the Medical Option pays 100% of in-network eligible expenses for the rest of the calendar year, with the exception of certain prescription drug expenses.

- The in-network deductible does not apply to the in-network out-of-pocket maximum.
- Beginning January 1, 2014, co-pays for in-network services do apply to the out-of-pocket maximum. Once the OOP max is met, co-pays are waived.

Negotiated Rates: The Medical Option offers a network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. The negotiated rates save you and the Company money when you or your covered dependent needs medical care and chooses an in-network provider.

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

Hospital-based services include: hospital facility charges, freestanding surgical facilities, physician charges, room and board, diagnostic testing, X-ray and lab fees, anesthesia, dialysis, chemotherapy and MRIs.

Emergency care: If you have a medical emergency, go directly to an emergency facility. Benefits are paid at the in-network level regardless if your provider is in-network or out-of-network. You should arrange any follow-up treatment through your PCP. Call your Network/Claims Administrator as soon as possible. If you go to an out-of-network emergency room for a non-emergency medical issue, your claim will be processed at the out-of-network benefit level.

Urgent/immediate care: If you are in your network service area and need urgent or immediate care, but you do not have an actual emergency, contact your PCP first. He or she will direct you to the appropriate place for treatment.

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

See the definition of urgent/immediate care in the "Glossary" in the *Reference Information* section).

Specialist care: To receive the in-network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use an in-network specialist, and services must be eligible under the terms of the Plan.

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

Diagnostic testing: Diagnostic testing (e.g., lab work, X-rays, MRI, CT scan, etc.) that is performed in a network physician's office (PCP or specialist) or at a network non-hospital imaging center or lab is covered at a 100% if medically necessary.

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

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

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

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

Network/Claims Administrator: Your Network/Claims Administrator establishes standards for participating providers, including physicians, hospitals and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges and medical outcomes. They also periodically monitor whether participating providers continue to meet network standards. Your Network/Claims Administrator also processes claims, negotiates fees and contracts with care providers. **Please note that if BCBSTX is your Network/Claims Administrator and you live in or seek care in California, you will need to use providers in the BlueCross network to receive the in-network level of benefits.**

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

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

If you move to an area where the Medical Option is available, you remain enrolled in the Medical Option and retain your current Network/Claims Administrator.

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

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

Covered and Excluded Expenses

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

Filing Claims

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

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

Each bill or receipt submitted to your Network/Claims Administrator must include the following:

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

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

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

If you have questions about your coverage or your claim under the VALUE Medical Option, contact your Network/Claims Administrator (see "Contact Information" in the *Reference Information* section).

Claims Filing Deadline

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

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

Prescription Drug Benefits

Prescription drug coverage is based upon a formulary. The amount of co-insurance you pay under the VALUE Medical Option is based upon whether the medication is a generic drug, a preferred brand drug (formerly known as a "formulary drug") or a non-preferred brand (formerly known as a "non-formulary drug").

- Generic drugs are drugs that are chemically and therapeutically equivalent to the corresponding brand name drug, but cost less.
- Preferred brand drugs are in Express Scripts' formulary drugs.
- Non-preferred brand drugs are that are not in Express Scripts' formulary. They have preferred alternatives (either generic or brand) that are in Express Scripts' formulary.

Express Scripts (ESI) (formerly known as ESI) is the prescription drug vendor for the VALUE Medical Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the ESI Mail Order Prescription Drug Benefit. Only eligible expenses for covered prescription drugs apply to your out-of-pocket maximum.

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

Retail Drug Coverage

Always try to have your prescriptions filled at a network pharmacy or through ESI Mail Order. You must present your Express Scripts prescription drug card *every time* you purchase prescription drugs in order to receive the discounted medication rates and to have your pharmacy claim processed at the time of purchase. If you do not present your Express Scripts prescription drug card at the time of purchase, you will have to pay the full cost. By showing your Express Scripts ID card, the pharmacy will process your claim at the time of purchase and you will only pay your co-insurance portion. Showing your Express Scripts ID card also allows your out-of-pocket pharmacy expense to be applied toward satisfaction of your annual out-of-pocket maximum. Co-insurance, which is subject to change, is currently:

- **Generic Drugs:** $10 co-pay
- **Preferred Brand Drugs:** 30% co-insurance per prescription or refill for these drugs. The minimum amount you will pay is $20 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $75.
- **Non-preferred Brand Drugs:** 50% co-insurance per prescription or refill for these drugs. The minimum amount you will pay is $35 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $90.

If you select a brand name drug when a generic is available, you will pay the generic co-pay plus the cost difference between generic and brand name prices. Maximums do not apply. Once you have met your annual out-of-pocket maximum, you will continue to pay the cost difference between generic and brand name prices.

Note: You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted price and to have your pharmacy claim processed at the time of purchase.

Filling Prescriptions and Filing Claims

Follow these steps to fill prescriptions:

Network pharmacies:

- Present your Express Scripts ID card at the in-network pharmacy
- Pay your portion of the cost for the prescription

Out-of-network pharmacies:

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

- At the time of purchase, you will pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Express Scripts. See *Filing Claims for Prescriptions* for more information on how to file a claim.

Value Option OON Rx Reimbursement Example	
Cost of Non-preferred prescription at pharmacy	$250
Express Scripts discount price	$90
You Pay	$45 (50% co-insurance of $90 max), plus $160 (the difference between the pharmacy cost and the Express Scripts discount price)
Your Total	$205

Note: If you purchase prescription drugs at an out-of-network pharmacy, you will be reimbursed based on the Express Scripts discount price, **not** the actual retail cost of the medication.

Filing Claims for Prescriptions

If you are enrolled in the VALUE Medical Option and you participate in the Health Care Flexible Spending Account (HCFSA), your eligible retail drug out-of-pocket expense is reimbursable under your FSA (see "Covered Expenses" in the *Health Care Flexible Spending Account* section). If you have funds in your Health Incentive Account (HIA), you can use those funds to pay eligible retail drug out-of-pocket expenses once your HCFSA funds have been exhausted.

If you have questions concerning your prescription drug coverage, call the Express Scripts Member Services number on your Express Scripts ID card. (Your ID card may still reflect "Express Scripts")

Retail Refill Allowance — Long-Term Medications

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

Beginning with your fourth purchase of a Long-Term Medication, you should utilize ESI Mail Order for these refills. You can purchase up to a 90-day supply of your Long-Term Medications,

which can ultimately save you money on your prescription costs. See *ESI Mail Order* in this section for more information.

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

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

Retail Prescription Clinical Programs

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

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

Generic Drugs

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

Prior Authorization

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

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

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

Ask your physician to contact Express Scripts or to complete Express Scripts' prior authorization form with the following information:

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

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

Specialty Pharmacy Services

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

Accredo Health Group, a subsidiary of Express Scripts, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications. Express Scripts also has specialty pharmacists trained in specific medical conditions (e.g., diabetes, cardiovascular, cancer, etc.). If you would like to talk to a pharmacist, call the Member Services phone number on your pharmacy ID card.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at an in-network retail pharmacy or one of Accredo's Health Group pharmacies (mail order) through Express Scripts:

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

This is not an all-inclusive listing. Please note that other conditions are added as appropriate and as required.

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

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

Express Scripts Mail Order

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

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

- **Generic Drugs:** 20% co-insurance per prescription or refill for generic drugs. The minimum amount you will pay is $0 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $80.
- **Preferred Brand Drugs:** 30% co-insurance per prescription or refill for formulary/brand name drugs. The minimum amount you will pay is $40 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $150.
- **Non-preferred Brand Drugs:** 50% co-insurance per prescription or refill for non-formulary/brand name drugs. The minimum amount you will pay is $70 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is $180.

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

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100% under the VALUE Medical Option through ESI Mail Order only. If you purchase contraceptives from a retail pharmacy, no benefits are payable. If you purchase a brand name contraceptive that has a generic equivalent, you are responsible for the cost difference between brand and generic.

Mail Order Prescription Clinical Programs

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

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

Generic Drugs

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

Ordering Prescriptions by Mail

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

- Complete the Mail Order Form.
- Complete the Health, Allergy, and Medical Questionnaire (found on Express Scripts). The questionnaire will not be necessary on refills or future orders unless your health changes significantly.
- Include the original written prescription signed by your physician.
- Indicate your method of payment on the form.
- A major credit or debit card, or
- Personal check or money order.

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

- Mail your order to the address on the Mail Order Form.
- Generally, your order is shipped within three working days of receipt. All orders are sent by UPS or first class mail. UPS delivers to rural route boxes but not to P.O. Boxes. If you have only a P.O. Box address, your order is sent by first class mail.
- Once you have established mail order service, your physician can fax new prescriptions directly to Express Scripts.

Internet Refill Option

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

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

Other Refill Options

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

- Call 1-800-988-4125 to request a refill. You will be asked for your Express Scripts ID number, current mailing address and Express Scripts Health Rx Services prescription number.
- Complete and mail in your Mail Order Form. Attach your ESI Mail Order refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order. You can also use the form that was delivered with your prescription.

Claims Filing Deadline

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

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

Reimbursement of Co-insurance

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

If you have exhausted your HCFSA, and have funds in your Health Incentive Account (HIA), you can receive reimbursement for your co-insurance.

HIA - Health Incentive Account

If you participate in the Healthmatters wellness program, dollars that you earn for completing certain activities will be deposited into your HIA. You can earn up to $250 for you plus $250 for your spouse/DOMESTIC PARTNER (DP). You can use these funds to help offset eligible medical and prescription out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your HCFSA. Funds must be in the account before you can use them.

Core Medical Option

This section includes:

- How the CORE Medical Option Works
  - In-Network Services
  - Out-of-Network Services
  - Network/Claims Administrator
  - Special Provisions
- Covered and Excluded Expenses
- Filing Claims
  - Claims Filing Deadline
- Prescription Drug Benefits
  - Retail Drug Coverage
  - Express Scripts Mail Order
  - Reimbursement of Co-insurance
- Health Savings Account (HSA)
  - HSA Funds
  - Setting Up an HSA
  - Using Your HSA Funds
  - Eligible HSA Expenses
  - Ineligible HSA Expenses
  - Limited Purpose Health Care Flexible Spending Account (LPFSA)

This Medical Benefit Option is non-grandfathered.

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

As of January 1, 2012, Home-Based Representatives or Level 84 Premium Services Representatives are only eligible to enroll in this Option.

Your Network/Claims Administrator

The CORE Medical Option is administered by three Network/Claims Administrators:

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

Access to each administrator's network is determined by your alternate address. If you do not have an alternate address on file, your state will be determined by your permanent address. Go to the "Update MY Information" page of Jetnet to verify your address on record.

If you relocate to a new state, your medical plan Option election and contribution rates remain the same for the remainder of the plan year. Your elected Network/Claims Administrator does not change based on your relocation.

You must wait until the next Annual Benefits Enrollment period to change your medical option election and your Network/Claims Administrator, unless you experience a relocation Life Event. See "Life Events" in the Life Events: Making Changes During the Year section for more information.

Network/Claims Administrator- Buy-up Option

When you enroll for the CORE Medical Option, you have a choice among the three Network/Claims Administrators- the preferred, Tier 1 and Tier 2 administrator. When you elect an administrator that is not the preferred for your state it is referred to as the "Buy-up Option".

The administrator with the lowest employee contribution costs will be the preferred Network/Claims Administrator for your state. You can choose a non-preferred Network/Claims Administrator — called Tier 1 or Tier 2 — but you will pay more in employee contributions. *The only difference in the choice of administrators is the network of physicians. The benefit coverage is the same.*

The preferred, Tier 1 and Tier 2 non-preferred Network/Claims Administrators will vary from state to state. For example, Aetna may be a preferred Network/Claims Administrator in one state, but a Tier 1 or Tier 2 Network/Claims Administrator in another.

Tier 1 and Tier 2 Network/Claims Administrators reflect monthly contributions that are 25% and 50% higher than the cost of the preferred Network/Claims Administrator, as this chart demonstrates:

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

*Preferred rate increases are subject to change.

The map of the Network/Claims Administrators by state can be found on my.aa.com

Medications taken for preventive purposes are not subject to the deductible. Visit the Express Scripts website or call Express Scripts at 1-800-988-4125 for information about eligible medications. The deductible does apply to all other medications.

If more than one person is covered under this Option, you must meet the family deductible before benefits begin paying on any one individual. The family out-of-pocket maximum will also apply.

The deductible and co-insurance amounts DO APPLY to the out-of-pocket maximum.

This Option is compatible with a Health Savings Account (HSA) and a Limited Purpose Flexible Spending Account (LPFSA).

How the CORE Medical Option Works

The CORE Medical Option offers a network of preferred physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. You may use any qualified licensed physician you wish. If you use an in-network provider, the CORE Medical Option will pay your expenses at a higher level of benefit. When you use an in-network provider, you pay only a co-pay or deductible and co-insurance for most services. If you choose to use an out-of-network provider, the charges will be subject to usual and prevailing fee limits and the CORE Medical Option will pay your expenses at a lower level of benefit.

Go online or call your Network/Claims Administrator for more information and to access a list of in-network providers. See "Negotiated Rates" in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

Benefit Overview				
VALUE Medical Option	Annual Deductible		Annual Out-of-Pocket Maximum	
	Individual	Family	Individual	Family
In-Network	$2,000	$4,000	$6,000	$12,000
Out-of-Network	$4,000	$8,000	$12,000	$24,000

In-Network Services

You must satisfy the individual in-network annual deductible of $2,000 (if you cover yourself only) or the family in-network annual deductible of $4,000 (if you elect coverage for yourself and any dependents) before the Option begins paying a percentage of eligible benefits.

After you meet the annual in-network deductible, the CORE Medical Option pays 70% of in-network eligible expenses up to the negotiated rate. You pay 30% co-insurance for in-network services. After you meet the annual out-of-pocket maximum, eligible expenses are covered at 100% for the remainder of the year, with the exception of certain prescription drug expenses. The family out-of-pocket maximum applies if you cover dependents. The deductible applies to the out-of-pocket maximum.

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

Out-of-Network Services

You must satisfy the individual out-of-network annual deductible of $4,000 (if you cover yourself only) or the family out-of-network annual deductible of $8,000 (if you elect family coverage) before the Option begins paying a percentage of eligible benefits.

After you meet the annual out-of-network deductible, the CORE Medical Option pays 50% of out-of-network eligible expenses, up to usual and prevailing fee limits of 80th percentile of Fair Health, for most medically necessary services. You pay 50% co-insurance for out-of-network services, up to usual and prevailing fee limits for most medically necessary services. After you meet the annual out-of-pocket maximum, eligible expenses are covered at 100% for the remainder of the year. The deductible applies to the out-of-pocket maximum. The family out-of-network out-of-pocket maximum applies if you cover dependents.

Special Features of the CORE Medical Option

Individual In-Network Annual Out-of-Pocket Maximum: After you satisfy the individual in-network annual out-of-pocket maximum of $6,000 for eligible expenses, the CORE Medical Option pays 100% of in-network eligible expenses for the rest of the calendar year (with a few exceptions).

Family In-Network Annual Out-of-Pocket Maximum: If more than one person is covered under this Option, you must satisfy the $12,000 in-network annual family out-of-pocket maximum before the CORE Medical Option pays 100% of in-network eligible expenses for the rest of the calendar year. Under the CORE Medical Option, the covered person's co-insurance amounts apply to the annual out-of-pocket maximum. Deductibles apply toward the out-of-pocket maximum.

Negotiated Rates: The CORE Medical Option offers a network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. The negotiated rates save you and the Company money when you or your covered dependent needs medical care and chooses an in-network provider.

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

Preventive care: You and each covered family member are eligible to receive 100% coverage for in-network annual routine physical exams, preventive care, routine screenings and immunizations.

No claims to file: In most cases, when you use network providers, the provider files your claims for you.

Co-insurance: For services received in-network other than preventive care, you pay 30% co-insurance (a percentage of the cost) after you satisfy the annual in-network deductible. For all eligible out-of-network services you pay 50% out-of-network co-insurance after you satisfy the annual out-of-network deductible.

Hospital-based services include: hospital facility charges, freestanding surgical facilities, physician charges, room and board, diagnostic testing, X-ray and lab fees, anesthesia, dialysis, chemotherapy and MRIs.

Emergency care: If you have a medical emergency, go directly to an emergency facility. Benefits are paid at the in-network level regardless if your provider is in-network or out-of-network. You should arrange any follow-up treatment through your PCP. Call and notify your Network/Claims Administrator. If you go to an out-of-network emergency room for a non-emergency medical issue, your claim will be processed at the out-of-network benefit level.

Urgent/immediate care: If you are in your network service area and need urgent or immediate care, but you do not have an actual emergency, contact your PCP first. He or she will direct you to the appropriate place for treatment.

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

See the definition of urgent/immediate care in the "Glossary" in the *Reference Information* section).

Specialist care: To receive the in-network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use an in-network specialist, and services must be eligible under the terms of the Plan.

If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your PCP or your Network/Claims Administrator to determine if a referral to an out-of-network specialist is needed. In these rare instances, your out-of-network care is covered at the in-network benefit level, but only with prior approval through your Network/Claims Administrator. When you enroll, you should check to see if there are specialty providers within a comfortable distance from your home and/or work site.

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

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

Transition of care:

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

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

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

Covered and Excluded Expenses

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

Filing Claims

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

Complete a Medical Benefit Claim Form.

Submit the completed form to your Network/Claims Administrator, along with all original itemized receipts from your physician or other health care provider. A cancelled check or credit card receipt is not acceptable.

Each bill or receipt submitted to your Network/Claims Administrator must include the following:

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

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

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

If you have questions about your coverage or your claim under the CORE Medical Option, contact your Network/Claims Administrator (see "Contact Information" in the *Reference Information* section).

Claims Filing Deadline

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

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

Prescription Drug Benefits

Express Scripts (formerly known as Express Scripts) is the prescription drug vendor for the CORE Medical Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the ESI Mail Order benefit. Only eligible expenses for covered prescription drugs apply to your deductible and/or out-of-pocket maximum.

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

Retail Drug Coverage

You may have your prescriptions filled at any pharmacy. However, you receive greater benefits when you use a participating in-network pharmacy. Go to the Express Scripts website or call 1-800-988-4125 to locate an in-network pharmacy.

When you fill your prescriptions at a network retail pharmacy, you must first satisfy your annual deductible before benefits begin (with the exception of certain preventive medications).

Once you meet your deductible, you pay 30% co-insurance for the cost of your prescriptions.

You pay 30% co-insurance for medications taken for preventive purposes as identified by Express Scripts, but these medications are not subject to the deductible. Visit the Express Scripts website or call 1-800-988-4125 to find out if your prescription meets the criteria for a preventive medication.

Filling Prescriptions and Filing Claims

Follow these steps to fill prescriptions:

Network pharmacies:

- Present your Express Scripts ID card at the in-network pharmacy.
- Pay your portion of the cost for the prescription.
- Express Scripts will notify your Network/Claims Administrator of all amounts applied to the deductible and out-of-pocket maximum.

Out-of-network pharmacies:

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

- At the time of purchase, you will pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Express Scripts. See *Filing Claims for Prescriptions* for more information on how to file a claim.

Cost of prescription at pharmacy	$250
Express Scripts discount price	$100
You Pay	$30 (30% co-insurance of $100), plus $150 (the difference between the pharmacy cost and the Express Scripts discount price)
Your Total	$180

Note: If you purchase prescription drugs at an out-of-network pharmacy, you will be reimbursed based on the Express Scripts discount price, **not** the actual retail cost of the medication.

Retail Refill Allowance — Long-Term Medications

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

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

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

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

Retail Prescription Clinical Programs

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

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

Generic Drugs

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

Prior Authorization

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

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

When you fill your prescription, your pharmacist will call Express Scripts. Your pharmacist and a Express Scripts pharmacist will review the request for approval. Express Scripts will send you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for up to one year. Prior authorizations must be renewed

periodically. When the renewal date approaches, you should contact Express Scripts for renewal instructions.

Ask your physician to contact Express Scripts or to complete Express Scripts' prior authorization form with the following information:

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

If the pharmacy does not fill a prescription, the pharmacy's denial will not be treated as a claim for benefits. You must submit the request for prior authorization to Express Scripts. If the prior authorization is denied, you must file a first level appeal through Express Scripts if you want coverage for that medication.

Specialty Pharmacy Services

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

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

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at an in-network retail pharmacy or one of Accredo's Health Group pharmacies through Express Scripts:

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

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

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

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

Express Scripts Mail Order

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

When you fill your prescriptions through Express Scripts Mail Order, you must first satisfy your annual deductible before benefits begin.

Once you meet your deductible, you pay 30% co-insurance for the cost of your prescriptions purchased through Express Scripts Mail Order.

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100% under the CORE Medical Option through Express Scripts Mail Order only. If you purchase contraceptives from a retail pharmacy, no benefits are payable. If you purchase a brand name contraceptive that has a generic equivalent, you are responsible for the cost difference between brand and generic.

You pay 30% co-insurance for medications taken for preventive purposes as identified by Express Scripts, but these medications are not subject to the deductible. Contact Express Scripts to find out if your prescription meets the criteria for a preventive medication.

Mail Order Prescription Clinical Programs

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

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

Generic Drugs

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

Ordering Prescriptions by Mail

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

Complete the Mail Order Form, and the Health, Allergy, and Medical Questionnaire (found on the Express Scripts website). The questionnaire will not be necessary on refills or future orders unless your health changes significantly.

Include the original written prescription signed by your physician.

Indicate your method of payment on the form.

- A major credit or debit card, or
- Personal check or money order, or
- Your Health Savings Account (HSA) debit card, or
- Express Scripts will bill you when your medications are delivered (up to $100).
- If paying by check or money order, enclose your payment with the order. Do not send cash. For pricing information, access the Express Scripts website or call Express Scripts (see "Contact Information" in the *Reference Information* section).

Mail your order to the address on the Mail Order Form.

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

Internet Refill Option

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

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

Other Refill Options

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

Call 1-800-988-4125 to request a refill. You will be asked for your Express Scripts ID number, current mailing address and Express Scripts Health Rx Services prescription number.

Complete and mail in your Mail Order Form. Attach your Express Scripts refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

Reimbursement of Co-insurance

Your retail and mail order co-insurance is the out-of-pocket amount you must pay when you purchase your prescription drugs. It is not eligible for reimbursement under the CORE Medical Option. However, if you elected to participate in the Health Savings Account (HSA), your co-insurance may be eligible for reimbursement. See "HSA - Health Savings Account " section for more information.

HSA - Health Savings Account

A Health Savings Account (HSA) is only available if enrolled in the CORE Medical Option and it is your only health plan coverage. An HSA is a tax-advantaged savings account that you can establish to pay for current and future medical expenses. This account can be funded with employee and employer contributions. Once you open an HSA it is your account and so are all the funds that are in it.

Employee contributions are the pre-tax payroll amounts that you elect to be deducted when you enroll in an HSA with WageWorks on Benefits Service Center . You can change your election amount anytime during the year.

Employer contributions are the reward dollars that you earn by completing specific Healthmatters activities. You can earn up to $250 for you plus $250 for your spouse/DOMESTIC PARTNER (DP)

The IRS sets the HSA limits, including catch-up contribution amounts for individuals over the age of 50. These limits may increase or decrease in the future.

The amounts noted below are the maximum contribution amounts if you earn the full amount of employer contributions via Healthmatters Rewards dollars.

Employee Only:	$3,050
Employee + Covered Spouse/Domestic Partner:	$6,050
Employee + Family:	$6,050
Employee + Child(ren):	$6,050

HSA Funds

You must have the money in your HSA before the funds are available to pay for eligible expenses. There is no “use it or lose it” rule with an HSA. Your funds remain in your account, until you choose to withdraw them. You may enhance account growth through investment earnings such as mutual funds, money markets or other investment type products.

Setting Up an HSA

The rules for setting up and using an HSA are determined by the Internal Revenue Service (IRS).

When you enroll in the CORE Medical Option via the Benefits Service Center, you will be given the opportunity to enroll in an HSA with Wageworks as your HSA administrator. You can make your contributions through automated pre-tax payroll deductions.

You determine how much to contribute on an annual basis (up to the federal allowed maximum limits). Then the total annual amount is divided by the amount of paychecks you receive in a year. The resulting dollar amount is your pre-tax per pay period payroll deduction.

For example:

My annual HSA deduction is $5,000
I get paid 2 times/month = 24 times a year.
My pre-tax per pay period payroll deduction = $208.33

You do not have to open an HSA account with Wageworks. You can select another financial institution that manages HSAs. However, your contributions will not be pre-tax. You will need to

make the contributions and they will not be through payroll deductions. Keep in mind that banking institutions offer a variety of arrangements when it comes to account fees, management and investment options.

If you are no longer enrolled in the CORE Medical Option, you may still access your HSA funds to pay for eligible medical expenses. You may not, however, contribute to the HSA if you are not enrolled in the CORE Medical Option, or another HSA-compatible medical coverage.

Using Your HSA Funds

After enrollment you will automatically receive a Health Care debit card to access your HSA funds during the year. You can use your card at the point of purchase to pay for eligible medical, dental and vision expenses.

At the same time you receive your card, you will receive instructions on how to access your Wageworks online account. When you are logged onto your account you can review your account payment history, request to be reimbursed for eligible expenses paid out-of-pocket and learn more about how to manage your HSA.

You may need to prove to the IRS that distributions from your HSA were for eligible expenses and not otherwise reimbursed. It is an IRS requirement that participants keep all receipts when using an HSA to pay for eligible expenses. The IRS levies a financial penalty if you use your HSA to purchase non-eligible expenses.

Federal laws allow financial institutions to place “reasonable limits” on funds regarding the size or frequency of HSA distributions. Check with the financial institution that manages your HSA directly for details.

HSAs are subject to all the legal and regulatory requirements and limitations as any other financial account. Employees are responsible for complying with those requirements.

HSAs are subject to the financial institutions’ banking, processing and administrative fees associated with the establishment and maintenance of the HSAs. It is the employee’s responsibility to pay any banking fees associated with an HSA.

You do not have to pay account management fees with Wageworks as an American employee when you initiate your HSA and remain enrolled year-over-year. If you have an HSA from the previous year and elect not to contribute to the HSA the following year, you will be responsible for any account fees.

HSA Expenses	
This table contains an alphabetical list of some items that are eligible/ineligible HSA expenses. For a full list of eligible HSA expenses, see IRS Publication 969.	
Eligible HSA Expenses	**Ineligible HSA Expenses**
Acupuncture Blood tests Chiropractor Contraceptives Diagnostic devices (such as a blood sugar monitor) Hearing aids Hospital services Insulin (including administration supplies) Lab tests Prescription medications Nursing services Wheelchairs	Athletic club memberships Cosmetic surgery Cosmetics, hygiene products and similar items Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits Over-the-counter medications without a doctor’s prescription Tobacco cessation programs Weight loss programs

Limited Purpose Health Care Flexible Spending Account (LPFSA)

IRS regulations do not permit CORE Medical Option participants to contribute to both an HSA and a Health Care FSA. However, you can elect a Limited Purpose Health Care FSA. The Limited Purpose FSA can be used for eligible vision and dental expenses. See the Health Care Flexible Spending Accounts section for more information.

Out-of-Area Coverage

This section includes:

- How Out-of-Area Coverage Works
  - Network/Claims Administrator
  - Special Provisions
- Covered and Excluded Expenses
- Filing Claims
  - Claims Filing Deadline
- Prescription Drug Benefits
  - Retail Drug Coverage
  - Filling Prescriptions at a Network Pharmacy
  - Filling Prescriptions at an Out-of-Network Pharmacy
  - Reimbursement of Co-insurance
  - ESI Mail Order
  - Mail Order Prescription Clinical Programs
  - Generic Drugs
  - Ordering Prescriptions by Mail
  - Internet Refill Option
  - Other Refill Options
  - Claims Filing Deadline
  - Reimbursement of Co-insurance
  - Health Reimbursement Account

This Out-of-Area Medical Option is non-grandfathered.

Employees whose alternate address ZIP code is not part of their preferred administrator's network of providers will be offered the OUT-OF-AREA Coverage as an Option. You can cover yourself, your spouse/Company-recognized Domestic Partner, your dependent children and/or your spouse/Company-recognized Domestic Partner's children under OUT-OF-AREA coverage.

The sole Network/Claims Administrator for the OUT-OF-AREA Medical Option is UnitedHealthcare. Each covered person, which includes you and any covered dependents, must satisfy an individual annual deductible before the Option begins paying a percentage of the eligible expenses.

Each covered person, which includes you and any covered dependents, must satisfy an individual annual out-of-pocket maximum before the Option begins paying 100% of the eligible expenses.

When you use a UHC contracted physician, hospital and/or other medical service provider, your eligible expenses will be based on the negotiated rates.

Eligible expenses are based on 90% of Usual & Prevailing fees (U&P).

Benefit Overview

Individual Annual Deductible	Family Annual Deductible	Individual Annual Out-of-Pocket Maximum	Family Annual Out-of-Pocket Maximum
$750	$2,250	$2,000	$5,000

How Out-of-Area Coverage Works

In rare cases, a U.S. employee may live outside all of the network areas and not have ready access to any of the provider networks. Employees who do not have access to network providers that meet the guidelines determined by the Network/Claims Administrator will have OUT-OF-AREA coverage as an Option. If you are eligible for OUT-OF-AREA coverage, you will see it listed as an Option in the Benefits Service Center when you enroll.

OUT-OF-AREA coverage offers a preferred provider network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. You may use any qualified licensed physician you wish, but you will receive the discount if you use an in-network provider. Contact your Network/Claims Administrator for more information and to access a list of in-network providers. See “Negotiated Rates” in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

See “Medical Benefits Option Comparison” in the *Medical Benefits Options Overview* section to see a comparison of your benefits under the OUT-OF-AREA Medical Option.

Each covered person, which includes you and any covered dependents, must satisfy an individual annual deductible of $750 before the Option begins paying a percentage of the eligible expenses (with the exception of preventive care and prescription drugs). After you and your covered dependents meet the annual deductible, the OUT-OF-AREA Medical Option pays 80% of eligible expenses up to the negotiated rate or usual and prevailing. You pay 20% co-insurance for services. After you meet the annual out-of-pocket maximum, eligible expenses are covered at 100% for the remainder of the year, with the exception of certain prescription drug expenses.

Network/Claims Administrator

OUT-OF-AREA coverage is administered by UnitedHealthcare (UHC). Therefore, you cannot select a different Network/Claims Administrator for OUT-OF-AREA coverage.

If you relocate to a new state, your Network/Claims Administrator does not change. Your medical plan Option election and contribution rates remain the same for the remainder of the plan year.

Special Provisions

OUT-OF-AREA Coverage includes the following special provisions:

Individual Annual Out-of-Pocket Maximum: The covered persons coinsurance and copay amounts apply to the out-of-pocket maximum. After you satisfy the individual annual out-of-pocket maximum of $2,000 for eligible expenses, OUT-OF-AREA coverage pays 100% of eligible expenses for the rest of the calendar year. Under OUT-OF-AREA coverage. Deductibles do not count towards the out-of-pocket maximum.

Negotiated Rates: If you are enrolled in OUT-OF-AREA coverage, it is because there are not any network providers where you reside. However, there may be instances in which you receive services from a network provider.

OUT-OF-AREA coverage offers a network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. The negotiated rates save you money when you or your covered dependent needs medical care and chooses a participating provider.

This negotiated rate is automatic when you present your medical ID card to an in-network provider. In-network providers who contract with your Network/Claims Administrator agree to

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

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

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

If you go to an in-network hospital but receive services from a provider who is not an in-network provider, you will receive the in-network negotiated rate for hospital charges; however, the physician's fee is not eligible for the in-network negotiated rate.

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

In all cases, the out-of-network provider fees will be subject to usual and prevailing fee limits. U&P for OOA services is 90th percentile of Fair Health.

Covered and Excluded Expenses

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

Filing Claims

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

Complete a Medical Benefit Claim Form.

Submit the completed form to your Network/Claims Administrator, along with all original itemized receipts from your physician or other health care provider. A cancelled check or credit card receipt is not acceptable.

Each bill or receipt submitted to your Network/Claims Administrator must include the following:

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

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

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

If you have questions about your coverage or your claim under the OUT-OF-AREA Medical Option, contact your Network/Claims Administrator (see "Contact Information" in the *Reference Information* section).

Claims Filing Deadline

For all claims incurred on or after 1/1/10, you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

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

Prescription Drug Benefits

Express Scripts is the prescription drug vendor for the OUT-OF-AREA Medical Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the ESI Mail Order benefit. Only eligible expenses for covered prescription drugs apply to your out-of-pocket maximum.

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

Retail Drug Coverage

You may have your prescriptions filled at any pharmacy but will receive better coverage at a network pharmacy or by using mail order. You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted medication rates at network pharmacies. If you do not present your Express Scripts prescription drug card at the time of purchase at a network pharmacy, you will pay the non-discounted price at that time and reimbursement from the plan will be based on the discounted price. This means you pay the difference between the non-discounted and the discounted price, in addition to paying the co-insurance.

Here is an example:

Cost of prescription at pharmacy:	$250
Express Scripts discount price:	$100
You Pay:	$20 (20% co-insurance of $100), plus $150 (the difference between the actual pharmacy cost and the Express Scripts discount price)
Your Total:	$170

Generic Drugs: 20% co-insurance ($10 min/$40 max per prescription)

Formulary/Brand Name Drugs: 30% co-insurance ($30 min/$100 max per prescription)*

Non-Formulary/Brand Name Drugs: 50% co-insurance ($45 min/$150 max per prescription)*

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

Note: You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted price if using a network pharmacy.

Filling Prescriptions at a Network Pharmacy

Follow these steps to fill prescriptions:

Network pharmacies:

Present your Express Scripts ID card at the in-network pharmacy

Pay your portion of the cost for the prescription

Express Scripts reports the claim to your Network/Claims Administrator. Any eligible amounts will be applied to your out-of-pocket maximum.

Filling Prescriptions at an Out-of-Network Pharmacy

Follow these steps to fill prescriptions:

Out-of-Network pharmacies:

- Pay the full cost for the prescription
- Send your prescription receipt to Express Scripts
- Express Scripts reports the claim to your Network/Claims Administrator. Any eligible amounts will be applied to your out-of-pocket maximum.

Reimbursement of Co-insurance

If you are enrolled in the OUT-OF-AREA Medical Option and you participate in the Health Care Flexible Spending Account, your eligible retail drug out-of-pocket expense is reimbursable under your FSA (see "Covered Expenses" in the *Health Care Flexible Spending Accounts* section. If you have funds in your Health Reimbursement Account, you can use those funds to pay out-of-pocket expenses. However, keep in mind that you can access your Health Reimbursement Account only after you've exhausted your Health Care Flexible Spending Account.

If you have questions concerning your prescription drug coverage, call the Express Scripts Member Services number on your Express Scripts ID card. If you have questions about the benefit amount reflected on your EOB, call your Network/Claims Administrator (for specialty medications see "Specialty Pharmacy Services" in this section).

Retail Refill Allowance — Long-Term Medications

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

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

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

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

Retail Prescription Clinical Programs

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

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

Generic Drugs

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

Prior Authorization

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

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

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

Ask your physician to contact Express Scripts or to complete Express Scripts' prior authorization form with the following information:

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

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

Specialty Pharmacy Services

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

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

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

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

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

Whether these prescriptions are self-administered or administered in a physician's office, the prescriptions to treat the above conditions will no longer be reimbursed through your medical benefit Option and must be filled at a retail pharmacy using your Express Scripts ID card or through ESI Mail Order for you to receive prescription drug benefits. Express Scripts can ship the prescription to your home for self-administration or to your physician's office for medications which are to be administered by a physician.

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

ESI Mail Order

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

You may order up to a 90-day supply of your prescription drug (but no more than the number of days prescribed by your physician). You pay co-insurance (with no annual deductible) for each prescription or refill. Co-insurance, which is subject to change, is currently:

Generic Drugs: 20% co-insurance per prescription or refill for generic drugs (or the actual cost of the drug, if the prescription cost is less). The minimum amount you will pay is $5 and the maximum you will pay is $80.

Formulary Brand Name Drugs: 30% co-insurance per prescription or refill for formulary/brand name drugs (or the actual cost of the drug, if the prescription cost is less). The minimum amount you will pay is $60 and the maximum you will pay is $200.

Non-formulary Brand Name Drugs: 50% co-insurance per prescription or refill for non-formulary/brand name drugs (or the actual cost of the drug, if the prescription cost is less). The minimum amount you will pay is $90 and the maximum you will pay is $300.

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100% under the OUT-OF-AREA Medical Option through ESI Mail Order only. If you purchase contraceptives from a retail pharmacy, no benefits are payable. If you purchase a brand name contraceptive that has a generic equivalent, you are responsible for the cost difference between brand and generic.

Mail Order Prescription Clinical Programs

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

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

Generic Drugs

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

Ordering Prescriptions by Mail

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

Complete the Mail Order Form.

Complete the Health, Allergy, and Medical Questionnaire (found on the Express Scripts website). The questionnaire will not be necessary on refills or future orders unless your health changes significantly.

Include the original written prescription signed by your physician.

Indicate your method of payment on the form.

- A major credit or debit card, or
- Personal check or money order.

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

Mail your order to the address on the Mail Order Form.

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

Internet Refill Option

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

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

Other Refill Options

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

Call 1-800-988-4125 to request a refill. You will be asked for your Express Scripts ID number, current mailing address and Express Scripts Health Rx Services prescription number.

Complete and mail in your Mail Order Form. Attach your ESI Mail Order refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

Claims Filing Deadline

For all claims incurred on or after 1/1/10, you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

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

Reimbursement of Co-insurance

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

If you have exhausted your Health Care Flexible Spending Account, and have funds in your Health Reimbursement Account, you can receive reimbursement for your co-insurance.

HRA - Health Reimbursement Account

If you participate in the Healthmatters wellness program, dollars that you earn for completing certain activities will be deposited into your HRA. You can use these funds to help offset medical and prescription out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. Funds must be in the account before you can use them.

Health Maintenance Organizations (HMOs)

This section includes:

- Eligibility
  - Children Living Outside of the Service Area
  - Termination of Coverage
  - If You Reach Age 65 and are Still an Active Employee
- How HMOs Work
- HMO Contact Information
  - Problems and Complaints

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

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

If you enroll in an HMO Medical Option, you will receive information from the HMO describing the services and exclusions of that HMO.

Company-recognized Domestic Partners may be eligible for coverage under HMOs. Contact your HMO directly to learn about their eligibility rules.

Most HMOs require you to choose a primary care physician (PCP) who coordinates your medical care.

Expenses such as prescription drugs and mental health care may be covered by HMOs.

HMO Medical Option Eligibility

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

Eligibility

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

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

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

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

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

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

Children Living Outside of the Service Area

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

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

Termination of Coverage

Your HMO coverage terminates on the date when:

Your employment terminates. If your employment terminates, you may be eligible to continue HMO coverage under COBRA. You may also apply for individual HMO coverage. You will automatically be solicited for continuation of your HMO coverage under COBRA by Benefit Concepts, Inc., the COBRA administrator.

You leave the service area. You must register this move as a Life Event on Benefits Service Center, and enroll in another HMO (if available) or self-funded Medical Benefit Option. Contact HR Services within 60 days of your move. Click on the "Start a Chat" button on the top of this page. If you do not notify HR Services of your move, you will be enrolled the default Medical Benefit Option for your workgroup and will receive a confirmation statement indicating your new coverage.

You retire. If you retire while covered by an HMO, your coverage will change. See the Retiree Medical Benefit Guide for your workgroup eligibility. HMO membership is not currently available to retirees unless you live in Puerto Rico. Retirees on or after 11/1/12 in Puerto Rico may enroll in the Humana of Puerto Rico HMO.

However, you may continue coverage in an HMO through COBRA for a period of 18 months at the time of your retirement. You will automatically be solicited for continuation of your HMO coverage under COBRA by Benefit Concepts, Inc., the COBRA administrator.

If You Reach Age 65 and are Still an Active Employee

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

How HMOs Work

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

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

Glossary Term: Primary Care Physician (PCP)

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

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

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

- In general, features of HMOs include:
- A network of providers,
- A PCP who coordinates your covered medical care,
- Covered preventive care, and
- No claims to file.

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

HMO Contact Information

For more information on HMOs, contact the individual HMO.

HMO Name	Phone Number	Website Address	Group Number
CommunityCare Managed Healthcare Plans of Oklahoma	1-800-777-4890	http://www.ccok.com/	C01338
Health Plan Hawaii	1-808-948-6372	http://www.hmsa.com/	24759-1 17579-1
Humana Health Plans of Puerto Rico	1-800-314-3121	http://www.humana.com/	113262
Kaiser Northern California	1-800-464-4000	http://www.my.kp.org/americanairlines	8653
Kaiser Southern California	1-800-464-4000	http://www.my.kp.org/americanairlines	102105
Kaiser Mid-Atlantic States (Maryland and Washington, D.C.)	1-800-777-7902	http://www.my.kp.org/americanairlines	3381
TRIPLE-S Inc. (Puerto Rico only)	1-787-774-6060	http://www.ssspr.com/	SP0003447 AA

Problems and Complaints

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

Dental Benefits

This section includes:

- How the Dental Benefit Works
  - Eligibility
  - Plan Comparison Chart
  - Special Provisions
- Covered Expenses
  - Preventive Services
  - Basic and Major Services
  - Orthodontia
- Excluded Expenses
- Filing Claims
  - Claim Filing Deadline

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

- Eligible employees and their eligible dependents can enroll in Dental Benefits, even if they do not elect medical coverage.
- You must enroll yourself in the Dental Benefit if you would like to cover any dependents under the Dental Benefit.
- Orthodontia coverage is included for eligible children and adults.
- MetLife administers a Preferred Dental Provider (PDP) network that offer services at discounted rates. You may use any dentist you wish, but preventive services are covered at 100% if you use an in-network PDP provider or 80% if you use an out-of-network PDP. For TWU-Represented employees preventative services are covered at 100% if you use an in-network or out-of-network PDP.
- The Dental Benefit covers medically necessary dental and orthodontic items and services for covered eligible adults and children.

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

Benefit Overview

Eligibility	Coverage Levels	Key Features
All eligible employees and their eligible dependents	▪ Employee ▪ Employee + Spouse/Company-recognized Domestic Partner ▪ Employee + Child(ren) ▪ Employee + Family	▪ Annual deductible of $50 ▪ Preventive care provided by an in-network dentist at 100% ▪ Preventive care provided by an out-of-network dentist at 80% ▪ Basic and major care at 80% ▪ Orthodontia services at 50% ▪ For TWU-Represented employees, in-network or out-of-network preventive care is covered 100%

How the Dental Benefit Works

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

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

FAQ: How do I find a PDOMESTIC PARTNER (DP) network dentist?

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

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

Eligibility

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

Plan Comparison Chart

These are the features of the Dental Benefit Options:

Feature	Benefit
Annual Deductible (You pay this amount before benefits are paid)	$50 per person
Dental Services Plan pays:	
Preventive Service - Services Provided by a Network Provider ▪ Twice per year: exams and cleanings ▪ Once per year: routine X-rays	100% (Deductible does not apply)
Preventive Service - Services Not Provided by a Network Provider ▪ Twice per year: exams and cleanings ▪ Once per year: routine X-rays	80% (Deductible does apply) 100% for TWU-Represented employees
Basic & Major Services (fillings, extractions, crowns, bridges, dentures)	80%
Maximum Benefit (per person per year)	$1,500
Orthodontia Services Plan pays:	
Orthodontia Services (annual deductible does not apply)	50%
Maximum Lifetime Orthodontia Benefit (Adult or eligible dependent child)	$1,500

Special Provisions

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

Covered Expenses

There are two types of Covered Expenses:

- Preventive Services
- Basic and Major Services

Glossary Term: Usual and Prevailing Fee Limits

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

Preventive Services

Preventive treatment:

- Exams twice per calendar year
- Routine X-rays once per calendar year
  - TWU-Represented employee adults can have bitewings 2x a year
  - Children can have bitewings 2x a year
- Full mouth X-rays once every five years; three years for TWU-Represented employees
- Teeth cleaning twice per calendar year
- Fluoride treatments once a year for children under age 18 (not covered on or after the child's 18th birthday)
- Sealants for children under age 15 (not covered on or after the child's 15th birthday)
- Space maintainers

Basic and Major Services

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

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

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

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

Extractions, medically necessary surgery and medically necessary related anesthetics: These services are considered covered dental treatments. Treatment of certain injuries and conditions may be covered under Medical Benefit Options. See "Covered Expenses" in the *Medical Benefits Options Overview* section.

Fillings and crowns: Silver, porcelain or composite fillings and plastic restorations subject to the following:

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

Dental implants, implant restorations: Only if medically necessary and approved by independent dental consultants selected by the Company.

Inlays and onlays: Only if medically necessary and approved by independent dental consultants selected by the Company.

Oral examinations, X-rays and laboratory tests: These are covered if medically necessary to determine dental treatment.

Oral surgery: If you have medically necessary oral surgery and it requires medically necessary hospitalization, the expenses for the hospitalization would be payable under the Medical Benefit Option. See "Covered Expenses" in the *Medical Benefits Option Overview* section.

Periodontal treatment: Medically necessary periodontal treatment of the gums and supporting structures of the teeth and medically necessary anesthetics are covered, with the frequency of treatment based on generally accepted standards of good periodontal care. Examples are scaling and root planing, and gingivectomy.

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

Orthodontia

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

Orthodontic coverage includes:

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

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

The following explains additional information about orthodontia coverage:

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

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

- The provider of service (orthodontist) should submit one billing that reflects the total cost of the patient's orthodontic treatment – even if the duration of treatment moves across calendar years. The Dental Benefit will pay up to the maximum benefit of $1,500, in one lump sum, based upon the orthodontist's lump-sum billing for orthodontia treatment (provided the treatment is determined to be an eligible expense under the Dental Benefit).
- Coordination of benefits applies if the patient has other orthodontia coverage. If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the $1,500 maximum benefit.

Excluded Expenses

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

Anesthesia: General anesthetics (unless medically necessary and required for oral surgery or periodontics).

Cosmetic treatment: Treatment or services partly or completely for cosmetic purposes or characterization or personalization of dentures or appliances for specialized techniques.

Crowns or appliances: Crowns, adjustments or appliances used to splint teeth, increase vertical dimensions or restore occlusion. Replacement of crowns less than five years old will not be covered, regardless of the reason for replacement.

Education or training: Education, training or supplies for dietary or nutritional counseling, personal oral hygiene or dental plaque control.

Free care: Charges for services or supplies that you are not legally required to pay.

Medical expenses: Any charge for dental care or treatment that is an eligible expense under your Medical Benefit Option.

Night guards: Also referred to as occlusal guards and bruxism appliances.

Prescription drugs: Dental prescriptions are covered under your Prescription Drug Benefit, not under your Dental Benefit. If you are enrolled in an HMO, check with your HMO to find out if your HMO covers dental prescriptions.

Relatives: Treatment by a dentist or physician who is a close relative, including your spouse/Company-recognized Domestic Partner, children, adopted and step relatives, sisters and brothers, parents and granDomestic Partner (DP)arents of you or your spouse/Company-recognized Domestic Partner.

Replacement dentures or bridges: Replacement charges for full or partial dentures or a fixed or removable bridge that is less than five years old. Appliances that are over five years old but can be made serviceable will be repaired, not replaced. Also excluded are any charges that exceed the cost of a standard prosthetic appliance.

Services not provided by dentist, orthodontist or physician: Any service not provided by a dentist, orthodontist or physician, unless performed by a licensed dental hygienist under the supervision of a dentist or physician or for X-ray or laboratory tests ordered by a dentist or physician.

Temporary dentures, crowns or bridges after 12 months: A temporary fixture, such as a temporary denture, crown or bridge that remains in place for 12 months or more is considered permanent and the cost of replacement is only covered when the item is more than five years old.

Temporomandibular joint dysfunction (TMJD): TMJD is considered a medical condition and has limited coverage only under the Medical Benefit Options.

U. S. government services or supplies: Charges for services or supplies furnished by or for the U. S. government.

Usual and prevailing: Charges that exceed the usual and prevailing fee limits.

War-related: Services or supplies received as a result of a declared or undeclared act of war or armed aggression.

Work-related claims: Dental care received because of a work-related injury or illness sustained by you or your covered dependent, whether or not it is covered under Workers' Compensation, occupational disease law or similar law.

Filing Claims

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

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

Health Care Flexible Spending Account: Certain out-of-pocket dental expenses may be eligible for reimbursement from your Health Care Flexible Spending Account, Health Savings Account (CORE Medical Option) or Limited Purpose Health Care Flexible Spending Account. Dental expenses are not reimbursable under the Health Reimbursement Account (STANDARD Medical Option) or Health Incentive Account (VALUE Medical Option). (See "Covered Expenses" in the *Health Care Flexible Spending Account* section.)

Injury by others: If you are injured by someone else and your American Airlines Dental Option pays a benefit, the Company will recover payment from the third party (see "Subrogation" under the "Claims—For Non-Grandfathered Medical Options (Standard, Core, Value, Out-of-Area and HMO Medical Options)" section in the *Plan Administration* section).

Claim Filing Deadline

For all claims incurred on or after 1/1/10, you must submit all dental claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.

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

If the service or supply you've received is more expensive when a less expensive alternative is available, the Plan(s) pays benefits based on the less expensive service or supply that is consistent with generally accepted standards of appropriate medical, dental or other professional health care.

Vision Benefit

This section includes:

- How the Vision Insurance Benefit Works
  - Eligibility
- Covered Expenses
  - In-Network Provider Benefits
  - Out-of-Network Provider Benefits
- Filing Claims

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

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

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

Benefit Overview

Benefit	Coverage Tiers	Key Features
Vision Insurance Benefit	▪ Employee ▪ Employee + Spouse/Domestic Partner ▪ Employee + Child(ren) ▪ Employee + Family	▪ $10 co-pay for in-network eye exam ▪ $25 co-pay for in-network eyeglass lenses with a $130 frame allowance ▪ $25 co-pay for in-network contact lenses (in lieu of eyeglass lenses and frames) ▪ Out-of-network reimbursement rates

How the Vision Insurance Benefit Works

Spectera Vision's network of providers includes retail chains, such as VisionWorks, Wal-Mart or Sam's Club, as well as independent providers. You can locate participating providers by visiting the Spectera Vision website or you can contact Spectera Vision at 1-800-217-0094 to locate a provider near you. Or see "Contact Information" in the *Reference Information* section).

FAQ: How do I find a participating provider?

Visit the Spectera Vision website or call 1-800-217-0094.

To review your vision benefits, refer to the Spectera Vision Rates and Services Chart and Spectera's Vision Care Brochure on the Spectera Vision website.

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

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

Eligibility

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

Covered Expenses

In-Network Provider Benefits

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

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

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

Glossary Term: In-Network Provider

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

Covered Services	Cost
Comprehensive Vision Exam	$10 co-pay
Glasses (lenses and frames)	
▪ Clear single vision, lined bifocal or lined trifocal ▪ Selection frames (minimum frame allowance is $130 for frames purchased at an in-network retail chain provider)	$25 co-pay
▪ Clear single vision, lined bifocal or lined trifocal ▪ Non-selection frame	$25 co-pay, plus the difference, if any, of Spectera Vision's preferred price and the $130 frame allowance
Contact Lenses (in lieu of lenses and frames)	
▪ Selection contact lenses ▪ Non-disposable	$25 co-pay (per single pair of contacts)
▪ Non-selection contact lenses or special contact lenses (gas permeable, bifocal, astigmatism lenses, etc.) ▪ Non-disposable	$150 allowance toward the evaluation, fitting fees and a single pair of contact lenses
Patient Options	
▪ Selection contact lenses, disposable	$25 co-pay (up to 6 boxes per year included in $25 co-pay)
▪ Progressive lenses and tints, etc.	No additional charge (included in the $25 co-pay)
▪ Scratch-coating protection for lenses	No additional charge (included in the $25 co-pay)

Out-of-Network Provider Benefits

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

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

Filing Claims

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

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

Fast Fact

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

Flexible Spending Accounts

This section includes:

- How the Health Care Flexible Spending Account (HCFSA) Works
  - Special Provisions
- Covered Expenses
  - Reimbursable Medical Expenses
  - Reimbursable Hearing and Vision Expenses
  - Reimbursable Dental Expenses
- Excluded Expenses
- Filing Claims
- How the Limited Purpose Health Care Flexible Spending Account (LPFSA) Works
  - Reimbursable Expenses
  - Receiving Reimbursement Under the LPFSA
- If You Elect Both a Health Care and a Dependent Care FSA
- How the Dependent Care Flexible Spending Account Works
  - Special Provisions
  - Who is Covered
- Covered Expenses
- Filing Claims
- If You Elect Both a Health Care and a Dependent Care FSA

There are three types of flexible spending accounts that American offers. Each account has its own eligibility and expense rules.

1. HCFSA- Health Care Flexible Spending Account
2. LP FSA- Limited Purpose Flexible Spending Account
3. DDFSA -Dependent Care Flexible Spending Account

Account Administrator
The HCFSA, LPFSA and DDFSA administrator is WageWorks. The WageWorks website allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access “Frequently Asked Questions (FAQs),” and manage direct deposit.

How the HCFSA - Health Care Flexible Spending Account Works

The HCFSA allows you to set aside money on a pre-tax basis to pay for eligible health care expenses. Paying for these expenses pre-tax helps reduce your taxes.

IRS rules specify the types of expenses eligible for reimbursement from your HCFSA. Eligible health care expenses that can be reimbursed from your HCFSA include:

- Medical
- Dental
- Vision
- Prescription drugs
- Certain over-the-counter items.
- Other expenses not paid by your Medical Benefit Option, such as deductibles, co-insurance, co-pays and any amounts above the usual and prevailing fee limits.

See "Covered Expenses" and "Excluded Expenses" in this section for a list of eligible and ineligible expenses.

You can contribute through payroll deduction up to $2,500 a year in your HCFSA.

Following your first payroll deposit, the full amount of your elected HCFSA amount for the entire year is available for your use, regardless of the actual balance in your account.

You may carry over any unused funds remaining in your HCFSA as of December 31 into the next calendar year. You have until March 15 of the following year to use your HCFSA balance and until June 15 to file claims on your previous year's eligible expenses.

Benefit Overview		
Option	**Who Can Be Reimbursed**	**Key Features**
HCFSA-Health Care FSA	You can be reimbursed for expenses for your: ▪ Self ▪ Spouse ▪ Children and young adults ▪ Parents ▪ Other dependents, if you claim them as dependents on your federal income tax return ▪ Company-recognized Domestic Partners and their dependents are not considered eligible dependents, per IRS regulations	Deposit up to $2,500 a year ▪ Pre-tax contributions ▪ Have until March 15 to use your prior year's balance ▪ Have until June 15 to file claims for previous year's eligible expenses ▪ Eligible dependents do not have to be covered under your medical, dental or vision plan to be eligible for reimbursement ▪ If both you and your spouse are employed by American Airlines, both employees may each deposit up to $2,500 in an HCFSA

Special Provisions

You can only stop or change your election mid-year if you experience certain Life Events.

If you experience a Life Event and decide to reduce the amount of your HCFSA, you cannot reduce your account balance to an amount that is less than the claims that have already been paid.

If you incur expenses after your Life Event, your claims are payable up to the amount of your newly elected deposit amount.

If you decide to stop the amount of your HCFSA deposits mid-year, this will affect how your claims are paid. You cannot stop if you have already received reimbursement exceeding the amount contributed into your HCFSA account. If your eligible health care expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your HCFSA. You cannot receive reimbursement for expenses incurred after the date you stopped making contributions to your HCFSA; however you can submit claims up to the amount in your account, provided they were incurred before the date you stopped.

If you choose to stop the amount of your HCFSA mid-year, you will lose any remaining balance you have if the contributions you made before your Life Event are greater than your claims before the Life Event.

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your HCFSA terminates. You may elect to continue your HCFSA as part of your COBRA Continuation of Coverage options. If you do not continue your HCFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any contributions that were made and not used before your termination date.

Covered Expenses

You can incur claims that meet reimbursement rules for your HCFSA only for eligible expenses through March 15 of the following year. You have until June 15 to file your claims for reimbursement for eligible expenses.

FAQ: How do I know if my OTC items are covered?

Go to the WageWorks website or the IRS website.

Expenses that can be reimbursed through an HCFSA include the following:

Out-of-pocket expenses, deductibles, co-insurance, co-pays, prescription medications and supplies not paid by your medical, dental or vision benefit options, whether your coverage is under an American Airlines-sponsored plan or any other health plan.

Certain types of over-the-counter items purchased with a physician's written prescription and used to alleviate or treat personal injuries or sicknesses of the employee and/or the eligible dependents may be eligible for reimbursement through your HCFSA. For instance, insulin, bandages, crutches and contact lens solution, and the like. Refer to the list of eligible items by visiting the WageWorks website.

Reimbursable Medical Expenses

Some medical expenses may not be covered at all by your Medical Benefit Option. However, they may be reimbursed under your HCFSA. Examples include:

- Acupuncture
- Ambulance service
- Artificial insemination
- Bandages, support hose, other pressure garments (when prescribed by a physician to treat a specific ailment)
- Blood, blood plasma or blood substitutes
- Braces, appliances or equipment, including procurement or use
- Car controls for the handicapped
- Charges in excess of usual and prevailing fee limits
- Confinement to a facility primarily for screening tests and physical therapy
- Experimental procedures
- Foot disorders and treatments such as corns, bunions, calluses and structural disorders
- Halfway house care
- Home health care, hospice care, nurse or home health care aides
- Hypnosis for treatment of illness
- In-vitro fertilization and infertility treatment
- Learning disability tutoring or therapy
- Nursing home care
- Physical therapy
- Prescription vitamins
- Psychiatric or psychological counseling
- Radial keratotomies, lasik and vision correction procedures
- Sexual transformation or treatment of sexual dysfunctions or inadequacies
- Smoking cessation program costs and prescription nicotine withdrawal medications
- Speech therapy
- Syringes, needles and injections

- Transportation expenses to receive medical care, including fares for public transportation and private auto expenses (consult your tax advisor for the current IRS mileage allowance)
- Work-related sickness or injury (not covered by Workers' Compensation)

For a full list of covered medical expenses, go to the IRS website.

Reimbursable Hearing and Vision Expenses

Some hearing and vision expenses that may be reimbursed under your HCFSA include:

Hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading) and the cost of acquiring and training a service animal for the deaf.

Vision expenses, including eyeglasses, contact lenses, ophthalmologist fees, the cost of a service animal for the blind and special education devices for the blind (such as an interpreter).

For a full list of covered hearing and vision expenses, go to the IRS website.

Reimbursable Dental Expenses

Some medical expenses may not be covered at all by your Dental Benefit. However, they may be reimbursed under your HCFSA. Examples include:

- Anesthesia
- Cleaning more than twice per year
- Charges in excess of usual and prevailing fee limits
- Drugs and their administration
- Experimental procedures
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents
- Myofunctional therapy
- Replacement of dentures or bridgework less than five years old
- Replacement of lost, stolen, or missing dentures or orthodontic devices

For a full list of covered dental expenses, go to the IRS website.

Excluded Expenses

Some expenses may not be reimbursed through your HCFSA; examples include:

- Medical insurance premiums/contributions
- Air conditioning units
- Capital expenses
- Cosmetic medical treatment, surgery, and prescriptions and cosmetic dental procedures, such as cosmetic tooth bonding or whitening
- Electrolysis
- Health club fees and exercise classes (except in rare cases for treatment of medically diagnosed obesity where weight loss is part of the program)
- Marriage and family counseling
- Massage therapy
- Over-the-counter medications without a prescription
- Personal care items including cosmetics and toiletries
- Structural additions or changes
- Swimming pools
- Transportation expenses for the handicapped to and from work
- Vacation travel for health purposes
- Vitamins and nutritional supplements, unless prescribed by a doctor
- Weight loss programs (unless for treatment of medically diagnosed morbid obesity)
- Wheelchair ramps
- Whirlpools

For a full list of excluded expenses, go to the IRS website.

Filing Claims

Following the first payroll deduction, the full amount of your elected HCFSA amount for the entire year is available for your use, regardless of the actual balance in your account. You may access the funds via the following claim methods:

Health Care Card: Once activated you can use this card like a debit card to pay for eligible expenses at the time of purchase.

Auto reimbursement: With auto reimbursement your claims are automatically sent from your Network/Claims Administrator to WageWorks for reimbursement. Once claims are submitted, the cost of your out-of-pocket expenses will be reimbursed. See the WageWorks website for more information.

Manual reimbursement: you have the option of submitting claims manually to Wageworks. Manual reimbursement allows you to choose when to pay the claim.

You may elect to have your reimbursements deposited directly into your checking or savings account simply by providing your account information online via the Direct Deposit link on the WageWorks website.

Per IRS regulations, expenses for your Company-recognized Domestic Partner and their dependents are not eligible for HCFSA reimbursement. Thus, HCFSA claims for you and your eligible dependents must be filed via paper, online or fax submissions. This is so claims can be verified by patient identity. Auto reimbursement is not permitted if you have a covered Company-recognized Domestic Partner.

You have until March 15 to use your prior year's balance and until June 15 to file claims for the previous year's eligible expenses.

How the LPFSA -Limited Purpose Flexible Spending Account Works

The LPFSA is offered to CORE Medical Option participants only, in lieu of the Health Care FSA.

The LPFSA allows you to set aside money on a pre-tax basis to pay for eligible vision and dental expenses. Paying for these expenses pre-tax helps reduce your taxes.

Following your first payroll deposit, the full amount of your elected LPFSA amount for the entire year is available for your use, regardless of the actual balance in your account.

You may carry over any unused funds remaining in your LPFSA as of December 31 into the next calendar year. You have until March 15 of the following year to use your LPFSA balance and until June 15 to file claims on your previous year's eligible expenses.

Benefit Overview		
Option	**Who Can Be Reimbursed**	**Key Features**
LPFSA-Limited Purpose Health Care FSA (dental and vision expenses only) Must be enrolled in CORE Option	You can be reimbursed for expenses for your: ▪ Self ▪ Spouse ▪ Children and young adults ▪ Parents ▪ Other dependents, if you claim them as dependents on your federal income tax return ▪ Company-recognized Domestic Partners and their dependents are not considered eligible dependents, per IRS regulations	Deposit up to $2,500 a year ▪ Pre-tax contributions ▪ Have until March 15 to use your prior year's balance ▪ Have until June 15 to file claims for previous year's eligible expenses ▪ If both you and your spouse are employed by American Airlines, both employees may each deposit up to $2,500 in an LPFSA

Reimbursable Expenses

IRS rules specify the types of expenses eligible for reimbursement from your LPFSA. Some vision expenses that may be reimbursed under your LPFSA include:

- Eyeglasses
- Contact lenses
- Ophthalmologist fees
- The cost of a guide dog for the blind and special education devices for the blind (such as an interpreter)
- Some dental expenses that may be reimbursed under your LPFSA include:
- Anesthesia
- Cleaning more than twice per year
- Charges in excess of usual and prevailing fee limits
- Drugs and their administration
- Experimental procedures
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents
- Myofunctional therapy
- Replacement of dentures or bridgework less than five years old
- Replacement of lost, stolen, or missing dentures or orthodontic devices
- You cannot use an LPFSA for medical expenses. If you are enrolled in the CORE Medical Option, you may use a Health Savings Account to pay for eligible health care expenses. See the CORE Medical Option section for more information.

Receiving Reimbursement Under the LPFSA

Following the first payroll deduction, the full amount of your elected LPFSA amount for the entire year is available for your use, regardless of the actual balance in your account. You may access the funds via the following claim methods:

Health Care Card: Once activated you can use this card like a debit card to pay for eligible expenses at the time of purchase. If you enroll in both an LPFSA and H SA, you will automatically receive one Health Care Card to use for both accounts.

Auto reimbursement: With auto reimbursement your claims are automatically sent from your Network/Claims Administrator to WageWorks for reimbursement. Once claims are submitted, the cost of your out-of-pocket expenses will be reimbursed. See the WageWorks website for more information.

Manual reimbursement: you have the option of submitting claims manually to Wageworks. Manual reimbursement allows you to choose when to pay the claim.

You may elect to have your reimbursements deposited directly into your checking or savings account simply by providing your account information online via the Direct Deposit link on the WageWorks website.

Per IRS regulations, expenses for your Company-recognized Domestic Partner and their dependents are not eligible for LPFSA reimbursement. Thus, LPFSA claims for you and your eligible dependents must be filed via paper, online or fax submissions. This is so claims can be verified by patient identity. Auto reimbursement is not permitted if you have a covered Company-recognized Domestic Partner.

You have until March 15 to use your prior year's balance and until June 15 to file claims for the previous year's eligible expenses.

How the DDFSA- Dependent Care Flexible Spending Account Works

The DDFSA allows you to set aside money on a pre-tax basis to help pay for eligible day care expenses for your eligible adult and adolescent dependents. Paying for these expenses with pre-tax money helps reduce your taxes.

A single employee or an employee who files a joint income tax return with his or her spouse and both earn over $5,000 for the year, may contribute up to $5,000 per calendar year. A lower limit applies to employees who file separate returns and special rules apply if your spouse does not work. If both you and your spouse work for American Airlines, your combined DDFSA total contribution cannot exceed $5,000.

As funds are deposited into your account, you can pay for eligible day care expenses.

You can incur claims until the last calendar date of the plan year and submit incurred claims for reimbursement 90 days after that date.

Important Note: If you put money into a DDFSA and you do not have any eligible dependents, once the plan year begins that money cannot be refunded to you, per IRS regulations.

Benefit Overview		
Option	**Reimbursement**	**Key Features**
Dependent Care FSA	You can be reimbursed for: Licensed child and adult day care centers Private kindergarten Babysitters Au pairs	Contribute up to $5,000 a year Pre-tax contributions Have until 12/31 of the benefit year to use your prior year's balance Have until 3/31 to file claims for previous year's eligible expenses You cannot use your funds until they are deposited in your account

Special Provisions

You and your spouse (if you are married) must be employed or actively seeking employment to be eligible to receive reimbursement from your DDFSA. This benefit limits the amount you may contribute and the type of expenses that may be paid from your DDFSA.

Your family and tax filing status determine the maximum amount you can contribute per calendar year:

- A single employee may contribute up to $5,000.
- A couple filing a joint income tax return, where both spouses participate in DDFSAs, may contribute a combined amount of up to $5,000.
- A couple filing separate income tax returns may each contribute up to $2,500.
- A couple (if both individuals are employed) may contribute up to $5,000, or the income amount of the lower-paid spouse (if it is less than $5,000).
- If you are a Highly Compensated Employee, as defined by the Internal Revenue Code, your allowable annual pre-tax contribution may be less than $5,000 per calendar year. For example, as defined by the Internal Revenue Code in 2012, a Highly Compensated Employee is an individual who has an annual income of $115,000 or more. This amount may be subject to change, and you will be notified if your maximum contribution changes. For more information about Highly Compensated Employee limits, go to the IRS website.

Fast Fact

If you are single or married and file your taxes jointly, you can contribute up to $5,000 a year in your DDFSA.

You can only stop or change your election mid-year if you experience certain Life Events.

If you experience a Life Event and decide to reduce the amount of your DDFSA, you cannot reduce your account balance to an amount that is less than the claims that have already been paid.

If you incur expenses after your Life Event, your claims are payable up to the amount of your newly elected deposit amount.

If you decide to stop the amount of your DDFSA deposits mid-year, this will affect how your claims are paid.

You cannot stop if you have already received reimbursement exceeding that amount contributed into your DDFSA account.

If your eligible expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your DDFSA.

You cannot receive reimbursement for expenses incurred after the date you stopped making contributions to your DDFSA; however you can submit claims up to the amount in your account, provided they were incurred before the date you stopped.

If you chose to stop the amount of your DDFSA mid-year, you will lose any remaining balance you have if the contributions you made before your Life Event are greater than your claims before the Life Event.

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your DDFSA terminates. You may elect to continue your DDFSA as part of your COBRA Continuation of Coverage options. If you do not continue your DDFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any contributions that were made and not used before your termination date.

Who Is Covered

You may claim Dependent Care expenses for your eligible dependents including:

Children under age 13

A person over age 13 (including your child, spouse, or parent), if the person meets **all** of the following criteria:

- Lives with you and depends on you for support,
- Is claimed as a dependent on your federal income tax return,
- Is physically or mentally incapable of self-care, and
- Has a gross income less than the federal income tax personal exemption.

Go to the IRS website for more information.

Because of IRS rules, Company-recognized Domestic Partners and their dependents are not considered eligible dependents under your DDFSA.

Glossary Term: Eligible Dependent (under the DDFSA)

Children under 13 and anyone over 13 who lives with you, is your dependent, is not capable of self-care and makes less than the federal income tax personal exemption is considered an eligible dependent under the DDFSA.

Covered Expenses

Expenses paid to the following providers may be reimbursed through your DDFSA, if you can provide their Social Security or taxpayer identification number:

- Someone who cares for an elderly or disabled dependent inside or outside your home
- A licensed child-care center or adult day care center, including churches or non-profit centers
- A private kindergarten (used for day care of child(ren), rather than for educational purposes
    - If the private kindergarten provides both day care and educational services for your dependent child(ren), only the day care portion of the kindergarten's charges are eligible for reimbursement
    - The private kindergarten must separate and itemize the charges on its invoices for payment, clearly separating the day care expenses from the educational expenses
- If you cannot provide a separation/itemization of charges on the invoice, you will not receive reimbursement from your DDFSA
- A babysitter inside or outside your home if the sitter does not care for more than six children at a time (not including the sitter's own dependents)
- A housekeeper whose duties include Dependent Care
- A relative who cares for your dependents, but is neither your spouse nor your dependent child under age 19
- Au pairs (foreign visitors to the U.S. who perform day care and domestic services in exchange for living expenses, provided the au pair agency is a non-profit organization or the au pair obtains a U.S. Social Security number for identification purposes)

Filing Claims

Participants who have a Dependent Daycare Flexible Spending Account may file claims on the WageWorks website, by fax, or through the US Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the WageWorks website.

If you do not have adequate funds in your DDFSA account, a partial payment of the claim will be made and the balance of your claim will pay out as payroll deposits are made.

You can incur claims until the last calendar date of the plan year and submit incurred claims for reimbursement 90 days after that date.

If You Elect Both an HCFSA/LPFSA and a DDFSA

Your FSA and DDFSA Funds are managed separately.

To get reimbursement for eligible DDFSA expenses submit claims via mail, fax, online, or utilize Pay My Provider online on the WageWorks website.

Auto reimbursement is not permitted.

The funds in your DDFSA are only available as funds are contributed into your account.

You have until March 15 to use your prior year's balance and until June 15 to file claims for the previous year's eligible expenses.

Life Insurance Benefits

This section includes:

- How the Life Insurance Benefit Works
  - Basic Term Life Insurance Benefit
  - Voluntary Term Life Insurance Benefit
  - Spouse and Child Term Life Insurance Benefit
- Designating Beneficiaries
- Coverage if You Become Disabled
- Special Provisions
  - Accelerated Benefit Option (ABO)
  - Taxation of Life Insurance
  - Conversion and Portability
  - Assignment of Benefits
  - Total Control Account
  - Verbal Representation
- Filing Claims

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

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

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

FAQ: Do I have to pay for coverage?
Basic Term is offered at no cost to you. You pay the full cost of Voluntary Term, Spouse Term and Child Term Life Insurance.

How the Life Insurance Benefit Works

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

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

Benefit Overview

If you are a Home-Based Representative and Level 84 Premium Services Representative, you are not eligible for Basic Term Life Insurance.

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

Basic Term Life Insurance Benefit

If you are a Home-Based Representative and Level 84 Premium Services Representative, you are not eligible for Basic Term Life Insurance.

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

As an eligible employee, the Company provides coverage equal to two times your pay up to a maximum of $70,000, at no cost to you. You may elect a level of coverage lower than the amount you are eligible for, and may receive a credit for this lower amount. However, if you do not elect the maximum coverage amount you are eligible for as a new employee, or if you decide to decrease your basic coverage at a later date, you will be required to submit a Statement of Health to later increase your Basic Life coverage.

Coverage After Age 65

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

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

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

Voluntary Term Life Insurance Benefit

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

If you elect a level of coverage that requires a Statement of Health as a new employee and MetLife does not approve your coverage, you will not have any level of Voluntary Term Life coverage.

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

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

Below are the available Voluntary options:

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

Cost of Coverage

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

The following table defines pay for Employee Term Life Insurance:

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

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

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

Spouse and Child Term Life Insurance Benefit

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

Spouse and Child Term Life Insurance options are as follows:

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

Spouse Term Life Insurance

To add or increase Spouse Term Life Insurance, your spouse must complete a Statement of Health Form from MetLife. You must then forward the completed form to MetLife for review within 30 days of your election. Upon approval from MetLife, coverage will be added or increased. Coverage that requires *proof of good health* becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction. New employees may elect any of the three levels of spouse life with proof of good health.

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

Child Term Life Insurance

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

Filing a Claim

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

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

- Upon the death of your covered spouse or child, you or your supervisor should inform HR Services of the death. You are the sole beneficiary for your spouse or child's term life insurance.
- After HR Services is notified of the death, it sends you a letter verifying the amount of life insurance payable. The letter will include a Beneficiary Life Insurance Claim Statement.
- Complete the Beneficiary Life Insurance Claim Statement and return it, along with a certified copy of the death certificate, to HR Services. Upon receipt of both items, HR Services will submit the claim to MetLife on your behalf.
- The life insurance claim will be paid in approximately four to six weeks after MetLife receives all necessary documentation. You may assign part of the benefits to pay funeral expenses, (see "Assignment of Benefits".)
- When a spouse or covered dependent dies, you may want to make changes to your benefits coverages. To process these changes, contact HR Services. Click on the "Start a Chat" button on the top of this page. For a list of allowable changes that may be appropriate at this time, see "Life Events" in the *Life Events: Making Changes During the Year* section. Updates to your beneficiary designation can be completed online through the Benefits Service Center.

Designating Beneficiaries

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

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

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

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

Type of Designation	Sample Wording (always include your beneficiary's address)
One person, related	Jane Doe, spouse
One person, not related	Jane Doe, friend
Your estate	Estate
Member of a given religious order	Mary L. Jones, known in religious life as Sister Mary Agnes, niece
Two beneficiaries with the right of survivorship	John J. Jones, father, and Mary R. Jones, mother, equally or to the survivor
Three or more beneficiaries with the right of survivorship	James O. Jones, brother; Peter I. Jones, brother; Martha N. Jones, sister; equally or to the survivor(s)
Unnamed children	My children living at my death
One contingent beneficiary	Lois P. Jones, wife, if living; otherwise, Herbert I. Jones, son
Unnamed children as contingent beneficiaries	Lois P. Jones, wife, if living; otherwise, my children living at my death
Trustee (a trust agreement must be in existence)	ABC Trust Company of Newark, NJ, Michael W. Jones, Trustee, in one sum, under Trust Agreement dated (insert date)

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

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

To avoid complications in paying beneficiaries, an organization or endowment should not be named unless it is a legal entity (has a legal existence, such as a corporation or trust that has been legally established). If you designate a trust, MetLife assumes that the designated trustee is acting in proper fiduciary capacity unless written notice to the contrary is received at the home office of MetLife. MetLife and the Company are not liable for any payment made to a trustee before receiving such written notice. If the full amount of your insurance is not payable to the trustee, or if a testamentary trustee is named, write to MetLife for assistance in proper documentation.

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

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

Coverage if You Become Disabled

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

FAQ: What should I do if I become disabled?

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

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

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

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

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

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

Special Provisions

Accelerated Benefit Option (ABO)

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

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

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

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

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

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

Taxation of Life Insurance

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

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

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

An example of how imputed income works:

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

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

   $108,000 – $50,000 = $58,000

2. Divide that amount by $1,000:

   58,000 / $1,000 = 58

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

   58 × $0.08 = $4.64

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

Conversion and Portability

Conversion

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

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

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

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

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

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

Requesting Conversion

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

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

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

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

Portability

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

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

Assignment of Benefits

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

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

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

Total Control Account

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

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

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

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

Verbal Representation

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

Filing Claims

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

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

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

Accident Insurance Benefits

This section includes:

- Accidental Death & Dismemberment Insurance (AD&D)
  - What is Covered
  - Special Benefit Features
  - Exclusions
  - Filing a Claim
  - Conversion Rights
  - Insurance Policy
- Other Accident Insurance: Special Risk Accident Insurance (SRAI) Benefit, Special Purpose Accident Insurance (SPAI) Benefit and Management Personal Accident Insurance (MPAI)
  - SRAI Benefit
  - SPAI Benefits
  - MPAI Benefits (For Management/Specialist and Officer employees only)
  - Policy Aggregates
  - Exclusions
  - Insurance Policy

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

- As an eligible employee, you may elect to purchase Accidental Death and Dismemberment (AD&D) Insurance for yourself and your family.
- Special Risk and Accident Insurance (SRAI) pays a benefit up to a maximum of $500,000 if accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world.
- Special Purpose Accident Insurance (SPAI) coverage provides two types of insurance coverage:
  - Up to $100,000 if injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device.
  - Pays up to $100,000 for accidental death or dismemberment for non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft.
- **For Management/Specialist and Officer employees only**: Management Personal Accident Insurance provides a maximum of $200,000 in coverage for Management employees while traveling on Company business and for non-occupational accidents involving any land or water vehicle.

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

Benefit Overview

Option	Key Features
Accidental Death & Dismemberment (AD&D) Insurance	▪ Benefit paid in the event of your covered accidental injury or death ▪ You pay premiums through after-tax payroll deduction. ▪ Coverage in $10,000 increments up to $500,000 for employee coverage and up to $350,000 for spouse coverage. $10,000 coverage for each dependent child, regardless of the number of children covered.
Special Risk Accident Insurance (SRAI)	▪ Coverage is paid for by the Company ▪ Pays a benefit of five times your annual base salary, up to a maximum of $500,000 if accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world.
Special Purpose Accident Insurance (SPAI)	▪ Coverage is paid for by the Company. ▪ Pays up to $100,000 to each employee injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne. ▪ Covers non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft, and pays up to $100,000 for accidental death or dismemberment.
Management Personal Accident Insurance (MPAI) - For Management/Specialist and Officer employees only	▪ Provides a maximum of $200,000 in coverage for Management employees while traveling on Company business and for non-occupational accidents involving any land or water vehicle.

Accidental Death & Dismemberment Insurance (AD&D)

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

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

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

What Is Covered

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

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

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

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

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

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

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

Special Benefit Features

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Covered rehabilitative expense means an expense that:

- Is charged for a medically necessary rehabilitative training session of the participant, performed under the care, supervision or order of a physician,
- Does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for hospital room and board charges, does

not exceed the most common charge for hospital semi-private room and board in the hospital where the expense is incurred, and
- Does not include charges that would not have been made if no insurance existed.

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

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

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

Hospital means a facility that:

- Is operating according to law for the care and treatment of injured people,
- Has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a pre-arranged basis,
- Has 24-hour nursing service by registered nurses, and
- Is supervised by one or more physicians.

A hospital does not include:

- A nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care,
- A facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, or
- Any military or veteran hospital or soldiers' home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Special education benefit: If either you or your spouse dies as the result of an accident and your children are all covered by the family AD&D, the coverage pays 5% of that parent's total coverage amount (up to $10,000 per year) to each dependent child for higher education. This benefit is payable for up to four consecutive years, as long as the child is enrolled in school beyond 12th grade. If coverage is in force but there are no children who qualify at the time of the accident, the coverage pays an additional $1,000 to the designated beneficiary.

Spouse critical period: If you or your covered spouse dies as a result of an accident, AD&D pays the surviving spouse an additional monthly benefit of a half of a percent (0.5%) of the deceased person's coverage amount. This benefit, provided to help the surviving spouse cope with the difficult period immediately following a death, is paid monthly for 12 months.

Spouse retraining or refreshing skills benefit: If you die accidentally and your spouse is also covered by the family AD&D, the coverage pays up to a maximum of $10,000 for your spouse to enroll as a student in an accredited school within 365 days of your death. This benefit is in addition to all other benefits.

Uniplegia benefit: If a participant is involved in an accident resulting in the loss of use of only one arm or one leg, the participant will receive a benefit equivalent to 50% of his/her principal sum benefit.

Waiver of premium: If you elect AD&D coverage for you and your dependents and you die as the result of an accident, any AD&D coverage you have elected for your spouse and children continues without charge for 24 months.

Travel Assistance Services

If you elect AD&D coverage for yourself, you may also take advantage of travel assistance services when you and your covered family members travel internationally. This package of valuable services and benefits is called CIGNA Secure Travel and is provided by Worldwide Assistance Services, Inc.

Through CIGNA Secure Travel, you have access to more than 250,000 service professionals in over 200 countries. These agents are available 24 hours a day, seven days a week to provide you with the highest level of service whenever you need it.

CIGNA Secure Travel offers the following services for international travel:

- Services before your departure, including:
  - Immunization requirements
  - Visa and passport requirements
  - Foreign exchange rates
  - Embassy/consular referral
  - Travel/tourist advisories
  - Temperature and weather conditions
  - Cultural information
- Prescription assistance to refill a prescription that has been lost, stolen or depleted
- Assistance in replacing lost luggage, documents and personal items
- Legal referrals to local attorneys, embassies and consulates; you will need to pay for any professional services rendered
- Medical referrals to local physicians, dentists and medical treatment centers in the event of an accident or illness; you must follow your Medical Benefit Option rules to receive reimbursement for any eligible expenses
- Emergency message relay to notify friends, relatives or business associates if you have a serious accident or illness while traveling
- Emergency medical evacuation for transportation to the nearest adequate hospital or treatment facility, if medically necessary
- Repatriation of remains in the event of death overseas to cover the cost of returning remains to the place of residence and arranging necessary government authorizations to transfer remains
- Return of dependent children (who are under age 16) traveling with a covered member and who are left unattended when the covered member is hospitalized. Worldwide Assistance Services will arrange and pay for their transportation home. If someone is needed to accompany the children, a qualified escort will be arranged and expenses paid.

If a covered member is traveling alone and must be hospitalized for 10 or more consecutive days, arrangements will be made and paid to provide round-trip economy class transportation for an immediate family member or friend designated by the covered member from his or her home to the place where the covered member is hospitalized.

Worldwide Assistance Services will also arrange and pay for a maximum of $100 per day for up to seven days for meals and accommodations for the family member or friend while they are visiting the hospitalized covered member.

Exclusions

AD&D coverage does not cover loss caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, suicide or attempted suicide
- Declared or undeclared act of war within the U.S. or any nation of which you are a citizen
- An accident that occurs while you are serving full-time active duty for more than 30 days in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from the vehicle or device while:
  - The vehicle is being used for experimental purposes
  - You are operating, learning to operate or serving as a member of the crew of an aircraft other than an aircraft operated by or under contract with the Company
- Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed physician (accidental ingestion of a poisonous substance is covered, as well as accidents caused by use of legal, over-the-counter drugs)
- Commission of a felony including, but not limited to: robbery, rape, arson, murder, kidnapping or burglary

Filing a Claim

AD&D is provided under group insurance policies issued by the Life Insurance Company of North America (LINA). CIGNA processes all claims for LINA. To file a claim for AD&D benefits:

- Contact HR Services to request a CIGNA AD&D Claim Form within 30 days of the death or injury. Complete the form according to accompanying directions. All claims must be submitted on CIGNA forms. Click on the “Start a Chat” button on the top of this page.
- In the event of your death, your manager/supervisor will notify Survivor Support Services, who will coordinate filing for benefits, similar to the procedures outlined for life insurance claims in Filing Claims.
- Send the completed claim form to HR Services along with documentation of the claim, such as a police report of an accident and a certified copy of the death certificate. HR Services sends the claim to CIGNA for processing.
- CIGNA processes claims within 90 days from the day they are received. In some cases, however, more time may be needed. If this is the case with your claim, CIGNA will notify you that an additional 90 days will be required. At any point during the claim review period, you may be asked to supply additional information and/or submit to a medical examination at LINA’s expense.
- If your claim is approved, the insurance proceeds will be deposited into a CIGNA Resource Manager Account (similar to a money market checking account) that earns interest.
- If your claim is denied, you or your beneficiary will be notified in writing. Notification explains the reasons for the denial and specifies the provisions of the LINA group policy that prevent approval of the claim. The notification may also describe what additional information, if any, could change the outcome of the decision.
- If your claim is denied or you have not received a response by the end of the second 90-day review period, you may request a review of your claim.

- No one may take legal action regarding the claim until 60 days after filing the claim. No legal action may be taken more than three years after filing the claim (with the exception of five years in Kansas and six years in South Carolina). You must exhaust your administrative appeals before filing any legal action regarding a claim denial.

Conversion Rights

You can convert up to $250,000 in Accidental Death and Dismemberment (AD&D) Insurance Benefits coverage for you and your spouse and up to $10,000 in coverage for each eligible child to individual policies offered by LINA within 31 days of termination of coverage if coverage terminates for one of the following reasons:

- Your employment ends,
- Your eligibility ends (however, a dependent who is no longer eligible for coverage may not convert to an individual policy while you remain eligible for coverage), or
- The coverage ends.

Contact LINA at 1-800-238-2125 for details on conversion.

Insurance Policy

The terms and conditions of this AD&D coverage are set forth in the group insurance policies issued by LINA. These group policies are available for review from LINA. In the event of a conflict between the description in this Guide and the provisions of the insurance policies, the insurance policies will govern.

Other Accident Insurance: Special Risk Accident Insurance (SRAI) Benefit, Special Purpose Accident Insurance (SPAI) Benefit and Management Personal Accident Insurance (MPAI)

The Company provides other accident insurance for certain situations described in this section. Other accident insurance programs include Special Risk Accident Insurance (SRAI) Benefit and Special Purpose Accident Insurance (SPAI) Benefit. These insurance coverages all have the following features:

- Premiums are paid by the Company.
- Coverage is provided without regard to your health history.
- The insurance provides 24-hour protection while you are traveling on Company business, from the time you leave until you return home or to your base, whichever occurs first.
- Benefits are payable in addition to any other insurance you may have.
- Covered losses include death or loss of limb, sight, speech or hearing. The insurance pays a benefit if you have a loss within one year of an accidental injury.
- No more than one Other Accident Insurance Benefit will be paid with respect to injuries resulting from one accident. If you have more than one loss from the same accident, you are entitled to the largest benefit amount for a single loss.
- Benefits payable under these other accident coverages do not reduce any accident benefits you may receive under the AD&D Insurance Benefits coverage.

SRAI Benefit

SRAI Benefit provides insurance coverage for employees for accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world. You are covered while performing daily assignments at your home base and during business travel. Hostile acts of foreign governments are also covered for any occurrences outside the U.S.

SRAI pays a benefit of five times your annual base salary, up to a maximum of $500,000. This coverage only applies to employees on active payroll.

SPAI Benefits

This insurance coverage pays up to $100,000 to each employee who is injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.

SPAI Benefit also covers non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft, and pays up to $100,000 for accidental death or dismemberment.

MPAI Benefits (For Management/Specialist and Officer employees only)

MPAI provides insurance coverage for Management employees while traveling on Company business and for non-occupational accidents involving any land or water vehicle. Coverage is three times your salary, to a maximum of $200,000.

Policy Aggregates

An accident may involve more than one employee. Total benefits to all covered employees involved in a single incident are limited to:

- $10,000,000 under SRAI Benefit.
- $2,000,000 per aircraft accident under SPAI Benefit.
- $5,000,000 per aircraft accident under MPAI Benefit. (For Management/Specialists and Officer employees only)

If benefits for one incident would exceed the limit, benefits are distributed to beneficiaries in proportion to the amounts of insurance covering all employees who suffer losses in the same incident.

Exclusions

These accident insurance policies do not cover losses caused by or resulting from any of the following:

- Suicide, attempted suicide or intentional self-inflicted injuries.
- Declared or undeclared act of war (Under SRAI Benefit, hostile acts of foreign governments are not covered within the U.S.)
- An accident that occurs while you are serving on full-time, active duty in the armed forces of any country or international authority.
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound.
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting, while:
    - The vehicle is used for test or experimental purposes.

- You are operating, learning to operate or serving as a member of the crew except while riding solely as a passenger, mechanic, substitute flight attendant or acting as a crewmember on any aircraft owned by or under contract to American Airlines.
- Being operated under the direction of any military authority other than transport-type aircraft operated by the Military Airlift Command (MAC) of the U.S. or a similar air transport service of any other country.
- Commuting to and from work (SRAI Benefit).

Insurance Policy

The terms and conditions of the coverages are set forth in the group insurance policies issued by the Life Insurance Company of North America (LINA). The group policies are available for review from the Plan Administrator.

In the event of a conflict between the description and the provisions of the insurance policies, the insurance policies will govern.

Disability Benefits

This section includes:

- Optional Short Term Disability (OSTD) Insurance
  - How the OSTD Insurance Benefit Works
  - Definition of Total Disability
  - Appropriate Care and Treatment
  - OSTD Insurance Benefits
  - Filing a Claim
  - Return-to-Work Program
  - Family Care Incentive
  - When Benefits Begin
  - Benefits from Other Sources
  - When Benefits End
  - Exclusions and Limitations
- Long-Term Disability
  - How the Plan Works
  - Definition of Total Disability
  - Appropriate Care and Treatment
  - LTD Plan Benefits
  - Severe Condition Benefit
  - LTD Benefit Elimination Period
  - Duration of LTD Benefits
  - Filing a Claim for LTD Benefits
  - When LTD Benefits Begin
  - When LTD Benefits End
  - LTD Exclusions and Limitations
  - Benefits from Other Sources

The Company provides Optional Short Term Disability (OSTD) Insurance, as well as Long-Term Disability (LTD) Plan coverage in the event you are unable to return to work when your sick pay ends.

- OSTD Insurance:
  - Replaces a portion of your salary when you are unable to work as a result of a non-work related disability.
  - Is a fully-insured benefit from MetLife. Eligibility ends when your employment terminates.
- LTD Plan coverage:
  - LTD Plan coverage replaces a portion of your salary when you are unable to work as a result of a sickness or accidental bodily injury.
  - LTD Plan coverage begins paying benefits on the later of the date you are disabled for four consecutive months, the latest day you received salary/pay from the Company or the last day you receive other benefits for this disability.

Severe Condition Benefit provides a one-time payment of $5,000 if you are diagnosed with a qualifying critical illness.

MetLife's Role – OSTD/LTD Pay
MetLife is the claims processor for OSTD/LTD pay. Visit the MetLife website or contact MetLife at 1-888-533-6287 for more information.

Overview

The following table helps you understand the benefits you may be eligible to receive in event of an illness or disability.

Program Name	When Benefits Begin	When Benefits End	Amount of Benefit
Optional Short Term Disability (OSTD) Insurance	The later of: ▪ Eighth day of your illness or disability; or ▪ When sick pay is exhausted.	The earlier of the date: ▪ The claims processor determines you are no longer disabled; or ▪ You become gainfully employed in any type of job except under the Return-to-Work Program (see Return-to-Work Program); or ▪ The 26-week maximum period ends; or ▪ You die.	The amount of benefit: ▪ 50% of adjusted monthly salary (reduced by any state disability benefits you are eligible to receive). ▪ If you are enrolled in Long-Term Disability (LTD) Plan coverage, you will receive the full OSTD Insurance coverage, plus you will receive a minimum benefit from LTD Plan coverage (to begin at 4 months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD Insurance are exhausted, the full LTD Plan benefit will be payable.

Program Name	When Benefits Begin	When Benefits End	Amount of Benefit
Long-Term Disability (LTD) Plan	The latest of: ▪ The date you are disabled for four consecutive months; or ▪ The latest day you received salary/pay from the Company (both salary continuance or sick pay — sick pay must be exhausted); or ▪ The last day you receive other benefits for this disability.	The earlier of the date: ▪ The claims processor determines you are no longer disabled; or ▪ You become gainfully employed in any type of job for any employer, except under the Return-to-Work Program (see Return-to-Work Program); or ▪ The date you reach age 65 (unless disabled after age 60); or ▪ You reach the maximum benefit period (see Exclusions and Limitations); or ▪ You die.	The amount of benefit: ▪ Full-time employee: 60% of base monthly (reduced by benefits from other sources). Maximum covered salary is $200,000. ▪ Part-time employee: same as full-time, to a maximum monthly benefit of $500 (reduced by benefits from other sources).

Optional Short Term Disability (OSTD) Insurance

The Company provides a certain amount of paid sick time for salary continuance during disabilities. However, a gap may occur between the time accrued sick pay ends and Long-Term Disability (LTD) Plan benefits begin. In this case, the Company also offers Optional Short Term Disability (OSTD) Insurance benefits to provide income protection until LTD Plan benefits begin.

How the OSTD Insurance Benefit Works

OSTD Insurance benefits replace a portion of your salary when you are unable to work as a result of a non-work related disability. Before electing OSTD Insurance coverage, you should consider your accrued sick time because OSTD Insurance benefits are not payable until all of your accrued sick pay is used.

OSTD Insurance is insured through MetLife and is designed to supplement any other similar benefits to equal 50% of your adjusted monthly salary. For regular, full-time employees, “adjusted monthly salary” is defined as your annual base salary or annualized hourly pay, plus skill and license premiums and market differentials. It does not include profit sharing, bonus, overtime or incentive pay.

For converted and part-time employees, “adjusted monthly salary” is based on average weekly earnings for the last six months.

If you are enrolled LTD Plan coverage, you will receive the full OSTD Insurance benefit, plus you will receive a minimum benefit from LTD Plan coverage (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD Insurance are exhausted, the full LTD Plan benefit will be payable.

OSTD Insurance also offers a Return-to-Work Program that allows you to go back to work on a trial basis while recovering from a disability.

The cost of OSTD Insurance is collected through payroll deductions. If you enroll, your selection remains in effect for two calendar years. If you choose not to enroll when you are first eligible and decide to enroll later, proof of good health is required. Your OSTD Insurance will not become effective until you are actively at work and a payroll deduction has been taken.

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive OSTD Insurance benefits.

Definition of Total Disability

You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

Appropriate Care and Treatment

You will be required to receive Appropriate Care and Treatment (during your disability). Appropriate Care and Treatment means medical care and treatment that is:

- Given by a physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;

- Consistent with a physician's diagnosis of your disability; and
- Intended to maximize your medical and functional improvement.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

OSTD Insurance Benefits

If you have a qualifying disability, the OSTD Insurance benefit covers the difference between any state-provided benefit and 50% of your adjusted weekly salary on your last date worked. The maximum covered salary is $200,000.

In some cases, OSTD Insurance benefits may be limited:

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico, you may be eligible for state disability benefits. Employees based in California, Hawaii and Rhode Island must apply directly to the state for benefits.
- If you have accrued a significant number of unused sick days, you would not be able to collect OSTD Insurance until you have used all those days.
- If you are enrolled in the Long-Term Disability (LTD) Plan, you will receive the full benefit of OSTD Insurance, plus you will receive a minimum benefit from LTD Plan coverage (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD Insurance are exhausted, the full LTD Plan benefit will be payable.

The OSTD Insurance benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

Filing a Claim

If your disability continues for eight or more days, you should file your disability claim immediately. Do not wait until your sick pay is used up; file by the eighth day of your disability. The sooner you file, the sooner your claim can begin processing. However, the latest you can file your claim is six months after your disability began. If you are covered under a state-mandated short-term disability plan and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim beyond the six-month deadline (or the state-mandated deadline, if sooner), your claim will not be accepted and you will not be eligible for benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance benefit, state disability plans (other than California, Rhode Island and Hawaii, which have their own forms that must be filed directly with the respective states) and LTD Plan. You or your supervisor should request the Disability Claim Form as soon as you become disabled.
- You, your supervisor and your attending physician must each complete part of the form:
  - Disability Claim Employer Statement: Your supervisor completes this page.
  - Disability Claim Employee Statement: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see Benefits from Other Sources).
  - Disability Claim Attending Physician Statement: Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

MetLife is the claims processor for the Optional Short Term Disability Insurance Benefit. The OSTD Insurance and state disability coverages are insured plans (including state plans in New Jersey, New York and Puerto Rico). The states of California, Hawaii and Rhode Island administer their own disability plans.

Return-to-Work Program

You will collect a 50% OSTD Insurance benefit that is adjusted for income from other sources, a 10% Return-to-Work Program incentive and the amount you earn from participating in the voluntary Return-to-Work Program while you are disabled. Your OSTD Insurance benefit will be adjusted to reflect income from other sources (such as state disability, income from another employer, no-fault auto, third party recovery) and any amount of your work earnings while participating in the Return-to-Work Program that causes your income from all sources to exceed 100% of your pre-disability earnings. In no event can the total amount you collect from all sources or income exceed 100% of your pre-disability earnings while you are disabled. Your pre-disability earnings are determined as of the date you become disabled. For part-time employees, pre-disability earnings are based on a 20-hour work week.

Family Care Incentive

If you work part-time or participate in the Return-to-Work Program while you are disabled, MetLife will reimburse you for up to $100 for weekly expenses you incur for each child or family member incapable of independent living.

To provide care for your or your spouse's child, legally adopted child or a child for whom you or your spouse are legal guardian and who is:

- Living with you as part of your household;
- Dependent on you for support; and
- Under age 13,

child care must be provided by a licensed child care provider who may not be member of your immediate family or living in your residence.

This benefit also includes care for your family member who is living with you as part of your household and who is

- Chiefly dependent on your for support; and
- Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to your family member may not be provided by a member of your immediate family.

When Benefits Begin

Provided you qualify, OSTD Insurance benefits are payable on the eighth day of disability or when your accrued paid sick time is exhausted, whichever occurs later. If you are collecting vacation pay when OSTD Insurance benefits become payable, OSTD Insurance benefits will not begin until your vacation pay ends. Benefits are payable for a maximum of 26 weeks.

There is no limit to the number of times you may receive these benefits for different periods of disability. However, successive periods of disability separated by less than 60 days of full-time active work are considered a single period of disability. Such disability will be considered to be a part of the original disability. MetLife will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used for the original disability. This benefits you because if you become disabled again due to the same or related sickness or accidental injury, you will not be required to meet a new elimination period. The only exception is if the later disability is unrelated to the previous disability and begins after you return to full-time active work for at least one full day.

Benefits from Other Sources

Your OSTD Insurance benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- No-Fault Auto Laws: Periodic loss of income payments you receive under no-fault auto laws. Such payments will offset your OSTD Insurance benefit.
- Third Party Recovery: Recovery amounts that you receive from loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings may offset your OSTD Insurance benefit.

When Benefits End

Your OSTD Insurance benefit payments end automatically on the earliest of the following dates:

- The date the claims processor determines you are no longer disabled (e.g., you no longer meet the definition of total disability, you are no longer receiving Appropriate Care and Treatment, etc.); or
- The date you become gainfully employed in any type of job for any employer, except under the Return-to-Work Program; or
- The end of the maximum benefit period of 26 weeks; or
- The date you die.

If and when you return to work, you or your supervisor must notify MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repaying any overpayments you receive.

Exclusions and Limitations

The OSTD Insurance benefit has the following exclusions and limitations:

- Preexisting conditions exclusion: You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation of disability no longer applies, and you may receive benefits.
- If you are based in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island, then OSTD Insurance benefits are offset. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. If the state benefit is less than the OSTD Insurance benefit, an OSTD Insurance benefit is payable. If the state benefit is more than the OSTD Insurance benefit, an OSTD Insurance benefit is not payable.
- Benefits are not payable if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered work-related for OSTD Insurance purposes if the claim is denied by Workers' Compensation.
- If you become disabled before the effective date, you are not covered under this insurance until you return to work and deductions are taken from your pay.

- Benefits are payable to employees. Dependents are not eligible for this benefit.
- Benefits are not payable if you are disabled as a result of committing or trying to commit a felony, assault or other serious crime.
- Benefits are not payable if you are disabled as a result of self-inflicted injuries or attempted suicide.
- Benefits are not payable if caused by a declared or undeclared act of war.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling condition from a duly qualified physician.
- Benefits may be reduced if you participate in the Return-to-Work program.

Long-Term Disability

How the Plan Works

The Company offers eligible employees the opportunity to participate in the Long-Term Disability (LTD) Plan.

LTD Plan benefits replace a portion of your salary when you are unable to work as a result of a disability. Most absences from work due to disability are generally of short duration and covered by paid sick time or Optional Short Term Disability (OSTD) Insurance benefits. However, some absences may continue for longer periods. LTD Plan coverage provides you protection during these extended absences. LTD Plan benefits also provide you the opportunity to return to work on a trial basis and to participate in a rehabilitation program. You pay the cost of LTD Plan benefits through payroll deductions with after-tax contributions. If you choose not to enroll when you are first eligible and later decide to enroll, proof of good health is required.

MetLife is the claims processor. The LTD Plan is self-funded through employee contributions deposited to a Voluntary Employees Beneficiary Association (VEBA) trust established under Section 501(c)(9) of the Internal Revenue Code. Benefits are paid from trust assets.

The Company provides limited salary protection for non-work related disabilities through accrued sick pay and Optional Short Term Disability (OSTD) Insurance benefits. OSTD Insurance benefits end after a maximum period of 26 weeks. If you also participate in the LTD Plan, your LTD Plan benefits begin after the latest of:

- The date you are disabled for four consecutive months; the latest day you received salary/pay from the Company (both salary continuance [if applicable] and sick pay); or
- The last day you receive other benefits for this disability.

Definition of Total Disability

During the elimination period and the first 24 months for which LTD Plan benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties of your own occupation because of sickness or accidental bodily injury.

Appropriate Care and Treatment

You will be required to receive Appropriate Care and Treatment during your disability. Appropriate Care and Treatment means medical care and treatment that is:

- Given by a physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;

- Consistent with a physician's diagnosis of your disability; and
- Intended to maximize your medical and functional improvement.

After 24 months during which benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for any employer and are unable to perform major and substantial duties of any occupation or employment for wage or profit for which you have become reasonably qualified by training, education or experience.

The only conditions under which you may be gainfully employed in any type of job for wage or profit and still be considered totally disabled are described under the Return-to-Work Program.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

LTD Plan Benefits

LTD Plan benefits are not taxable income because you pay for this coverage with after-tax contributions.

Full-time employees: Your monthly LTD Plan benefit, together with benefits from other sources, equals 60% of your base monthly salary (up to $6,666.67) on your last day worked, plus 50% of the portion of your base monthly salary that is greater than $6,666.67, up to a maximum covered salary of $200,000.

Part-time employees: Your monthly LTD Plan benefit, together with benefits from other sources, is 60% of your base monthly salary. (Average monthly salary is based on average weekly earnings for the last six months.)

The minimum LTD Plan benefit for both full-time and part-time employees is the greater of 10% of your pre-disability base monthly salary on your last day worked or $100 per month.

Whether you are a full-time or part-time employee, the amount you receive from LTD Plan is reduced by your income from other sources, including, but not limited to, other disability plans, unemployment benefits, Social Security Disability Benefits and benefits from Workers' Compensation, occupational disease law or other similar law. If you have a family and are eligible for family Social Security Disability Benefits, total payments from all sources will not be more than 80% of your base monthly salary on your last day paid.

The LTD Plan may provide you the opportunity to return to work or enter a Company-paid rehabilitation program without losing your LTD Plan benefits. However, if you are approved to participate in the Return-to-Work Program, your monthly LTD Plan benefit is decreased by 50% of your earnings during the return-to-work period.

The Return-to-Work Program is separate from the Workers' Compensation Transitional Duty program for employees with a work-related injury or illness. Employees participating in the Transitional Duty program are not eligible for this MetLife program. For details, see the Return-to-Work Program and Vocational Rehabilitation Benefit.

Severe Condition Benefit

(This is a new benefit in the LTD Plan, and is effective for disabilities beginning on or after January 1, 2011.)

LTD Plan participants who are receiving LTD Plan benefits due to a Severe Condition often incur additional expenses that their health coverage and LTD Plan benefits don't cover — for example, living expenses, lodging expenses, household costs, medical expenses not covered by the medical coverage, etc. The LTD Plan now provides some financial help to those LTD Plan participants with Severe Conditions.

Severe Condition refers to only the following medical conditions:

- Cancer
- Heart attack
- Kidney failure
- Major organ failure requiring transplant
- Paraplegia
- Quadriplegia
- Stroke

Effective January 1, 2011, the LTD Plan will provide a tax-free $5000 lump sum Severe Condition Benefit (SCB) to LTD Plan participants who meet the eligibility requirements. This SCB is payable only one time during the entire time you are covered under the LTD Plan, irrespective of how many Severe Conditions you may have. To be eligible to receive this benefit, you must meet all of the following criteria:

- Be an LTD Plan participant with LTD Plan coverage in force
- Be totally disabled (as defined by the LTD Plan) and be receiving LTD Plan benefits
- Your Severe Condition begins on or after January 1, 2011, as documented by a board-certified physician certified in the appropriate medical specialty applicable to your Severe Condition

This $5000 SCB is payable only one time during the entire time you are covered under the LTD Plan, irrespective of how many Severe Conditions you may have. Your SCB benefit is tax-free, and is not reduced by your LTD benefit or by any other benefit sources that reduce your LTD benefit.

Severe Conditions are defined as follows:

Severe Condition	Definition/Documentation
Cancer	Presence of one or more invasive malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue that requires the following: • Medically necessary surgery, radiotherapy or chemotherapy; OR • Metastasis(es) has occurred (or is occurring); OR • The diagnosed cancer has a terminal prognosis, and the patient is not expected to live beyond 24 months from the date of diagnosis, and will not benefit from or has exhausted curative therapy; OR • Carcinoma *in situ* classified by the TNM Staging classification as TisN0M0 and requires medically necessary surgery, radiotherapy or chemotherapy; OR • Malignant tumors classified by the TNM Staging classification as T1N0M0 or greater, which are treated by endoscopic means; OR • Malignant melanoma(s) classified by the TNM Staging classification as T1N0M0, with a pathology report documenting a Breslow tumor thickness of 0.75 mm or less; OR • Tumors of the prostate classified by the TNM Staging classification as T1bN0M0 or T1cN0M0 and treated with radical prostatectomy or external beam radiotherapy.
Heart Attack (Myocardial infarction)	The death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus(i) or embolus(i)
Stroke	Cerebrovascular accident or incident producing measureable, functional, and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue: • Hemorrhage • Thrombus • Embolus from an extracranial source • Stroke does not include transient ischemic attack(s) or prolonged reversible ischemic attacks.
Kidney Failure	Total, end-stage irreversible failure of both kidneys' function, that requires the following: • Medically necessary immediate and regular (weekly) kidney dialysis that is expected to continue for at least 6 months; OR • Medically necessary kidney transplant
Major Organ Failure Requiring Transplant	• Irreversible failure of the participant's entire: • Heart, lung, kidney, pancreas, small intestine or any combination thereof, that requires medically necessary replacement with an entire organ(s) from a human donor, and the patient has been placed on the transplant list or the transplant has been performed; OR • Liver, that requires medically necessary complete or partial replacement with an entire liver or liver tissue from a human donor, and the patient has been placed on the transplant list or the transplant has been performed; OR • Bone marrow that requires medically necessary replacement with the bone marrow from either the patient himself or from a human donor
Paraplegia	Paralysis of the lower portion of the body (from waist or hip level), including both lower limbs
Quadriplegia	Paralysis of the upper and lower portions of the body (from neck, shoulder or chest level), including all four limbs

To apply for this benefit, you must submit to the claim processor proof that you've been diagnosed with a Severe Condition and the date of such diagnosis, and this proof must be signed and certified by your treating board-certified physician certified in the appropriate medical specialty applicable to your Severe Condition. You may also be asked to have your physician submit copies of his/her clinical records of your diagnosis and treatment for your Severe Condition, including one or more of the following:

- **Cancer:** Pathology reports confirming the diagnosis.
- **Heart Attack:** Proof of inpatient hospitalization, laboratory reports of elevated cardiac enzymes, toponins or cardiac markers, EKG changes reflecting an acute myocardial infarction, cardiac imaging studies reflecting an acute myocardial infarction.
- **Kidney Failure:** Nephrologist's confirmed diagnosis of kidney failure.
- **Recipient of Major Organ Transplant:** Specialist's confirmation of major organ failure, proof that patient has been placed on the transplant list, documentation that the transplant has occurred.
- **Paraplegia:** Successive neurological examinations with demonstrations of weakness of both lower limbs, usually accompanied by impairment of bladder/bowel control, motor weakness, muscle atrophy, abnormal deep tendon reflexes, radioimaging confirmation of neurological deficit.
- **Quadriplegia:** Successive neurological examinations with demonstrations of weakness of all four limbs, usually accompanied by impairment of bladder/bowel control, motor weakness, muscle atrophy, abnormal deep tendon reflexes, radioimaging confirmation of neurological deficit.
- **Stroke:** Clinical confirmation of the diagnosis of Stroke based on clinical evidence of significant neurological impairment that is functional, measureable, and permanent based on MRI, CT or other reliable imaging techniques demonstrating the affected areas of the brain. Such neurological impairment must be documented in the clinical records 30 or more days after the cerebrovascular accident/incident by the neurologist, and be based on clinical evidence of significant neurological, motor or sensory impairment.

The claim processor will review your claim, and if approved, will make the $5000 SCB payment to you, in one lump sum. This SCB is paid *in addition to* your monthly LTD Plan benefit, and the $5000 benefit is tax-free.

Benefits will not be paid for any Severe Condition that is:

- Caused by, contributed by or resulting from your voluntarily taking or using any drug, medication, sedative or other substance unless it is:
  - Taken or used as prescribed by your physician, or
  - An 'over the counter' drug, medication, sedative or other substance taken according to package directions.
- One for which diagnosis is made outside the United States, unless the diagnosis is confirmed in the United States.
- Does not first occur while you are covered under this LTD Plan.
- A diagnosis of stroke for cerebral symptoms due to migraine; cerebral injury resulting from hypoxia or trauma; or vascular disease affecting the eye, optic nerve, middle or inner ear or vestibular function.

- Cancer classified by the TNM Staging classification as less than T1N0M0, papillary tumor of the bladder classified as Ta, tumors of the prostate classified as T1N0M0 or T1aN0M0 or papillary tumors of the thyroid classified as T1N0M0 or less and are one centimeter or less in diameter.
- Tumor(s) in the presence of the human immunodeficiency virus.
- Any non-melanoma skin cancer unless there is metastasis or melanoma *in situ* classified as T1sN0M0.
- Chronic Lymphocytic Leukemia, classified by RAI classification as less than Stage III.
- Melanoma in situ classified by the TNM Staging classification as TisN0M0.

LTD Benefit Elimination Period

The elimination period is the waiting period before LTD Plan benefits are payable. It extends until the latest of the following:

- The date you have been continuously totally disabled for four consecutive months or
- The last day of salary continuation (injury-on-duty pay or sick pay) during total disability.

Duration of LTD Benefits

After you qualify for LTD Plan benefits, if you remain disabled, you receive a monthly benefit for the following maximum period:

Age at Which Disability Begins	Maximum Duration of Benefits
Under age 60 or the day you turn age 60	To age 65
After your 60th birthday	5 years

During your disability, you may be required to provide additional medical information or submit to periodic physical exams to confirm your continuing disability. LTD Plan benefits end if you do not agree to undergo a physical exam or provide the required information.

For age 60 or over employees who become disabled, the five-year maximum duration of benefits may allow your LTD Plan benefits to continue after you begin receiving your pension. If this occurs, your LTD Plan benefit will be offset by the amount of pension benefit you receive (or you are entitled to receive).

Filing a Claim for LTD Benefits

You should file LTD Plan claim as soon as you become disabled. Do not wait until your sick pay is used up or until your four-month elimination period expires — file your claim immediately. The latest you can file your LTD Plan claim is one year after your disability began. If you file your disability claim beyond this one-year deadline, your claim will not be accepted and you will not be eligible for LTD Plan benefits.

MetLife is the claims processor for the LTD Plan. The LTD Plan is funded by employee contributions and managed by the Company through a trust. Benefits are paid from trust assets.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance, state disability plans (other than California, Rhode Island and Hawaii, which have their own forms that must be filed directly with the respective states) and LTD Plan programs. You or your supervisor should request the Disability Claim Form as soon as you become disabled.

- You, your supervisor and your attending physician must each complete part of the form:
  - Disability Claim Employer Statement: Your supervisor completes this page.
  - Disability Claim Employee Statement: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see Benefits from Other Sources).
  - Disability Claim Attending Physician Statement: Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

When LTD Benefits Begin

Provided you qualify, LTD Plan benefits are payable at the end of the elimination period.

- The date you are disabled for four consecutive months;
- The latest day you received salary/pay from the Company (both salary continuance and sick pay) — sick pay must be exhausted; or
- The last day you receive other benefits for your disability.

If you are collecting vacation pay when LTD Plan benefits become payable, your LTD Plan benefits will not begin until your vacation pay ends. If you return to work in a capacity comparable to your pre-disability status during the elimination period, you are still considered continuously disabled if you become totally disabled again due to the same or related sickness or injury within 60 days after returning to work in your pre-disability occupation or other comparable work. However, days worked do not count toward your elimination period.

If you have received LTD Plan benefits for an earlier disability and become totally disabled again, your most recent disability is considered part of the previous disability. However, this provision does not apply if you have returned to work in a capacity comparable to your pre-disability status for at least three months or, if the cause of the later disability is totally unrelated to the earlier disability. If it is considered a separate period of disability, you must satisfy a new elimination period.

When LTD Benefits End

Your LTD Plan benefits automatically end on the earliest of the following dates:

- The date your benefits expire, as explained in Duration of Benefits;
- The date you reach age 65 (unless disabled after age 60);
- The date you are no longer disabled (e.g., you no longer meet the definition of total disability, you are no longer receiving Appropriate Care and Treatment, etc.);
- The date you become gainfully employed in any type of job, except under the Return-to-Work Program;
- The date benefits end, if disability is due to a mental health disorder or neuromuscular, musculoskeletal or soft tissue disorder — see Exclusions and Limitations; or
- The date you die.

If and when you return to work, you or your supervisor must contact MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repaying any overpayments you receive.

If your employment terminates from a sickness or injury Leave of Absence and you are receiving LTD Plan benefits, these LTD Plan benefits will continue until you meet one or more of the conditions listed above. However, when you meet one or more of these conditions and your LTD Plan benefits terminate, your LTD Plan coverage also terminates at the same time. After your LTD Plan benefits and LTD Plan coverage terminate, any later recurrence or relapse of your disabling condition or your development of any other disabling condition, will not reactivate your LTD Plan coverage, will not result in any reinstatement of LTD Plan benefits and will not cause any LTD Plan benefits to resume.

LTD Exclusions and Limitations

- The LTD Plan has the following exclusions and limitations:
- If you become disabled before the effective date, you are not covered under the LTD Plan until you return to work and deductions are taken from your pay.
- You are not covered under the LTD Plan for a disability if you received medical care or treatment for the disability within the three months before the effective date of coverage. However, after you have been covered for 12 months, this limitation on disability no longer applies and you may receive benefits.
- If you are disabled due to a mental health disability (this includes mental health disorders, emotional disease and/or alcohol/chemical/substance abuse/dependency), disability benefits under this coverage will end when you have received a maximum of 24 months of LTD Plan benefits for the entire time you are covered under the LTD Plan. This maximum benefit applies to the duration of your participation in this coverage. As part of a mental health disability, chemical abuse/dependency includes, but is not limited to, both prescription and over-the-counter medications, as well as illicit/illegal drugs; substance abuse/dependency includes, but is not limited to, any other non-drug substances such as aerosol propellants, glue, etc.

This 24-month maximum disability benefit applies whether or not you have been hospitalized, with the following exceptions:

- If you are confined in a hospital at the end of this 24-month maximum benefit period, benefits continue as long as you are confined.
- To enable a necessary recovery period, benefits also continue for up to 90 days following your release from hospital confinement, provided you were confined for at least 14 consecutive days.
- If you are reconfined during this 90-day recovery period, benefits continue during your reconfinement, together with another 90-day recovery period, provided you are reconfined for at least 14 consecutive days.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling conditions from a duly-qualified physician.
- Benefits are not payable if the Plan Administrator determines in its sole discretion that you are disabled as a direct or indirect result of committing or trying to commit a felony, assault or other serious crime or are engaged in an illegal occupation, regardless of whether or not you are ever charged with a crime or for engaging in an illegal occupation.
- Benefits are not payable if you are disabled as a result of intentionally self-inflicted injuries or an attempted suicide.
- Benefits are not payable if you are disabled as a result of a declared or undeclared act of war.
- Benefits are payable only to employees. Dependents are not eligible for this benefit.
- Preexisting Conditions Exclusion: You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation on disability no longer applies and you may receive benefits. (See Glossary for the OSTD Insurance benefit definition of a preexisting condition.)
- If you are disabled due to a neuromuscular, musculoskeletal and/or soft tissue disorder disability, the disability benefits under the LTD Plan will end when you have received a maximum of 24 months of disability benefits for the entire time you are covered under the LTD Plan. This 24-month maximum benefit applies to the duration of your participation in this coverage. Neuromuscular, musculoskeletal and/or soft tissue disorders include, but are not limited to any disease, injury or disorder of the spine, the vertebra(ae), their supporting structures, muscles and/or soft tissue; bones, nerves, supporting body structures, muscles and/or soft tissue of all joints, extremities and/or major body complexes of movement; sprains/strains of all joints and muscles. This 24-month maximum benefit does not apply to disabilities, if such disabilities have documented objective clinical evidence of:
    - Seropositive arthritis (inflammatory disease of the joints), supported by clinical findings of arthritis and positive serological tests for connective tissue disease;
    - Spinal (referring to the bony spine and/or spinal cord tumor(s) — abnormal growths — whether benign or malignant), malignancy or vascular malformations (abnormal development of blood vessels);
    - Radiculopathies (disease of the peripheral nerve roots) supported by objective clinical evidence of nerve pathology;
    - Myelopathies (disease of the spinal cord and/or nerves) supported by objective clinical evidence of spinal cord/nerve pathology;

- Traumatic spinal cord necrosis (injury or disease of the spinal cord) resulting from traumatic injury with paralysis; or
- Musculopathies (disease of the muscle/muscle fibers) supported by objective pathological evidence on muscle biopsy or electromyography.
- Disabilities caused by the aforementioned conditions — provided objective evidence confirms the diagnosis —will not be subject to the 24-month limitation, but will be benefited according to all other applicable LTD Plan provisions.

- The Plan Administrator in its sole discretion shall determine whether any exclusion or limitation applies.

Benefits from Other Sources

If you qualify for disability benefits from other sources, your LTD Plan benefits are reduced by the amount of the following periodic benefits. Your LTD Plan benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- Periodic benefits for loss of time because of this disability under:
  - Any employee benefit coverage for which the Company has paid any part of the cost or made payroll deductions, including a Company-sponsored annuity contract or disability retirement benefits plan
  - Any government law including no-fault motor vehicle insurance, other than a law providing benefits for military services.
- Periodic benefits for loss of time due to a work-related injury or illness or by reason of any Workers' Compensation, occupational disease law or other similar law.
- Unemployment benefits.
- Social Security Disability Benefits (SSDB) based on the amount of SSDB in effect as of the LTD Plan benefit start date. This may not apply if your disability is a result of a pregnancy or if your disability lasts less than one year. Periodic increases in monthly SSDB income (through cost-of-living increases) and additional Social Security retirement and survivor benefits are not subtracted from LTD Plan benefits.
- Earnings from employment activity not approved under return-to-work guidelines.
- Any LTD Plan benefit a participant receives while disabled may be offset by the amount of Retiree Benefit Plan pension benefits the participant is receiving (or is entitled to receive).

To alleviate potential financial hardship while waiting for a determination on a claim for Social Security, Workers' Compensation or other such benefits described above, you may request that such benefits not be deducted from your LTD Plan benefits. The Reimbursement Agreement is in the Disability Claim Form. It states that you agree to reimburse the appropriate amount of LTD Plan benefits paid if Social Security, Workers' Compensation or other such benefits are later payable.

Social Security Disability Benefits

Because the amount of LTD Plan benefits you receive is influenced by Social Security Disability Benefits (SSDB), you must apply for SSDB as soon as possible.

Within six months after your LTD Plan claim is approved, you must provide evidence to the claims processor that you have filed for SSDB or that your application has been denied. This does not apply if your disability is the result of pregnancy or is expected to last less than one year. Otherwise, your SSDB benefits will be estimated and your LTD Plan benefits will be reduced by the estimated amount.

Evidence may include a denial of benefits by the Social Security Administration, failure to qualify because of the length of your disability or a copy of the Receipt of Claim Form given to you by the Social Security Administration at the time of application. Please note that if your initial application is denied, you must file for reconsideration and/or appeal to the Social Security Administration.

Former Pension Benefit Supplement

Effective January 1, 2004, the Pension Supplement Benefit in the Long Term Disability Plan Ended

The Pension Benefit Supplement only applies to employees who are eligible to receive benefits from the defined benefit pension plan and were disabled prior to January 1, 2004. You are not accruing credited service toward your pension benefit. The LTD Plan pension supplement (also known as the “Deferred Benefit”) makes up for this loss of credited service. Your pension supplement benefit is payable to you when you begin taking your pension. However, this benefit is paid separately from your pension benefit. If you choose to take your pension early, your pension supplement begins paying at the same time with the same reduction, if any, as your early pension benefit.

The amount of your pension supplement benefit is determined by placing the number of months of LTD Plan benefits you received before your 65th birthday into the applicable benefit formula under your Retirement Benefit Plan. No additional months will be credited after age 65. The formulas are:

- Minimum Benefit formula
- Career Average formula
- Final Average Salary formula
- Social Security Offset formula

If you elected an optional form of payment under your Retirement Benefit Plan, your pension supplement benefit is computed and paid the same way.

When your pension supplement benefit begins, if your monthly benefit is less than $20, a lump sum payment may be made, rather than monthly benefit payments. The claims processor determines whether this is an option.

Freeze of Pension Supplement Benefit

As part of the Company's restructuring, American Airlines Inc. froze its defined benefit pension plans for all work groups. This freeze was effective November 1, 2012. This pension plan freeze prohibits participants from accruing additional Credited Service on or after November 1, 2012.

The LTD Plan's Former Pension Supplement Benefit calculation uses Credited Service and number of months the LTD benefit was paid. Because the defined benefit pension plans have been frozen, it is necessary to freeze this Former Pension Supplement Benefit as well. Therefore, employees who accrued this benefit will still be eligible, but the accrual of Credited Service and number of LTD payments made will cease on the earlier of the following:

- Your attaining age 65, or
- The date your LTD payments stop, or
- The date of the defined benefit pension plan freeze - November 1, 2012

Return-to-Work Program

The Return-to-Work Program, administered by MetLife, is a voluntary program that allows you, as a disabled employee collecting LTD Plan benefits, to work in an occupation or job for wage or profit for a trial period without losing your LTD Plan benefits. Your return to work must be approved by the claims processor and may not exceed one year. The claims processor will monitor your progress under this program. If you fully recover and are no longer disabled before the end of that year, you will no longer be eligible for the program.

During your trial work periods, you continue to receive LTD Plan benefits. However, your benefits are reduced by 50% of your earnings from employment. If your attempt to return to work is unsuccessful, you may return to your former LTD Plan status and receive your former benefit, provided you remain disabled and satisfy all other coverage provisions.

Employees who are participating in the Workers' Compensation Transitional Duty program are not eligible for this Return-to-Work Program and vice versa.

Following are the steps required to participate in the Return-to-Work Program:

- A request for consideration is initiated either by you, your supervisor, your physician or the claims processor.
- The request is distributed to all parties above and all must agree that you may return to work on a trial basis.
- When your return-to-work plan has been approved by all parties, MetLife will document the plan for signature. Documentation will include the following:
  - Written agreement from your physician, supervisor and you that you may return to work
  - Statement of approximate length of time for the trial work period
  - Statement of hours to be worked per day and rate of pay. (If hours per day vary, the claims processor will need regular bi-weekly or semi-monthly reports of earnings and hours worked.)
- The claims processor notifies you or your supervisor whether your return-to-work request has been approved.

If you are allowed to participate in the Return-to-Work Program, your supervisor must notify the claims processor of the date you return to work. In addition, if and when you can no longer work, both your supervisor and physician must send written notification to the claims processor of this change. If you return to work for the Company under this program, your supervisor should indicate “Returning to Work” on your Payroll Transaction Request (PTR).

Your LTD Plan payroll deductions will not resume until you are actively at work under the Return-to-Work Program for one consecutive year or when you are no longer disabled.

Vocational Rehabilitation Program

If you are receiving LTD Plan benefits, you may be eligible to receive assistance through the Vocational Rehabilitation Benefit if approved by the claims processor. This benefit is not available for participants receiving OSTD.

Vocational Rehabilitation Benefits may cover expenses such as:

- Vocational counseling
- Job search assistance
- Occupational training
- Vocational education
- Prosthetic devices
- Psychotherapy
- Physiotherapy

You may request consideration for this benefit by writing to MetLife. See “Contact Information” in the *Reference Information* section.

After reviewing your request, the claims processor may require an in-depth field evaluation of your potential to return to work. If so, your supervisor will be notified with the necessary details. The claims processor may also request a complete job description and other documentation. After reaching a decision, the claims processor notifies you of the rehabilitation benefits to which you are entitled.

Employee Assistance Program (EAP)

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

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

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

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

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

How do I enroll?

This section covers General Enrollment, when Coverage Begins and End.

- Annual Enrollment
- How to Enroll
  - New Employee Enrollment
  - When Coverage Begins as a Newly Hired Employee
  - When Coverage Begins as a Current Employee
  - Waiving Coverage
- Default Coverage
- HIPAA Special Enrollment Rights – Medical Benefit Option
- When Coverage Ends

You have the opportunity to select benefits tailored to your individual needs and preferences each year during annual enrollment. The annual enrollment period occurs in the Fall of each year. Employees enroll online using the Benefits Service Center. After annual enrollment is completed and the new benefit year has begun, you will only be able to make changes to your elections if you experience a Life Event.

The Plan year is January 1 through December 31.

If you do not enroll for benefits during the annual enrollment period, you will automatically default to your current selections (if available) for the following year, at the applicable rates for the following year (Note: this does not apply to Flexible Spending Accounts or the Health Savings Account).

If your current medical option is no longer available and you do not make another selection, you will default into the Core Option.

If you are adding new dependents to your benefits, you must request enrollment within 60 days of the event AND submit to HR Services proof that these dependents qualify as your eligible dependents within 60 days of the date you request enrollment.

The Benefits Service Center

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

Annual Enrollment

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

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

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

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

Once annual enrollment ends, your benefit elections for the upcoming plan year are recorded and “locked in”, and you are not allowed to make changes to these elections unless you experience a Life Event that would enable you to make such changes. However, between the close of annual enrollment through 12/31, you may be permitted to CORRECT any erroneous elections you made during annual enrollment, as long as you make those corrections before the start of the new plan year.

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

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

How to Enroll

All employees enroll using the online enrollment tool — the Benefits Service Center. Visit my.aa.com for information on enrolling.

IMPORTANT NOTICE: During the last two months of the current benefit year an employee cannot change or enroll in his/her HCFSA, DDFSA, or LPFSA elected amounts. This does not include the elections you make during the Annual Enrollment period for the next benefit year.

FAQ: When can I enroll for benefits?

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

New Employee Enrollment

As a new Officer or Management/Specialist employee, you will receive enrollment information shortly after you begin working.

As a new Agent/Representative/Planner, Home-Based Representative, Premium Service Representatives, Support Staff or TWU-Represented employee, you will receive a letter within 21 days of hire instructing on how to make their elections. Benefits will not become effective until day 31.

You may elect coverage for yourself and your eligible dependents (see the General Eligibility section) and have a one-time opportunity to enroll in the Employee Voluntary Term Life Insurance Benefit without having to provide proof of good health (coverage levels in excess of 1 times your salary require a Statement of Health).

Proof of good health is required if you wish to enroll in the Voluntary Term Life Insurance benefit at any level, at any time after you were first eligible, or to increase life insurance coverage levels. The employee can complete form on line via a SSO to Met's site when they elect the Vol coverage or increase. Your spouse will need to mail a completed, dated and signed Statement of Health form to MetLife, postmarked within 30 days after your enrollment deadline. If your Statement of Health is not postmarked within 30 days after the close of your new employee enrollment window, your application for this coverage will not be considered, and you must wait until the next annual enrollment (or your next Life Event) to apply for this benefit.

When Coverage Begins as a Newly Hired Employee

If you select the Standard, Value, or CORE Medical Option or an HMO and need medical care during this interim period, you must receive treatment from an in-network provider to receive in-network coverage. If not, you will be covered at the out-of-network level under the Standard, Value and CORE Medical Option, or you will have no coverage if enrolled in an HMO.

If you enroll by the enrollment deadline, your selected coverage (if different from default coverage) begins after you have been employed for one month. This does not apply to management/specialist workgroup.

When Coverage Begins as a Current Employee

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

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

Waiving Coverage

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

Default Coverage

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

NEW EMPLOYEE DEFAULT TABLE		
Benefit	**Default**	**Comments**
Medical Benefit Option	CORE Medical Option (Employee only)	
Dental Benefit Option	No coverage	N/A
Vision Insurance Benefit	No coverage	N/A
OSTD	No coverage	N/A
LTD Plan	LTD Coverage	Does not apply to TWU-Represented employees
Basic Term Life Insurance Benefit	2 times pay	Up to a maximum of $70,000 **This does not apply to Home-Based Representatives or Level 84 Premium Services Representatives**
Voluntary Term Life Insurance Benefit	No coverage	N/A
AD&D Insurance Benefit	No coverage	N/A
Spouse Life Insurance	No coverage	N/A
Child Life Insurance	No coverage	N/A
Flexible Spending Accounts (FSAs) (Health Care FSA and Dependent Care FSA and Limited Purpose Health Spending Account)	No coverage	Your FSA accounts will default to $0.00 unless you take action to establish the accounts and enter a dollar amount for the accounts

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

Flexible Spending Accounts (FSAs): If you do not elect an FSA, you will not have FSA accounts for the following year. Per IRS rules, you must actively elect an FSA each year you wish to participate. You may not elect an FSA if you enroll within the last 60days of the plan year. Employees enrolled in the Core option are only eligible for the Limited Purpose FSA.

Current Benefit Not Offered or Employee Not Eligible: If your current benefit is no longer offered in your area, or if you no longer qualify for the current year's benefit, you must select a replacement benefit or Option or you must waive coverage. If you do not either elect coverage or waive coverage, you will default to the coverages listed in the Default Coverage Table above.

HIPAA Special Enrollment Rights – Medical Benefit Option Only

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

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

The employer contributions to the other coverage have stopped.

The other coverage was COBRA and the maximum COBRA coverage period ends.

You and/or one of your dependents exhaust a lifetime maximum in another employer's health plan or other health insurance coverage.

You and/or one of your dependents' employers cease to offer benefits to the class of employees through which you (or one of your dependents) had coverage.

You and/or one of your dependents were enrolled under an HMO or other group or individual plan or arrangement that will no longer cover you (and/or one of your dependents) because you and/or one or your dependents no longer reside, live or work in its service area.

You have a new dependent as a result of your marriage common law marriage, or declaration of a Company-recognized Domestic Partner, your child's birth, adoption or placement for adoption with you. Coverage is retroactive to the date of birth, adoption or placement for adoption.

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

In addition, if you are not enrolled in these employee benefits as an employee, you also must enroll in the benefits when you request enrollment for any of these dependents. If your spouse

is not enrolled in the benefits, you may enroll yourself and request enrollment for your spouse, common law spouse, or Company-recognized Domestic Partner in the employee benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage, common law marriage, or declaration of a Company-recognized Domestic Partner, coverage will begin on the first day of the first calendar month after the completed enrollment request is received and proof of eligibility is timely provided. To request special enrollment or obtain more information, contact HR Services (see "Contact Information" in the *Reference Information* section).

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

When Coverage Ends

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

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

If you are over age 55 and working as an active employee, and were eligible to retire, if you die your under age 65 surviving spouse is eligible for the Retiree Medical Benefit.

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

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

Making Changes During the Year: Life Events

This section includes:

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

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

Life Events

Glossary Term: Life Event

A circumstance or change that happens during the year that allows you and/or your dependents to make changes to your coverage Options outside the Annual Benefits Enrollment period.

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

When you experience a Life Event, remember these guidelines:

Most Life Events are processed online through the Benefits Service Center. Visit Life Events on my.aa.com for a complete list of all Life Events and the correct procedures for processing your changes.

If you process your Life Event within 60 days of the event, your changes are retroactive to the date the Life Event occurred (or the date proof of good health is approved, as applicable).

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

You must timely provide acceptable proof of eligibility to HR Services before your dependent(s) can be enrolled in benefits.

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

Any change in your cost for coverage applies on the date the change is effective. Retroactive contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.

You may only stop or waive medical benefits for yourself if you have other medical coverage.

You cannot enroll your dependents in coverage if you are not covered under the same benefits.

You may start or increase a Flexible Spending Accounts or Health Savings Account only if you have enrolled a dependent that was not previously covered. Cannot make changes within the last 60 days of the year.

Starting or increasing either Life, Accident or Disability Benefits may require proof of good health and coverage will only be effective after the applicant is approved. If death occurs before a Life Event is processed, the amount of coverage payable is your current amount of Life and/or Accident Insurance.

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

If a death or accident occurs before your first-time enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Benefits that will be paid is your first time enrollment announcement. If you have coverage and you are requesting an increase, the amount payable is your current amount of coverage.

You may only increase your Life Insurance Benefit by one level per year, with proof of good health.

If you elect to enroll in any coverage requiring proof of good health, you must submit a Statement of Health from MetLife within 30 days after your enrollment/election date. If your Statement of Health is not submitted within 30 days after your enrollment/election date, your application for these coverages will not be considered, and you must wait until the next Annual Benefits Enrollment (or your next Life Event) to apply for any of these coverages.

Losing Medicaid or CHIP coverage enables you to enroll in medical, dental and/or vision benefits.

Becoming eligible for a state premium subsidy program enables you to enroll in medical, dental and/or vision benefits.

Also see birth or adoption for other information regarding Life Events that may trigger allowable changes in coverage.

If You Experience the Following Life Event…	Then, You Can…
You become eligible for Company-provided benefits for the first time	Enroll online through the Benefits Service Center.
Your spouse, Company-recognized Domestic Partner or dependent dies	**Medical and Dental Options and Vision Insurance:** Start/Stop coverage for your eligible SP/DOMESTIC PARTNER (DP), eligible dependent (dependent coverage may be subject to QMCSO) or yourself. You cannot change benefit Options at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your eligible spouse/Company-recognized Domestic Partner or eligible dependent in the applicable benefit Option. Contact your HMO for eligibility – eligibility is determined by the HMO. **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. **Long Term Disability Plan:** Start/Stop coverage; however, this coverage applies to the employee only. Does not apply to TWU-Represented employees. **Voluntary Term Life Insurance Benefit:** Start/Stop coverage for your eligible spouse and/or child, or increase or decrease existing employee coverage with proof of good health. **Spouse Term Life Insurance Benefit:** Start/Stop coverage. **Child Term Life Insurance Benefit:** Start/Stop coverage. **AD&D Insurance:** Start/Stop or increase/decrease coverage for yourself; eligible SP/DOMESTIC PARTNER (DP) or eligible child **Flexible Spending Account Benefits:** Start/ Stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Company-recognized Domestic Partners and their dependents are not eligible to participate in FSA.
You, your spouse/common law spouse/Company-recognized Domestic Partner gives birth or adopts a child or has a child placed with you for adoption or you add eligible dependent(s) to your household or your dependent regains eligibility for coverage under the Plan	
You get legally married (including legal opposite-sex and same-sex spouses, common law marriage), divorced or legally separated **-or –** **Declare a Company-recognized Domestic Partner/ relationship ends**	
Change in spouse's/Company-recognized Domestic Partner's employment or other health coverage **OR** **Your spouse's/Company-recognized Domestic Partner's employer no longer contributes toward health coverage** **OR** **Your spouse's/Company-recognized Domestic Partner's employer no longer covers employees in your spouse's position**	

If You Experience the Following Life Event…	Then, You Can…
You or your spouse/common law spouse/Company-recognized Domestic Partner becomes pregnant and you are covered under the following medical benefit Option	**All Medical Benefit Options (excluding HMOs):** Contact your Network/Claims Administrator and the Healthmatters MaternityMatters program. **HMO:** Contact your HMO. This does not permit you to make any changes to your benefit elections until the baby is born.
Your covered dependent no longer meets the Plan's eligibility requirement, i.e.: ▪ If the dependent attains the age at which he/she is no longer eligible to be covered as your dependent ▪ If the dependent is employed and becomes eligible for his/her employer's group health plan ▪ If the dependent marries and is no longer eligible for Dental and Vision Benefits ▪ If the dependent marries and enrolls in his/her spouse's employer group health plan	**Medical and Dental Options and Vision Insurance:** Stop coverage for your eligible dependent. You cannot change benefit Options at this time. **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. Does not apply to TWU-Represented employees. **Voluntary Term Life Insurance Benefit:** Stop coverage for your eligible dependent; increase or decrease existing coverage for you with proof of good health. **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible dependent or yourself; increase or decrease existing coverage. **Spouse Term Life Insurance Benefit:** Start or stop coverage. **Child Term Life Insurance Benefit:** Start or stop coverage. **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs. **Additionally:** Contact HR Services to advise that a COBRA packet should be sent to the dependent's address.

If You Experience the Following Life Event…	Then, You Can…
Your dependent child attains age 13 or he or she or no longer requires dependent day care **OR** **Your elderly parent no longer requires dependent day care**	**Dependent Care Flexible Spending Account:** Stop or reduce Dependent Care Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.
You or your dependents exhaust a maximum benefit limit in another medical plan **OR** **You or your dependents were enrolled in an HMO or another arrangement that will no longer cover you due to your failure to live, work, or reside in the arrangement's service area**	**Medical and Dental Options and Vision Insurance:** Add coverage for your eligible dependents or yourself; Stop coverage for your dependents, or yourself. You cannot change benefit plans at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your eligible dependents in applicable benefit Options. **Voluntary Term Life Insurance Benefit:** Start or stop coverage. **Spouse Term Life Insurance Benefit:** Start or stop coverage. **Child Term Life Insurance Benefit:** Start or stop coverage. **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible dependents or yourself; increase or decrease existing coverage. **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.
Your benefit coverages are significantly improved, lowered or lessened by the Company **(Plan Administrator/Sponsor will determine whether or not a change is "significant")** **OR** **Your contribution amount is significantly increased or decreased by the Company** **(Plan Administrator/Sponsor will determine whether or not a change is "significant")** Note: Long Term Disability Plan, as noted here, does not apply to TWU-Represented employees, as their Long Term disability coverage is offered by their union.	**Make changes to the applicable benefit coverages:** The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.

If You Experience the Following Life Event…	Then, You Can…
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMCSO) that requires you to provide health care coverage for a child	**Medical and Dental Option and Vision Insurance:** Start or add coverage for the eligible dependents and yourself. You cannot change benefit Options at this time (unless your existing Option cannot cover the child).
You, or your dependents enroll in Medicare or Medicaid	**Medical and Dental Options and Vision Insurance:** Stop coverage for the applicable eligible person. You cannot change benefit Options at this time.
You or your dependents lose Medicaid or CHIP coverage	**Medical and Dental Options and Vision Insurance:** Add coverage for yourself and your eligible dependents. If you are already enrolled in Medical, Dental and Vision Options, you cannot change medical, dental or vision Options at this time.
You or your dependents become eligible for a state premium assistance program	**Medical and Dental Options and Vision Insurance:** Add coverage for yourself and your eligible dependents. If you are already enrolled in Medical, Dental and Vision Options, you cannot change Medical, Dental or Vision Options at this time.
You move to a new home address: **Update both your permanent AND alternate addresses on the Update MY Information page of The Benefits Service Center.** **Submit a revised Federal Form W-4 Form for payroll tax purposes. The form is available online through the Pay and Compensation page of The Benefits Service Center** **Contact other organizations such as the American Credit Union and C. R. Smith Museum directly to update your contact information.** **Provide your new address and current emergency contact numbers to your manager/supervisor, as well.**	**Medical Option:** May select from medical Options available in new location. If you were in an HMO and you moved out of the service area or to any area with different Options available, then you may select from the medical Options available in your new location. Contact HR Services for more information. **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. Does not apply to TWU-Represented employees. **Voluntary Term Life Insurance Benefit:** Start or stop coverage for you and your eligible dependents; increase or decrease existing coverage. **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for you and your eligible dependents; increase or decrease existing coverage. **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-

If You Experience the Following Life Event…	Then, You Can…
	recognized Domestic Partners are not eligible to participate in Flexible Spending Accounts. **If you move or relocate to a new location within the last two months of the year, contact HR Services so they can ensure your elections are filed for this current year and for next year.**
You become disabled Note: Long Term Disability Plan, as noted here, does not apply to TWU-Represented employees, as their Long Term disability coverage is offered by their union.	**Notify:** Your manager/supervisor and download a Disability Claim Form. **Complete and submit:** Your claim for disability benefits.
You take an unpaid leave of absence	A letter from HR Services acknowledging your leave and instructing you to access Benefits Service Center to register your Leave of Absence Life Event and decide whether or not to continue your benefits while on your leave. Register your Going on Leave of Absence Life Event and your benefit elections in the Benefits Service Center and it will display for you a confirmation statement showing your choices, the monthly cost of benefits, etc. **Your cost depends on:** The type of leave you are taking.
You return from an unpaid leave of absence Note: Long Term Disability Plan, as noted here, does not apply to TWU-Represented employees, as their Long Term disability coverage is offered by their union.	If you did not continue payment of your benefits during your leave and wish to reactivate your benefits upon your return to work, you may do so; however, you will be required to provide proof of good health for certain benefits (i.e., Basic Term Life Insurance). Go to the Benefits Service Center register your Return to Work life event and make selections or changes to your benefits in the Benefits Service Center **Medical and Dental Options and Vision Insurance:** Resume coverage. You cannot change benefit Options at this time. **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. **Voluntary Term Life Insurance Benefit:** Start or stop coverage; increase or decrease existing employee coverage.

If You Experience the Following Life Event…	Then, You Can…
	Accidental Death & Dismemberment (AD&D) Insurance: Start or stop coverage for your eligible spouse/Company-recognized Domestic Partner, your dependent, or yourself; increase or decrease existing coverage. **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.
You change from part-time to full-time employment or full-time to part-time employment Note: Long Term Disability Plan, as noted here, does not apply to TWU-Represented employees, as their Long Term disability coverage is offered by their union.	**Medical and Dental Options and Vision Insurance:** Add coverage for your eligible dependents or yourself; stop coverage for your eligible dependents, or yourself. You cannot change benefit Options at this time, unless you have elected a reduced schedule (flex time). Company-recognized Domestic Partners and their dependents may be eligible for HMOs. Contact your HMO for eligibility – eligibility is determined by the HMO. **Optional Short-Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only. **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only. **Voluntary Term Life Insurance Benefit:** Start or stop coverage for your eligible dependents, or increase or decrease existing coverage. **Spouse Term Life Insurance Benefit:** Start or stop coverage. **Child Term Life Insurance Benefit:** Start or stop coverage. **Accidental Death & Dismemberment (AD&D) Insurance:** Start or stop coverage for your eligible dependents, or yourself; increase or decrease existing coverage. **Flexible Spending Account Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. Company-recognized Domestic Partners and the dependents of Company-recognized Domestic Partners are not eligible to participate in FSAs.

If You Experience the Following Life Event…	Then, You Can…
You die	**Continuation of Coverage:** Your eligible dependents should contact your manager/supervisor, who will coordinate with a Survivor Support representative in HR Services to assist with all benefits and privileges, including the election of Continuation of Coverage, if applicable.
Your spouse, common law spouse, or Company-recognized Domestic Partner dies or other dependent dies	**Continuation of Coverage:** You will receive information about Continuation of Coverage Overview through COBRA for the eligible surviving children of your spouse, common law spouse, or Company-recognized Domestic Partner, if you contact HR Services as required below. **Contact:** HR Services within 60 days of your eligible spouse, common law spouse, same-sex spouse, or Company-recognized Domestic Partner's death to update your records and make the appropriate changes, if applicable, to your benefits coverage. Click on the "Start a Chat" button on the top of this page.
You end your employment with the Company or you are eligible to retire	**Review: "**When Coverage Ends" in the *General Enrollment* section. **Review:** The information you receive regarding Continuation of Coverage through COBRA. **Contact:** HR Services for information on retirement. Click on the "Start a Chat" button on the top of this page.
You transfer to another workgroup or subsidiary of AMR corporation	**Contact:** Your manager/supervisor, HR Services or the new subsidiary to determine benefits available to you and to make new benefit elections.

If You Experience the Following Life Event…	Then, You Can…
You and/or your eligible dependent(s) declined AA medical coverage because you or they had coverage elsewhere (external to AA), and any of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your eligible dependents in a Medical Benefits Option: Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) Employer contributions for the other coverage stopped Other coverage was COBRA and the maximum COBRA coverage period ended Exhaustion of the other coverage's lifetime maximum benefit Other employer-sponsored coverage is no longer offered Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your eligible dependents no longer reside, live, or work in its service area You have a new dependent via your marriage/common law marriage/declaration of a Company-recognized Domestic Partner, your child's birth/adoption/placement for adoption with you	You have 60 days from the date of the event to enroll yourself and/or your eligible dependents in one of the Medical Benefit Options offered to you. You cannot change Medical Benefit Options at this time, if you are already enrolled. **This event allows you to add dependents to your medical coverage only.**

If Your Dependent(s) Lose Eligibility Under the Plan

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

If you contact HR Services after the 60-day deadline you will be able to remove your dependent(s) from coverage, but the effective date of the removal will be the date you notified HR Services, and your resulting contribution rate changes, if any, will be effective as of the date you notified HR Services.

You will not receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified HR Services of their ineligibility.

Important: If you do not file a Life Event, notify HR Services of your dependent(s) losing eligibility and request your dependent(s) be solicited for COBRA within the 60-day time frame, the dependent(s) will lose their right to continue coverage under COBRA, so it is important that you are timely in registering your dependent(s)' removal from coverage within the 60-day time frame.

If You Process Your Life Event after the Deadline

If you miss the 60-day deadline and the event occurred in the current year, you must wait until the next Annual Benefits Enrollment period to add your dependents.

If you are removing a dependent from coverage after the deadline, they will be removed effective the date that we receive your request and not retroactively.

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

Special Life Event Considerations

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

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

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

Relocation: If you are enrolled in the STANDARD, VALUE or CORE Medical Option and you move to a location where the STANDARD, VALUE or CORE Medical Option is available, you will stay enrolled in STANDARD, VALUE or CORE Medical Option and your *Network/Claims Administrator* will stay the same, or you may elect coverage that was not available in your prior location, such as an HMO.

If a STANDARD, VALUE or CORE Medical Option network is not available, you must choose another medical Option (OUT-OF-AREA), or you may waive coverage if you have other coverage (such as your spouse's employer-sponsored plan).

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

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

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

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

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

Benefit Coverages Affected by Life Events

Flexible Spending Accounts Benefit: If you change the amount of your contributions during the year, claims from your Health Care Flexible Spending Account for eligible health care expenses incurred before the change are payable up to the original amount you elected to contribute. Claims for expenses incurred after the change are payable up to your newly elected contribution amount. You forfeit part of your balance when the contributions before your change are greater than your claims before the change and you reduce the amount you elect to contribute. Your Dependent Care Flexible Spending Account reimburses based on the contributions in your account at the time of the claim. **If you are a Home-Based Representative or Level 84 Premium Services Representative, you may enroll in the Limited Purpose Health Care Flexible Spending Account, the Health Savings Account, and the Dependent Care Flexible Spending Account.**

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

Voluntary Term Life Insurance Benefit: You may only increase this coverage by one level per year with approved proof of good health.

Move/Relocation: If you want to process a Relocation or Move Life Event within the last two months of the year, you must contact HR Services so they can help you ensure that you make appropriate changes for the remainder of this current year and for next year

Benefit Coverages Not Affected by Life Events

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

Medical Benefit Options: You may change medical Options only if you relocate and your current medical benefit Option is not available in your new location.

HIPAA Special Enrollment Rights – Medical Benefit Option Only

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

Fast Fact

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

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

The employer contributions to the other coverage have stopped.

The other coverage was COBRA and the maximum COBRA coverage period ends.

You and/or one of your dependents exhaust a lifetime maximum in another employer's health plan or other health insurance coverage.

You and/or one of your dependents' employers cease to offer benefits to the class of employees through which you (or one of your dependents) had coverage.

You and/or one of your dependents were enrolled under an HMO or other group or individual plan or arrangement that will no longer cover you (and/or one of your dependents) because you and/or one of your dependents no longer reside, live or work in its service area.

You have a new dependent as a result of your marriage, your child's birth, adoption or placement for adoption with you. Coverage is retroactive to the date of birth, adoption or placement for adoption.

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

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

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

What if I have questions?

Additional Health Benefit Rules

This section applies to the following benefits (except as noted in the text):

- STANDARD Medical Option with Health Reimbursement Account
- CORE Medical Option with Health Savings Account
- VALUE Medical Option with Health Incentive Account
- OUT-OF-AREA (OOA) Medical Option with Health Reimbursement Account
- HMOs
- Dental Benefits
- Vision Insurance Benefits
- Health Care Flexible Spending Account
- Limited Purpose Health Care Flexible Spending Account

Plan Administration

This section includes administrative information about your benefits

Reference Information

This section includes:

- “Contact Information”
- “Glossary”
- “Archives”

Additional Health Benefit Rules

This section includes:

- Qualified Medical Child Support Orders (QMCSO) Procedures
  - Use of Terms
  - Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice
  - Review of a Medical Child Support Order or Notice
  - Procedures upon Final Determination
  - Appeal Process
- Coordination of Benefits
  - Other Plans
- Coordination with Medicare
  - Benefits for Individuals Who Are Eligible for Medicare
  - Benefits for Disabled Individuals
- When Coverage Ends
- Continuation of Coverage – COBRA Continuation
  - Eligibility
  - Continuation of Coverage for You and Your Dependents Qualifying Events
  - Continuation of Coverage for Your Dependents Only (Qualifying Events)
  - How to Elect Continuation of Coverage
  - Continuation of Coverage for Employees in the Uniformed Services
  - Continuation of Coverage While on a Family and Medical Leave
  - Other Employee Obligations
  - Other Special Rules
  - Trade Adjustment Act
  - Impact of Failing to Elect Continuation of Coverage on Future Coverage
  - Additional Questions
  - American Recovery and Reinvestment Act of 2009 (ARRA)
- HIPAA Certificate of Creditable Coverage

Qualified Medical Child Support Orders (QMCSO) Procedures

If you are a Home-Based Representative or Level 84 Premium Services Representative, please keep in mind that the only Medical Benefit you are eligible to enroll in is the CORE Medical Option.

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

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

- STANDARD Medical Option
- CORE Medical Option
- VALUE Medical Option
- Out of Area (OOA) Medical Option
- HMOs
- Dental Benefits
- Vision Insurance Benefits
- Health Care Flexible Spending Account

Use of Terms

- The term "Plan" as used in these procedures refers to the Options and benefits described above, except to the extent that a plan is separately identified.
- The term "Participant," as used in these procedures, refers to a Participant who is covered under the Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.
- The term "Alternate Recipient," as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.
- The term "Order," as used in these procedures, refers to a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

- The term “QMCSO” or “NMSN,” as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these Procedures, or a notice from a state agency ordering the coverage of an Alternate Recipient under health benefits with respect to a Participant under a plan and that meets the requirements to be an NMSM decreed to be a QMCSO.
- The term “Plan Administrator,” as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at P.O. Box 619616, MD 5146-HDQ, DFW Airport, TX 75261-9616. In addition, QMCSOs or NMSNs should be delivered to the same address.

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

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

- Must be a “medical child support order”, which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.
- Must relate to the provision of medical child support and create or recognize the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a Plan and that meets the requirements set out in these procedures.
- Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.
- Does not require the Plan to provide any type or form of benefit or Option that is not otherwise available under the Plan.

- Must clearly specify:
  - The name and last known mailing address of the participant and the name and address of each alternate recipient covered by the Order
  - A reasonable description of the coverage that is to be provided by the Plan to each Alternate Recipient or the manner that the coverage shall be determined
  - The period to which the Order applies (if no date of commencement of coverage is provided, or if the date of commencement of coverage has passed when the Order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the Order)
  - The name of each Plan to which the order applies (or a description of the coverage to be provided)
  - A statement that the Order does not require a plan to provide any type or form of benefit, or any Option, not otherwise provided under the Plan (except as a condition of receiving federal assistance for Medicaid)
  - The fact that all Plan contributions with regard to the Alternate Recipient shall be deducted from the Participant's pay.

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

Review of a Medical Child Support Order or Notice

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

Procedures upon Final Determination

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

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

Appeal Process

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

Coordination of Benefits

This section explains how to coordinate coverage between the Company-sponsored Medical, Dental and Vision Insurance Benefits and any other benefits/plans that provide coverage for you or your eligible dependents.

If you or any other covered dependents have primary coverage (see "Which Plan Is Primary" in this section) under any other group medical, group dental benefits/plans or vision insurance plans, your Company-sponsored Medical, Dental and Vision Insurance Benefits will coordinate to avoid duplication of payment for the same expenses. The benefit program will take into account all payments you have received under any other benefits/plans, and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical, Dental and Vision Insurance Benefits were your only coverage.

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

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

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

Other Plans

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

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

Which Plan Is Primary

This section explains how to coordinate coverage between the Company-sponsored Medical, Dental and Vision Insurance Benefits and any other benefits/plans that provide coverage for you or your eligible dependents.

If you or any other covered dependents have primary coverage (see “Which Plan Is Primary” in this section) under any other group medical or group dental benefits/plans, your Company-sponsored Medical, Dental and Vision Insurance Benefits will coordinate to avoid duplication of payment for the same expenses. The benefit program will take into account all payments you have received under any other benefits/plans, and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical, Dental and Vision Insurance Benefits were your only coverage.

For example, if your dependent is covered by another benefit/plan and the VALUE Medical Option is his or her secondary coverage, the VALUE Medical Option pays only up to the maximum benefit amount payable under the VALUE Medical Option, and only after the primary benefit/plan has paid.

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

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

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

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

- Employer-sponsored benefits/plans under which the employer pays all or part of the cost or takes payroll deductions, regardless of whether the plans are insured or self-funded

- Government or tax-supported programs, including Medicare or Medicaid
- Property or homeowner's insurance or no-fault motor vehicle coverage, except if the plan participant has purchased this coverage
- Other individual insurance policies

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

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.
- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under Medical, Dental and Vision Insurance Benefits and Medicare are paid according to federal regulations. In case of a conflict between Medical, Dental and Vision Insurance Benefits provisions and federal law, federal law prevails.
- If the coordination of benefits is on behalf of a covered child:
    - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise (see "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" in the Qualified Medical Child Support Order section).
    - For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. A stepchild not living in the employee's home is not an eligible dependent under the benefit program, regardless of any child support order.
- If the other plan has a gender rule, that plan determines which plan is primary.

Coordination with Medicare

Benefits for Individuals Who Are Eligible for Medicare

If you (or one of your dependents) are eligible for Medicare benefits, the following rules apply:

- The AMR Corporation plan is the primary payer – in other words, your claims go to the AMR Corporation plan first – if you are currently working for a participating AMR Corporation subsidiary.
- If you become eligible for Medicare due to you (or your dependent) having end-stage renal disease, then AMR Corporation is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer.
- If you become eligible for Medicare due to becoming eligible for Social Security disability and if your coverage under this plan is due to the current employment status of the employee, then this plan (the AMR Corporation plan) pays primary.
- Effective January 1, 2006, the federal Medicare program activates the Medicare Part D Benefit – Medicare benefits for prescription drug expenses. If you (or your dependent(s)) are eligible for Medicare benefits, including Medicare Part D, the aforementioned rules apply.
- The AMR Corporation plan pays secondary and Medicare is the primary payer if you (or your dependent) are covered by Medicare, do not have end-stage renal disease and you are not currently working for the AMR Corporation.
- If you (or your dependent) are over age 65 and the AMR Corporation plan would otherwise be the primary payer because you are still working, you or your dependent may elect Medicare as the primary payer of benefits. If you do, benefits under the AMR Corporation plan will terminate.

Benefits for Disabled Individuals

If you stop working for a participating AMR Corporation subsidiary because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you must apply for Medicare Parts A, B and D, or Parts C and D, whichever is applicable. Medicare Part A provides inpatient hospitalization benefits, Medicare Part B provides outpatient medical benefits, such as doctor's office visits and Medicare Part D provides prescription drug benefits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the AMR Corporation plan, the AMR Corporation plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the AMR Corporation plan considers eligible, the AMR Corporation plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any.

When Medicare is the primary payer, no benefits will be payable under the AMR Corporation plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

When Coverage Ends

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

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

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

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

Expenses incurred after the date your coverage (or your spouse's coverage) terminates are not eligible for reimbursement under the plan or benefit Option.

Continuation of Coverage – COBRA Continuation

If you are a Home-Based Representative or Level 84 Premium Services Representative, please keep in mind that the only Medical Benefit you are eligible to enroll in is the CORE Medical Option.

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your health benefits are cancelled, along with your other benefits. You may elect to continue your health benefits as part of your continuation of coverage options available through Benefit Concepts, Inc., the COBRA administrator. Benefit Concepts, Inc. will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your medical coverage through COBRA, claims incurred after the date of your termination are not payable.

Several of American Airlines, Inc. benefits or plans (STANDARD Medical Option, VALUE Medical Option, CORE Medical Option, OUT-OF-AREA Medical Option, Dental Benefits, Vision Insurance Benefits, HMOs and the Health Care Flexible Spending Account) provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain Qualifying Events. If you and/or your dependents have coverage at the time of the Qualifying Event, you may be eligible to elect continuation of coverage under the following:

- Medical Benefits
- Dental Benefits
- Vision Insurance Benefits
- Health Care Flexible Spending Account Benefit, for the remainder of the calendar year in which you became eligible for continuation of coverage. (Although you would not be able to make contributions on a pre-tax basis, by electing continuation of coverage for this account, you would still have the opportunity to file claims for reimbursement based on your account balance for the year.)

The coverage under COBRA is identical to coverage provided under the benefits or plans for similarly situated employees or their dependents, including future changes. Although your Company-recognized Domestic Partner and his or her children do not have rights to COBRA coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur. This is subject to change.

Eligibility

Eligibility for continuation of coverage depends on the circumstances that result in the loss of existing coverage for you and your eligible dependents. The sections below explain who is eligible to elect continuation of coverage and the circumstances that result in eligibility for this coverage continuation.

Continuation of Coverage for You and Your Dependents Qualifying Events

- You may elect continuation of coverage for yourself and your eligible dependents, including a Company-recognized Domestic Partner and his or her children, for a maximum period of 18 months if your coverage would otherwise end because of layoff or termination of your employment for any reason (except in the event of termination for gross misconduct).
- If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you (or any eligible dependent) are disabled at any time during the first 60 days of continuation of coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself and your dependents, including a Company-recognized Domestic Partner and his or her children. To qualify for this additional coverage, the Qualified Beneficiary must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (Benefit Concepts, Inc.) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.

Continuation of Coverage for Your Dependents Only (Qualifying Events)

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

- Your divorce or legal separation

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

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

How to Elect Continuation of Coverage

Solicitation of Coverage

Solicitation following layoff or termination: In the event that your employment ends through layoff or termination, you will automatically receive information from Benefit Concepts, Inc., the COBRA administrator, about electing continuation of coverage through COBRA.

Solicitation following a Qualifying Event: In the event of a Qualifying Event (as shown above as for your dependents only), you must notify American Airlines, Inc. by processing a Qualifying Event within 60 days of the event. You can process most Life Events on the Benefits Service Center. For more information, see "Life Events" in the *Life Events* section.

If you want your over-age dependent to be solicited for COBRA continuation of coverage, you must complete the Life Event within 60 days of the date of the event's occurrence, and you must request that your dependent who is losing coverage be solicited for COBRA. If you do not complete the Life Event within this 60-day period and request that your dependent be solicited for COBRA, your dependent will lose his or her opportunity to continue coverage under COBRA.

If you fail to notify the Company of a dependent's loss of eligibility within 60 days after the Qualifying Event, the dependent will not be eligible for continuation of coverage through COBRA, and you will be responsible for reimbursing the Company for any benefits paid for the ineligible person. You are also required to repay the Company for premium amounts that were overpaid for fully insured coverages.

Enrolling for Coverage

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

You (or your dependents) must provide written notification of your desire to elect to purchase continuation of coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage, or else you lose your right to elect to continue coverage. See "Contact Information" in the *Reference Information* section for Benefit Concepts, Inc.'s address.

You and your dependents may each independently elect continuation of coverage. Once you elect continuation of coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election.

If you waive continuation of coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify Benefit Concepts, Inc. before your 60-day election period expires.

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

Processing Life Events After Continuation of Coverage Is in Effect

If you elect continuation of coverage for yourself and later marry or declare a Company-recognized Domestic Partner, give birth, or adopt a child while covered by continuation of coverage, you may elect coverage for your newly acquired dependents after the Life Event. To add your dependents, contact Benefit Concepts, Inc., within 60 days of the marriage, Company-recognized Domestic Partner relationship, birth, or adoption.

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

All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to continuation of coverage.

Paying for or Discontinuing COBRA Coverage

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

Refund of Premium Payments

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

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

or her children do not have rights to COBRA coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur.

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

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

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

- The maximum continuation period (18, 29 or 36 months) expires. (See “Processing Life Events After Continuation of Coverage Is in Effect” in this section.)
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds (“NSF” or “bounced”) are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the participant is eligible for continuation of coverage up to the maximum time period.
- The Plan participant continuing coverage becomes eligible for Medicare
- The Company no longer provides the coverage for any of its employees or their dependents

See “Dependent Eligibility Criteria” in the *General Eligibility* section.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are eligible for the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your medical coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a two percent administrative fee.

The maximum period of continuation of coverage available to you and your eligible dependents is the lesser of 24 months (for elections of coverage on or after December 10, 2004) or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, you are eligible for reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days

The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Employee Policy Guide.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition

Depending on your state of residence, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Other Employee Obligations

In order to protect you and your family's rights, you should keep both Benefit Concepts, Inc. and the Company informed of any changes in the addresses of your family members.

Other Special Rules

If your event that qualified you for COBRA coverage was either a Company-mandated reduction in hours or termination of employment and your employment termination or reduction was due to reduced sales due to increased imports and it was certified by the U.S. Department of Labor so that you are a Trade Adjustment Act (TAA)-eligible individual, then you may be eligible for a second chance to elect COBRA continuation of coverage. You are only eligible for the second chance to elect COBRA coverage if all of the events described in this paragraph occurred within six months of your loss of coverage. If you are a TAA-eligible individual, you must elect coverage within six months of the date you lost coverage, or you lose the right to elect COBRA coverage as a TAA-eligible individual.

Trade Adjustment Act

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65 percent of premiums paid for qualified health insurance, including continuation of coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282.

Impact of Failing to Elect Continuation of Coverage on Future Coverage

In considering whether to elect continuation of coverage, you should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation of coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation of coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Plan coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment rights at the end of continuation of coverage if you get continuation of coverage for the maximum time available to you.

Additional Questions

If you have any additional questions on continuation of coverage under COBRA, you should contact Benefit Concepts, Inc. (see "Contact Information" in the *Reference Information* section).

American Recovery and Reinvestment Act of 2009 (ARRA)

If you (the retiree) were recalled back to active employment with American Airlines, Inc. and subsequently experience(d) involuntary termination of your employment during the period beginning September 1, 2008 and ending May 31, 2010, and are eligible for COBRA continuation of coverage, you might be eligible to participate in the COBRA contribution subsidy program provided under ARRA. If you are eligible, this program pays 65 percent of the contribution amount you are required to pay for COBRA continuation coverage, and you are required to pay 35 percent. This subsidy will be paid for up to nine (9) months.

Retirees whose employment was terminated between September 1, 2008 and May 31, 2010 will receive information from the COBRA administrator, advising who is eligible to receive this subsidy, how to elect this subsidy, income qualifications and other information. Not all employees whose employment was terminated during this period of time will be eligible for the COBRA subsidy; thus, read your information carefully. If you have questions, contact your COBRA administrator (see "Contact Information" in the *Reference Information* section).

You can also find more information about this COBRA subsidy on the U.S. Department of Labor website.

HIPAA Certificate of Creditable Coverage

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

To request a certificate of creditable coverage, contact HR Services (see "Contact Information" in the *Reference Information* section) and ask for a HIPAA certificate of creditable coverage.

Plan Administration

This section includes:

- Plan Information
- Administrative Information
  - Plan Sponsor and Administrator
- Plan Amendments
- Plan Funding
- Collective Bargaining Agreement
- Assignment of Benefits
- Claims — For Non-Grandfathered Medical Options (Standard, Core, Value, Out-of-Area and HMO Medical Options)
  - Confidentiality of Claims
  - Payment of Benefits
  - Right to Recovery
  - Subrogation
  - Claim Processing Requirements
- Appealing a Denial — For Non-Grandfathered Medical Options (STANDARD, CORE, VALUE, OUT-OF-AREA)and HMO Medical Options
- Notice of Privacy Rights — Health Care Records
  - Other Uses or Disclosures of Protected Health Information
  - Rights You May Exercise
- How AMR Corporation Subsidiaries May Use Your Health Information
  - This Section Applies To
  - This Section Does Not Apply To
- Separation of AMR Corporation Subsidiaries and the Group Health Plans
  - Noncompliance Issues
  - Organized Health Care Arrangement
- Your Rights Under ERISA 264
  - Information about Your Plan and Benefits
  - Prudent Actions by Plan Fiduciaries
  - Enforce Your Rights
  - Assistance with Your Questions

Plan Information

The Plans listed below are sponsored by American Airlines, Inc. as that term is defined under ERISA Section 3(16)(B), and comprise the plans, benefits and Options in the benefit program for Agents, Representatives and Planners.

Plan Name	Plan Number

The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries
This plan includes:
• **For Agents, Representatives, Planners, Officers, Management, Specialists, Support Staff and employees represented by Transport Workers' Union of America (AFL-CIO). EXCLUDING Home-Based Representatives or Level 84 Premium Services Representatives:**
• Medical Benefits
  ○ STANDARD Medical Option with Health Reimbursement Account
  ○ CORE Medical Option with Health Savings Account
  ○ VALUE Medical Option with Health Incentive Account
  ○ OUT-OF-AREA Medical Option with Health Reimbursement Account
  ○ Health Maintenance Organizations
• Dental Benefit Option
• Vision Insurance Benefit
• Employee Term Life Insurance Benefits
• Spouse Term Life Insurance Benefits
• Child Term Life Insurance Benefits
• Accidental Death & Dismemberment Insurance Benefits (Employee, Spouse, Child)
• Special Purpose Accident Insurance Benefit
• Special Risk and Accident Insurance
• Optional Short Term Disability Insurance
• Management Personal Accident Insurance (For Management, Specialist and Officer employees)
• Health Care Flexible Spending Account Benefit
• Dependent Care Flexible Spending Account Benefit
• Limited Purpose Health Care Flexible Spending Account Benefit
• **For Home-Based Representatives or Level 84 Premium Services Representatives:**
• Medical Benefit
  ○ CORE Medical Option with Health Savings Account
• Dental Benefit Option
• Vision Insurance Benefit
• Voluntary Employee Term Life Insurance Benefits
• Spouse Term Life Insurance Benefits
• Child Term Life Insurance Benefits
• Accidental Death & Dismemberment Insurance Benefits (Employee, Spouse, Child)
• Special Purpose Accident Insurance Benefit
• Special Risk and Accident Insurance
• Optional Short Term Disability Insurance
• Dependent Care Flexible Spending Account Benefit
• Limited Purpose Health Care Flexible Spending Account Benefit
	501

Plan Name	Plan Number
American Airlines Inc. Long Term Disability Plan For Agent, Representatives, Planners, Officers, Management, Specialists, Support Staff and Home-Based Representatives or Level 84 Premium Services Representatives. TWU-Represented employees have Long Term Disability available through their labor union.	509
Long-term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries	510
Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries	515

Administrative Information

Plan Sponsor and Administrator

American Airlines, Inc.

Mailing address:
Mail Drop 5141-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

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

The Plan Administrator for Urgent and Second Level Claim Appeals

Pension Benefits Administration Committee (PBAC)

American Airlines
Mail Drop 5134-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Agent for Service of the Legal Process

Managing Director, Health and Welfare

American Airlines, Inc.

Mailing address:
Mail Drop 5126-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Express Delivery address:
4333 Amon Carter Blvd.
Fort Worth, TX 76155

Network/Claims Administrator

The Network/Claims Administrator for each benefit or plan vary and are listed in *Contact Information*.

Trustee

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

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Participating Subsidiaries

American Airlines, Inc.

Plan Amendments

The Benefits Strategy Committee (BSC), as appointed by the Chief Executive Officer, has the sole authority to adopt new employee benefit plans ("Plans") and terminate existing Plans. The Pension Benefits Administration Committee (PBAC), under the authority granted to it by the Benefit Strategy Committee, has the sole authority to interpret, construe, determine claims and adopt and/or amend the Plans, as well as to make recommendations to the Benefit Strategy Committee for material amendments to the Plans. The PBAC, in consultation with actuaries, consultants, Employee Relations, Human Resources and the Legal Department, has the discretion to adopt such rules, forms, procedures and amendments it determines are necessary for the administration of the Plans according to their terms, applicable law, regulation, collective bargaining agreements or to further the objectives of the Plans. The PBAC may take action during a meeting if at least half the members are present or by a unanimous written decision taken without a meeting and filed with the Chairman of the PBAC.

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

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plans, including the establishment of any claims procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information

- To interpret and construe the terms of the Plans, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plans
- To decide all questions concerning the Plans, and to determine the eligibility of any person to participate in or receive benefits under the Plans and to determine if any exceptional circumstances exist to justify any extensions
- To compute the amount of benefits that will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plans and the applicable requirements of law
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plans
- To allocate and delegate its responsibilities under the Plans and to designate other persons to carry out any of its responsibilities under the Plans, any such action to be by written instrument and in accordance with ERISA Section 405
- To delegate its authority to administer Claims for benefits under the Plans by written contract with a licensed third party administrator
- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions and reports that are furnished by accountants, counsel or other experts employed or engaged by the PBAC

Plan Funding

This section describes the funding arrangements for the plans, Options and benefits in the Guide.

The coverage for the following benefits is self-funded through both Company and employee contributions:

- STANDARD Medical Option
- CORE Medical Option
- VALUE Medical Option
- OUT-OF-AREA Medical Option
- Dental Benefits
- Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries

The network and/or claims administrators are independent companies that provide claim payment services. They do not insure these benefits.

- Health Maintenance Organizations (HMOs) Vision Insurance Benefits and are fully insured and are funded through both Company and employee contributions.

Coverage for the following benefits is fully insured and premiums are paid by the Company:

- Employee Basic Term Life Insurance Benefit
- Special Purpose Accident Insurance Benefit
- Special Risk Accident Insurance Benefit

The following benefits are fully insured and paid entirely by employee contributions:

- Optional Short Term Disability Insurance
- Accidental Death & Dismemberment Insurance Benefit
- Optional (Additional) Levels of Employee Life Insurance Benefit
- Spouse Term Life Insurance Benefit

- Child Term Life Insurance Benefit
- Long-term Care Insurance Plan
- The following benefits are self-funded and paid entirely by employee contributions.
- American Airlines Inc. Long Term Disability Plan

Collective Bargaining Agreement

Certain benefits (medical and dental benefits, life insurance benefits, retiree medical benefits) described in this Guide are maintained subject to a collective bargaining agreement. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator. This agreement is also available for review during normal business hours at the corporate offices of American Airlines, Inc. (see "Contact Information" in the *Reference Information* section).

Assignment of Benefits

You may request that the network and/or claims administrator pay your service provider directly by assigning your benefits.

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

For information about assigning Life Insurance Benefits, see "Assignment of Benefits" under "Special Provisions" in the *Life Insurance* section.

Claims — For Non-Grandfathered Medical Options (Standard, Core, Value, Out-of-Area and HMO Medical Options)

This information regarding claims is for the above referenced non-grandfathered medical Options. This contains revised appeal information and requirements.

Confidentiality of Claims

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

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

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see "Notice of Privacy Rights — Health Care Records".

Payment of Benefits

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

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

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

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

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

Right to Recovery

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

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

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

Subrogation

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

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

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

- Cooperate with the Plans to protect the Plans' subrogation rights
- Provide the Plans with any relevant information they request
- Obtain consent of the Plans before releasing any party from liability for payment of medical expenses

- Sign and deliver documents regarding the Plans' subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plans' subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plans
- The Plans' claims and lien shall not be reduced by any "make whole" or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plans.

The Plans will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plans will not pay your or others' legal costs associated with subrogation.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from our recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Claim Processing Requirements

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), became effective on July 1, 2011. However, there are other rules and provisions that the U.S. Department of Labor continues to review and those rules may carry compliance dates of 2013 and 2014. American Airlines, Inc.-sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Time Frame for Initial Claim Determination

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

- As soon as possible after receipt of a claim initiated for urgent care, but no later than 72 hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification)
- Fifteen days after receipt of a pre-service claim

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

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

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

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the network and/or claims administrator or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the network and/or claims administrator or benefit administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

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

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

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

Urgent Care Claims

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

- Could seriously jeopardize the patient's life, health or ability to regain maximum function
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits

- An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim

Concurrent Care Claims

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

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

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination

If You Receive an Adverse Benefit Determination on a Health/Welfare Benefit Plan Claim

The network and/or claims administrator or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- Date of service, the health care provider, the claim amount (if applicable)
- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for internal appeal or external review, and will not trigger the start of an internal appeal or external review
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits.

- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim
- The network and/or claims administrator is required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale

When You Are Deemed to Have Exhausted the Internal Claim and Appeal Process

- If the Network/Claims Administrator or benefit administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review, you may pursue a civil action under ERISA §502(a), or you may pursue civil action under state law if the adverse benefit determination involved a fully-insured benefit. However, keep in mind that the claim and appeal process won't be deemed exhausted based on *de minimis* violations of law (as long as the Plan Administrator or Network/Claims Administrator that the violation was for good cause, was committed in a good faith exchange of information between you, or was due to matters beyond the Plan Administrator's or Network/Claims Administrator's control.
- You may request from the Plan Administrator or Network/Claims Administrator a written explanation of the violation, and such explanation must be provided to you within 10 days. This explanation should include a specific description of the bases, if any, for its assertion that the violation should not cause the internal claim and appeal process to be deemed exhausted.
- If an external reviewer or court rejects your request for immediate review because it finds that the Plan Administrator or Network/Claims Administrator met the standards for exception (*de minimis* violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or Network/Claims Administrator will notify you of your opportunity to file the internal appeal of your claim. The 12-month claim filing limit will begin to run upon your receipt of the Plan Administrator's or Network/Claims Administrator's notice.
- If your claim is filed under one of the Plan's fully-insured benefits (an HMO, for example), contact the insurer for information on the State process for immediate review.

Disability Claims (Applies to Short-Term Disability Pay, Optional Short-Term Disability Insurance Benefit and American Airlines, Inc. Long Term Disability Plan)

All Disability Benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the network and/or claims administrator. After the network and/or claims administrator has reviewed the claim for Disability Benefits and obtained any other information that it deems necessary or relevant, the network and/or claims administrator shall notify you within a reasonable period of time not to exceed 45 days after receipt of the acceptance or denial of the claim. The 45-day period during which a claim for Disability Benefits is reviewed may be extended by the network and/or claims administrator for up to 30 days, provided the network and/or claims administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 45-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 30-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 30-day period provided the network and/or claims administrator notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for Disability Benefits is denied, in whole or in part, the network and/or claims

administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

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

Effect of Failure to Submit Required Claim Information

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

All Other Claims

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

The Notice shall contain:

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

Effect of Failure to Submit Required Claim Information

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

Appealing a Denial — For Non-Grandfathered Medical Options (STANDARD, CORE, VALUE, OUT-OF-AREA)and HMO Medical Options

This contains appeal information and requirements specific to the Non-Grandfathered Medical Options.

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), to be effective on July 1, 2011. However, there are other rules and provisions that the U.S. Department of Labor continues to review. Those rules may carry a compliance date in 2013 and 2014. American Airlines, Inc.-sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

Important Information about Health Care Provider's Appeals

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

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

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

Procedures for Appealing an Adverse Benefit Determination

American Airlines, Inc., as Sponsor and Administrator for the Company-sponsored Health and Welfare Benefit plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the network and/or claim administrator or benefit administrator that rendered the adverse benefit determination. Second Level Appeals are conducted by the Pension Benefits Administration Committee (PBAC) at American Airlines, Inc. (Appeals may be filed on adverse benefit determinations such as claim denial or reduction in benefits, eligibility/enrollment denial, partial payment or partial denial of benefits, rescission of coverage, application of a benefit penalty, or other such adverse benefit determinations.)

This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document. The one exception to this mandatory two-tiered process is an appeal for an urgent care claim – for urgent care claim appeals, only Second Level Appeals are required – no First Level Appeals are necessary. Employees must use both levels of appeal (or the Second Level Appeal for urgent care claims) and must exhaust all administrative remedies to resolve any claim issues.

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

- Employee Term Life Insurance Benefit
- Accidental Death & Dismemberment Insurance Benefits (employee, spouse/Domestic Partner, child, VPAI and all Company-provided Accident Insurance Benefits)
- Vision Insurance Benefit
- HMOs
- Long-term Care Insurance Plan

the appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The PBAC cannot render a decision involving fully insured benefits (except for administrative, eligibility and enrollment issues, as stated previously). The insurers and HMOs

make the final appeal determinations for their respective insured coverages/benefits. Each insurer or HMO has its own appeal process, and you should contact the respective insurer or HMO for information on how to file an appeal (see "HMO Contact Information" in the *Health Maintenance Organizations (HMOs)* section.)

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the network and/or claim administrator or benefit administrator. You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the network and/or claim administrator or benefit administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination. For urgent care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

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

The network and/or claim administrator or benefit administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For pre-service claims – within 30 days of receipt of your First Level Appeal
- For post-service claims – within 60 days of receipt of your First Level Appeal
- For urgent care claims – within 72 hours of receipt of your First Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If the network and/or claim administrator or benefit administrator requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (the network and/or claim administrator or benefit administrator will notify you if this additional time period is needed to complete a full and fair review of your case). For disability claims, this process may also be referred to as a "Second Level Review."
- For all other claims for all benefits other than Medical or Disability, within 60 days of receipt of your First Level Appeal, if the network and/or claim administrator or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your First Level Appeal (the network and/or claim administrator or benefits administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal with the PBAC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the PBAC at American Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the PBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the PBAC, please complete an Application for Second Level Appeal, and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal.)

The PBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 30-day time period allotted for completion of both levels of appeal
- For post-service claims, within the 60-day time period allotted for completion of both levels of appeal
- For urgent care claims, within the 72-hour time period allotted for completion of both levels of appeal

Example: A participant appeals an adverse benefit determination (post-service claim). For both levels of appeal – First and Second Levels, the combined time taken by the network and/or claim administrator or benefit administrator and the PBAC to review and complete the appeals must be no more than 60 days. If the First Level Appeal review is completed by the network and/or claim administrator or benefit administrator in 15 days, then the PBAC has the remaining 45 days (for a total of 60 days) to complete its review and render its decision.

If the PBAC requires additional time to obtain information to evaluate your Second Level Appeal for Disability, it may have an additional 45 days to complete your Second Level Appeal. The PBAC will notify you if this additional time period is needed to complete a full and fair review of your claim.

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the PBAC. Appointed officers of American Airlines, Inc. are on the PBAC. In some cases, the PBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the network and/or claim administrator or benefit administrator, if appropriate, will be reviewed by the PBAC or its designee(s).

In the filing of appeals under Company-sponsored health and welfare benefit plans, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony.
- Receive from the Plan Administrator or Network/Claims Administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond t the new rationale
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination

- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the Plan Administrator or network/claim processor has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for urgent care, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
  - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

The External Review Process

After you have exhausted (of have been deemed to have exhausted) your internal appeal rights under the benefit plan(s), you have the right to request an external review of your adverse benefit determination. This external review process is defined by federal law—and American Airlines, Inc.-sponsored, non-grandfathered Medical Benefit Options will comply with the requirements of this external review process.

The external review process is applicable to adverse benefit determinations made under group health plans, in which the adverse benefit determination involved a medical judgment—such as:

- adverse determinations based on lack of medical necessity
- adverse determinations based on the assertion that the service or supply at issue was determined to be experimental, investigational, or unproven in nature
- adverse determinations based on the assertion that the service or supply was cosmetic in nature
- adverse determinations based on appropriateness or type of care, appropriateness of place of care, manner of care, level of care, or whether provider network status could have affected availability or efficacy of treatment
- adverse determinations based on the determination of whether care constituted "emergency care", "urgent care"
- adverse determination based on a plan exclusion or limitation of coverage for a particular treatment in the presence of certain medical conditions
- adverse determination based on the determination of whether care was "preventive" in nature and the care was not referenced by the US Preventive Care Task Force, the Advisory Committee on Immunization Practices, or the Centers for Disease Control
- adverse determination that brings into question if the benefit plan is complying with the nonquantitative treatment limitations in the Mental Health Parity and Addiction Equity Act (such as methods and limitations on medical management)

American Airlines, Inc. retains three Independent Review Organizations (IROs), as required by federal law, to conduct external reviews, and these IROs meet federal requirements as to levels of expertise, type and manner of reviews. They will conduct external reviews in compliance with the requirements of federal law. The three contracted IROs are:

- Network Medical Review (an ExamWorks company)
- Medical Review Institute of America
- American Medical Review, Inc.

An external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

You must use and exhaust Plans' administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plans' prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Notice of Privacy Rights — Health Care Records

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

This Notice is effective as of February 17, 2010, and applies to health information received about you by the health care components of the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (particularly, the STANDARD Medical Option, the CORE Medical Option, the VALUE Medical Option, the OUT-OF-AREA Medical Option, the HMOs, Dental Benefits, Vision Insurance Benefits, Health Care Flexible Spending Accounts Benefit, Limited Purpose Health Care Flexible Spending Account, Health Savings Account), the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, the Group Life and Health Benefits Plan for Retirees of Participating AMR Corp. Subsidiaries, TransWorld Airlines, Inc. Retiree Health and Life Benefits Plan and any other group health plan for which American Airlines, Inc. ("American") serves as Plan Administrator (collectively, the "Plan").

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations") and as amended by the Genetic Information Nondiscrimination Act ("GINA") and the American Recovery and Reinvestment Act ("ARRA"). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan's privacy practices.

The following uses and disclosures of your PHI may be made by the Plan:

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

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

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances. ARRA requires disclosures for purposes of the Plan's operations to meet its minimally necessary standard. The Plan is prohibited from disclosing any of your PHI that constitutes genetic information (as defined by GINA) for underwriting purposes.

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

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

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

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

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

Other Uses or Disclosures of Protected Health Information

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

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

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

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

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

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.
- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.

- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

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

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. The Plan is required to comply with your request not to disclose to another plan any PHI related to any claim for which you paid in full. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: Managing Director, Human Resources Delivery.

To Access. You have the right to request access to your PHI and to inspect and copy your PHI in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. You may also direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by you.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: Managing Director, Human Resources Delivery at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the following officer: Managing Director, Human Resources Delivery at American

Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. You or your personal representative will be required to complete a written form to request amendment of the PHI in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (such disclosures occurring after January 1, 2014, will be required to be included in the accounting); (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Obtain a Paper Copy of This Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Plan's Privacy Officer by calling the Managing Director, Human Resources Delivery, or by writing to American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

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

A Note About Personal Representatives

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

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

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

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and

practices described in this notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

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

Minimum Necessary Standard

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

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

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

The Plan may use or disclose "summary health information" or a limited data set on and after February 17, 2010 to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a "Limited Data Set" that may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, Mail Drop 5134-HDQ, P.O. Box 619616, DFW Airport, TX 75261-9616, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. You may obtain the address of the appropriate regional office of the Office for Civil Rights from the Privacy Complaint Official. If you would like to receive further information, you should contact the Privacy Official, the Managing Director, Human Resources Delivery at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616, or the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, Mail Drop 5134-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. This notice will first be in effect on February 17, 2010 and shall remain in effect until you are notified of any changes, modifications or amendments.

How AMR Corporation Subsidiaries May Use Your Health Information

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

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

- The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501)
- The Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries (Plan 515)
- Trans World Airlines, Inc. Retiree Health and Life Benefits Plan (Plan 511)
- Any other Group Health Plan for which American serves as Plan Administrator

This Section Applies To

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

This Section Does Not Apply To

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

- Disability plans (Short-Term, Optional Short-Term and Long Term Disability),
- Life Insurance plans, including Accidental Death & Dismemberment (AD&D) Insurance,
- Workers’ Compensation plans, which provide benefits for employment-related accidents and injuries, and
- Property and casualty insurance.

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

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

The Plans will disclose PHI to the employer Plan Sponsor (American Airlines, or other current or former AMR subsidiary) only upon receipt of a certification by the employer that the plan documents have been amended to incorporate all the required provisions as described below. To the extent that PHI is maintained by one of the Plans, American and all other participating current or former subsidiaries of AMR Corporation for which American administers the Plans have agreed to:

- Not use or further disclose the information other than as permitted or required by this Employee Benefits Guide, as it may be amended by American from time-to-time, or as required by law.
- Ensure that any agents, including a subcontractor, to whom the Plans give PHI, agree to the same restrictions and conditions that apply to the employer Plan Sponsor with respect to such information.
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the employer Plan Sponsor, unless that use or disclosure is permitted or required by law (for example, for Workers Compensation programs) or unless such other benefit is part of an organized health care arrangement with the plan.
- To the extent that the employer Plan Sponsor becomes aware that there is any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures, to report such improper uses or disclosures to the Plan.
- Make available PHI in accordance with individual rights to review their PHI.
- Make available PHI for amendment and consider incorporating any amendments to PHI consistent with the HIPAA rules.
- Upon request and to the extent mandated by applicable law, make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules.
- Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Plan.
- Agree to the same restrictions and conditions that apply to the Plan with respect to such information and enter into Business Associate agreements that comply with the standards for such agreements in the Privacy Regulations.
- Enter into limited data set use agreements when the Plan discloses data de-identified in compliance with the requirements for a limited data set as provided in the Privacy Regulations pursuant to a Limited Data Set use or disclosure agreement that meets the standards of the Privacy Regulations.
- Terminate any Business Associate agreement or Limited Data Set agreement in the event the Plan becomes aware of a pattern of non-compliance with the terms of the agreement.
- Provide the individual who is the subject of the PHI with the opportunity to request restrictions on the PHI's disclosure in accordance with the Plan's policy on requesting restrictions on disclosure of PHI.

- Provide the individual who is the subject of the PHI with the opportunity to request confidential communication of PHI from the Plan to the individual in accordance with the Plan's policies and procedures.
- Incorporate any amendments or corrections to PHI when such amendment is determined to be required by the Plan's policy on amendment of PHI.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plans.
- If feasible, return or destroy all PHI received from the Plans that the employer Plan Sponsor still maintains in any form. The employer Plan Sponsor will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if the return or destruction is not feasible, but the Plans must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that there is an adequate separation between the Plans and the employer Plan Sponsor as will be set forth below.

Separation of AMR Corporation Subsidiaries and the Group Health Plans

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

- Benefits Strategy employees involved in health plan design, vendor selection and administration of the Plans, and including the Plan Managers, and administrative assistants, secretarial and support staff; as well as any retirement strategy employees involved in health plan issues.
- PBAC, its delegated authority, and PBAC Advisory Committee members, due to their role in governing health plan matters, including reviewing and approving plan design changes, rendering appeal decisions and other health plan administrative matters.
- Benefits Compliance and the PBAC Appeals group personnel involved in receiving, researching and responding to health plan member appeals filed with the PBAC.
- People 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 People Services personnel, and thus have access to the call center systems.
- People Records Room personnel responsible for managing benefit plan record storage.
- Certain Employee Relations Operation Support personnel, but only those involved in investigating health plan fraud or abuse.
- Executive Compensation employees, including secretarial and support staff, who assist Company executives and certain other employees with health plan enrollment and payment issues on a day-to-day basis.

- Occupational Health Services/Clinical Services employees, including the Corporate Medical Director, EAP Manager, EAP nurses and support staff providing services through the Employee Assistance Program (EAP), including possible involvement in mental health and substance abuse benefits under the Plans, but only to the extent of their involvement with the Group Health Plans.
- Legal department employees, including Employment and Labor Attorneys, ERISA counsel, 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.
- People Department 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 the People Department and Benefits, including administrative staff, key vendor managers and certain management personnel responsible for disaster recovery procedures.
- Privacy Compliance Council and HIPAA Subcommittee members, due to their role in understanding and investigating the flow of PHI for the Group Health Plans, in order to ensure compliance with HIPAA and other privacy rules.
- On a need-to-know basis, appropriate personnel employed by the employer Plan Sponsor as independent contractors who have executed Business Associate agreements with the Plan to provide other necessary administrative services to the Plan that include, but are not limited to:
  - Insurance agents retained to provide consulting services and obtain insurance quotes,
  - Actuaries retained to assess the Plan's ongoing funding obligations,
  - Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities,
  - Consulting firms engaged to design and administer Plan benefits,
  - Financial accounting firms engaged to determine Plan costs, and
  - Claims processing companies engaged to assist the Plan Administrator in the processing of claims made against the Plan.

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

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

Noncompliance Issues

If the persons described above do not comply with the requirements included in this portion of the Plan, the Plan Sponsor shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions for the individuals involved in the violation, which sanctions are included in the policy on sanctions for violation of the privacy policies and procedures. The Plan's Policy Regarding Sanctions for Violation of the HIPAA Privacy Policies and Procedures shall be followed along with the Group Health Plan's Policy and Procedure on Mitigation of Damages for Violative Disclosure of PHI in the event of any violation of the Plan's HIPAA Privacy Provisions in this Article.

Organized Health Care Arrangement

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

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

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

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

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, co-insurance, deductibles and co-payments as determined for an individual's claim)
- Coordination of benefits
- Adjudication of health benefit claims (including appeals and other payment disputes)
- Subrogation of health benefit claims
- Establishing employee contributions
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Billing, collection activities and related health care data processing
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance)

- Determining medical necessity, experimental or investigational treatment or other coverage reviews or reviews of appropriateness of care or justification of charges (including hospital bill audits)
- Processing utilization review, including precertification, preauthorization, concurrent review, retrospective review, care coordination or case management
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for such purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan)
- Obtaining reimbursements due to the Plan

Health Care Operations. A disclosure for Health Care Operations will be limited to the amount minimally necessary. Health Care Operations include, but are not limited to, the following activities:

- Quality assessment,
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions,
- Rating providers and plan performance, including accreditation, certification, licensing or credentialing activities,
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance),
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies,
- Business management and general administrative activities of the Plan, including but not limited to:
  - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  - Participant service, including the provision of data analyses for participants or the plan sponsors
- Resolution of internal grievances, and
- The sale, transfer, merger or consolidation of all or part of the Plan with another covered entity, or an entity that following such activity will become a covered entity, and due diligence related to such activity.

Treatment. Disclosures for treatment are not limited by the minimally necessary requirement if the disclosures are made to, or the requests are made by, a health care provider for the treatment of an individual. Treatment means the provision, coordination or management of health care and related services by one or more health care provider(s). Treatment includes:

- The coordination or management of health care by a health care provider and a third party,
- Consultation between health care providers about an individual patient, or
- The referral of a patient from one health care provider to another.

Limited Data Set. The Plan may disclose PHI in the form of a limited data set as provided in 45 CFR §164.514(e) provided that the disclosure is in accordance with such provisions.

Your Rights Under ERISA

Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We believe that the Plan that has been developed is only good if you receive the benefits to which you are entitled. We encourage you to come to us if you have any questions or problems. In addition, as already noted, the Plan documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

For general information contact:

People Services
Mail Drop 5141-HDQ-1
American Airlines, Inc.
P.O. Box 619616
DFW Airport, Texas 75261-9616
1-800-447-2000

You can chat live with HR Services by clicking on the “Chat with HR Services” icon.

For information about your claims, contact the appropriate Network/Claims Administrator or benefits plan administrator at the addresses and phone numbers located in the “Contact Information” in the *Reference Information* section.

Reference Information

This section includes:

- Contact Information
- Glossary
- Archive

Contact Information

The following table lists the names, addresses, phone numbers and websites (when available) for these important contacts.

For Information About:	Contact:	At:
Health and Welfare Benefits General questions, dependent eligibility, information updates,	HR Services AMR Corporation MD 5141-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	1-800-447-2000 Website: http://www.Jetnet.aa.com Chat live with HR Services: Click on the "Start a Chat" button on the top of this page. Chat hours are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday.
Forms, Guides and Contact Information	Jetnet (Benefits page)	
Medical and Mental Health/Chemical Dependency Coverage		
▪ Standard Medical Option ▪ Core Medical Option ▪ Value Medical Option ▪ Out-of-Area Medical Option Network/Claims Administrator	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908 Website: https://www.jetnet.aa.com/jetnet/go/ssoaetna.asp Provider directory: http://www.aetna.com/docfind/custom/americanairlines
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp Provider directory: http://www.bcbstx.com/americanairlines
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp Provider directory: http://www.myuhc.com/groups/americanairlines
Health Maintenance Organizations (HMOs)	See the Health Maintenance Organizations (HMOs) section	Call the number on your HMO ID card.
▪ Coverage for Incapacitated Child ▪ Standard Medical Option ▪ Core Medical Option ▪ Value Medical Option ▪ Out-of-Area Medical Option (HMOs – contact your elected HMO)	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908 Website: https://www.jetnet.aa.com/jetnet/go/ssoaetna.asp
	Blue Cross and Blue Shield of Texas P.O. Box 833940 Richardson, TX 75083	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp

For Information About:	Contact:	At:
CheckFirst (Predetermination of Benefits) (Except HMOs)		
▪ Standard Medical Option ▪ Core Medical Option ▪ Value Medical Option ▪ Out-of-Area Medical Option	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908 Website: https://www.jetnet.aa.com/jetnet/go/ssoaetna.asp
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
QuickReview (Pre-authorization for Hospitalization)		
▪ Standard Medical Option ▪ Core Medical Option ▪ Value Medical Option ▪ Out-of-Area Medical Option	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908 Website: https://www.jetnet.aa.com/jetnet/go/ssoaetna.asp
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
Medical Case Management and Wellness		
▪ Nurseline ▪ Informed Care Management ▪ Health Advocate ▪ Lifestyle Coaching ▪ Health Assessment	ActiveHealth Management	1-888-227-6558 Website: https://www.jetnet.aa.com/jetnet/go/ssoactivehealth.asp
▪ *Short-Term Case Management* ▪ *Standard Medical Option* ▪ Core Medical Option ▪ Value Medical Option ▪ Out-of-Area Medical Option	Aetna P.O. Box 981106 El Paso, TX 79998-1106	1-800-572-2908 Website: https://www.jetnet.aa.com/jetnet/go/ssoaetna.asp
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp

For Information About:	Contact:	At:
Prescription Drugs (Except HMOs)		
Mail Service Drug Option (Mail Order Pharmacy Service)	Express Scripts (formerly known as Medco) P.O. Box 3938 Spokane, WA 99220-3938	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions-Prior Authorization	Express Scripts (formerly known as Medco) 8111 Royal Ridge Parkway, Suite 101 Irving, TX 75063	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions-Retail	Express Scripts (formerly known as Medco) Member Services - Phone Inquiries	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Filing Retail Prescription Claims	Express Scripts (formerly known as Express Scripts) P.O. Box 2160 Lee's Summit, MO 64063-2160	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Employee Assistance Program		
Employee Assistance Program	EAP at American Airlines	1-800-555-8810
Dental Coverage		
Dental Benefits Network/Claims Administrator	MetLife AMR Dental Claim Unit P.O. Box 981282 El Paso, TX 79998-1282	1-866-838-1072 Website: https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Provider Listing Participating Dentists	Preferred Dentist Program	1-800-474-7371 Website: https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Vision Insurance		
Vision Insurance Benefit	SpecteraVision 2811 Lord Baltimore Drive Baltimore, MD 21244	1-800-217-0094 Website: http://myspectera.com
Life Insurance		
Life Insurance Benefits	MetLife American Airlines Customer Unit P.O. Box 3016 Utica, NY 13504-3016	1-800-638-6420

For Information About:	Contact:	At:
Accident Insurance		
▪ Accidental Death & Dismemberment (AD&D) Insurance Benefit ▪ Other Accident Insurance Benefits	Contact HR Services	1-800-447-2000 Chat live with HR Services: Click on the "Start a Chat" button on the top of this page. Chat hours are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday.
Disability Coverage for Agents, Representatives, Planners, Officers, Management/Specialists and Support Staff		
Optional Short Term Disability (OSTD) Insurance	MetLife Disability American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590	1-888-533-6287 FAX: 1-800-230-9531 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Long Term Disability (LTD) Plan	MetLife Disability American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590	1-888-533-6287 FAX: 1-800-230-9531 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Disability for TWU-Represented Employees		
Optional Short Term Disability (OSTD) Insurance	MetLife Disability American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590	1-888-533-6287 FAX: 1-800-230-9531 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Long Term Disability Coverage	Your Local TWU Office	Your LTD coverage is offered through the TWU and is not an American Airlines, Inc.-sponsored benefit

For Information About:	Contact:	At:
Flexible Spending Accounts (FSAs), Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA), Health Incentive Account (HIA)		
▪ HSA (applies to Core Option Only) ▪ HRA (applies to Standard and Out-of-Area Options Only) ▪ HIA (applies to Value Option Only) ▪ Health Care FSA (for Standard, Value, and Out-of-Area Options Only) ▪ Limited Purpose Health Care FSA (applies to Core Option Only) ▪ Dependent Care FSA	WageWorks	1-877-WAGEWORKS Website:
Long-Term Care Insurance Plan		
Long-Term Care Insurance Plan	MetLife Long-Term Care 57 Greens Farms Road Westport, CT 06880	1-888-526-8495 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Continuation of Coverage (COBRA)		
Continuation of Coverage (COBRA Administrator)	Benefit Concepts Inc. P.O. Box 246 Barrington, RI 02806-0246	1-866-629-0274 Website: http://www.benefitconcepts.com/
Other Information		
Pension Benefits Administration Committee (Information about appeals)	PBAC American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	ICS or 1-817-967-1412

For Information About:	Contact:	At:
Other Options (Not Company-Sponsored) The following program options are offered to eligible employees (and eligible dependents). American Airlines, Inc. does not sponsor these programs. For information about these options, contact the sponsor(s) directly:		
Group Prepaid Legal Services	Hyatt Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2507	1-800-821-6400
Group Homeowners' and/or Automobile Insurance	Metropolitan Property & Casualty Insurance Company 477 Martinsville Road, 4th Floor Liberty Corner, NJ 07938	1-800-438-6388

Glossary

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

Accidental injury

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

Alternative and/or Complementary medicine

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

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

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

Alternative mental health care centers

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

Ancillary charges

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

Assignment of benefits (medical, dental, vision coverages and other health benefits)

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

However, not all Network/Claims Administrators will accept assignments for out-of-network providers.

Assignment of benefits (Applies active employees/dependents and to retired employees who retired on or prior to October 31, 2012)

You may make an irrevocable assignment (a permanent, unchangeable transfer) of the value of your life insurance benefit. This action permanently transfers all rights and interest, both present and future, in the benefits under this life insurance. Anyone considering assignment of life insurance should consult a legal or tax advisor before taking such action.

Bereavement counseling

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

Chemical dependency treatment center

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

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

Chiropractic care

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

Co-insurance

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

Common accident (for AD&D Insurance for active employees/dependents—not applicable to retirees)

With respect to Accidental Death and Dismemberment (AD&D) Insurance, this refers to the same accident or separate accidents that occur within one 24-hour period.

Company

Participating AMR Corporation subsidiaries.

Convalescent or skilled nursing facility

A licensed institution that:

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

Conventional Medicine

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

Co-pays

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

Custodial care

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

Deductible

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

Dental

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

Detoxification

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

Developmental therapy

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

Durable medical equipment (DME)

Medical equipment intended for use solely by the participant for the treatment of his or her illness or injury. DME is considered to be lasting and would have a resale value. DME must be usable only by the participant and not the family in general.

The equipment must be medically necessary and cannot be primarily for the comfort and convenience of the patient or family. A statement of medical necessity from the attending physician and a written prescription must accompany the claim. DME includes (but is not limited to): prosthetics, casts, splints, braces, crutches, oxygen administration equipment, wheelchairs, hospital beds and respirators.

Eligible medical expenses or eligible expenses

The benefit or plan covers the portion of regular, medically necessary services, supplies, care and treatment of non-occupational injuries or illnesses up to the usual and prevailing fee limits,

when ordered by a licensed physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage.

Emergency

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

Enter-on-duty date (applies to active employees only)

The first date that you were on the U.S. payroll of American Airlines, Inc. as a regular employee.

Experimental or investigational service or supply

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

- It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.
- Reliable Evidence shows that the drug, device, procedure or medical treatment is the subject of ongoing phase I, II or III clinical trials or under study (or that the consensus of opinion among experts is that further studies or clinical trials are necessary) to determine its maximum tolerated dose, toxicity, safety or efficacy, both in diagnosis and treatment of a condition and as compared with the standard means of treatment or diagnosis.
- The drug or device, treatment or procedure has FDA approval, but is not being used for an indication or at a dosage that is accepted and approved by the FDA or the consensus of opinion among medical experts.
- Reliable Evidence shows that the medical service or supply is commonly and customarily recognized throughout the physician's profession as accepted medical protocol, but is not being utilized in accordance or in compliance with such accepted medical protocol and generally recognized standards of care.
- The drug, device, treatment or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure that is used with a patient informed consent document that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function.
- A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- The treatment or procedure is less effective than conventional treatment methods.
- The language appearing in the consent form or in the treating hospital's protocol for treatment indicates that the hospital or the physician regards the treatment or procedure as experimental.

Explanation of benefits (EOB)

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

Freestanding surgical facility

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

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

Home health care agency

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

Home health care

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

Hospice care

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

Incapacitated child

A child who is incapable of self-support because of a physical or mental condition and who legally lives with you and wholly depends on you for support.

Individual annual deductible

An annual deductible is the amount of eligible expenses you must pay each year before your medical option coverage will start reimbursing you. After you satisfy the deductible, your selected Medical Option or Retiree Medical Option pays the appropriate percentage of eligible covered medical services.

Infertility treatment or testing

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

Inpatient or hospitalization

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

Life event

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

Loss or impairment of speech or hearing

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

Mammogram or mammography

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

Maximum medical benefit (applies to Retiree Medical Benefit only)

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

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

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

If your selected medical coverage (for both the retiree and covered eligible dependents) is one of the self-funded medical coverages and you and/or your eligible dependents exhaust the maximum medical benefit under the self-funded medical coverage, neither you nor your eligible dependent may elect other retiree medical coverage, including the Retiree HMO.

If you and your covered eligible dependents exhaust the maximum medical benefit, you may continue other coverages/benefits in the retiree life insurance. The medical coverage is the only coverage that terminates for the affected individual.

Maximum Out-of-Network Reimbursement Program (MNRP) (applies only to Retiree Value Plus Option for those retired employees who retired on or prior to October 31, 2012 and their dependents)

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

Medical benefit

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

Medical necessity or medically necessary

A medical or dental service or supply required for the diagnosis or treatment of a non-occupational, accidental injury, illness or pregnancy. The benefit or plan determines medical necessity based on and consistent with standards approved by the Network/Claims

Administrator's medical personnel. To be medically necessary, a service, supply, or hospital confinement must meet all of the following criteria:

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

Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening or seriously debilitating condition. The treatment must be considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications.

A service or supply to prevent illness must meet the above conditions to be considered medically necessary. A service is not considered medically necessary if it is educational, experimental or unproven in nature.

In the case of hospital confinement, the length of confinement and hospital services and supplies are considered medically necessary to the extent the Network/Claims Administrator determines them to be:

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

Mental health disorder

A mental or emotional disease or disorder.

Multiple surgical procedures

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

Network

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

Nurse

This term includes all of the following professional designations:

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

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

Original Medicare

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

Outpatient

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

Over-the-counter (OTC)

Drugs, products and supplies that do not require a prescription by federal law.

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

- You
- Your spouse
- A parent, child, sister or brother of you or your spouse
- The term physician includes the following licensed individuals:
- Audiologist
- Certified social worker or advanced clinical practitioner
- Chiropractor
- Clinical psychologist
- Doctor of Osteopathy (DO)
- Doctor of Medicine (MD)
- Nurse anesthetist
- Nurse practitioner
- Physical or occupational therapist
- Physician Assistant (PA)
- Speech pathologist or speech language pathologist or therapist

Post-fund, postfunding, postfunded (applies to Retiree Medical Benefits only)

A mechanism by which retirees pay for the cost of their Retiree Medical Benefit. To post-fund their Retiree Medical Benefit means that these retirees are required to pay ongoing monthly contributions during their retirement in order to obtain and maintain Retiree Medical Benefit coverage. All employees who retired on or after November 1, 2012 are required to postfund their Retiree Medical Benefit. For details of postfunding, see the Eligibility Section of the Retiree Benefit Guide.

Prefund, prefunding, prefunded

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

Pre-existing condition (or pre-existing condition limitation (applies to Optional Short Term Disability Insurance and American Airlines, Inc. Long Term Disability Plan for active employees only A pre-existing condition includes any physical or mental condition that was diagnosed or treated before the participant's original coverage effective date (the date first enrolled in coverage) in a plan and that will not be covered under that plan for a specified period after enrollment.

Preferred Provider Organization (PPO) (applies to the Medical Benefits and Dental Benefit for active employees, and to the Retiree Medical Benefits)

A group of physicians, hospitals and other health care providers who have agreed to provide medical services at negotiated rates.

Pre-retirement monthly salary (applies to Retiree Life Insurance Benefit, which is available for employees who retired on or before October 31, 2012)

Your base monthly salary in effect on your retirement date. Pre-retirement monthly salary does not include overtime pay, premium pay, shift differential, bonuses, approved expenses or other allowances. Your pre-retirement monthly salary may determine the amount of your Retiree Life Insurance coverage

Prescriptions

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

Primary care physician

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

Primary surgical procedure

The principal surgery prescribed based on the primary diagnosis.

Prior authorization for prescriptions

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

Proof of Good Health or Statement of Health (also referred to as Evidence of Insurability or EOI, and applies to active employee only)

Some benefit plans and coverages 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 Optional Short Term Disability Insurance, the American Airlines, Inc. Long Term Disability Plan (this plan is not for TWU-Represented employees) or increase levels of Life Insurance for you or your spouse/DOMESTIC PARTNER (DP). Life Insurance coverage amounts will not increase, nor will you be enrolled in the Optional Short Term Disability Insurance, or the American Airlines, Inc. Long Term Disability Plan until the Plan Administrator approves your Statement of Health Form and you pay the initial/additional contribution for coverage.

If a death or accident occurs before your enrollment for coverage or increase in coverage is processed, the amount of Life Insurance, Accidental Death & Dismemberment (AD&D) Insurance, or VPAI coverage that will be payable is your current amount of coverage or default coverage (if you have not enrolled following your initial period of eligibility). You may obtain a Statement of Health Form from the Plan Administrator for each benefit plan.

Provider

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

Psychiatric day treatment facility

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

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

Psychiatric hospital

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

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

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

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

Qualifying event

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

Regular employee (this refers to active employees only)

An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, or a Flexible Work Arrangement, depending on the business needs of the organization or the terms of the applicable labor agreement. A regular employee is eligible for the benefits and privileges that apply to his or her workgroup or as outlined in his or her applicable labor agreement.

Reliable Evidence

Reliable Evidence includes:

- Published reports and articles in the authoritative peer reviewed medical and scientific literature including: American Medical Association (AMA) Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Dispensing Information and National Institutes of Health, U.S. Food and Drug Administration

- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment or procedure
- Written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure
- Reliable Evidence does not include articles published only on the Internet

Residential treatment center

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

Restoration of medical maximum benefit under the Retiree Standard Medical Option Only

Each January 1, you are eligible to have part of your medical maximum benefit automatically restored. The amount restored will be the lesser of:

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

Restorative and rehabilitative care

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

School/Educational Institution

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

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

Secondary surgical procedure

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

Special dependent

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

Summary Plan Description

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

Timely pay, timely payment

This term applies to plans, benefits, or options for which you are required to pay ongoing contributions or premiums in order to maintain coverage under the plans, benefits, or options. Timely payment means payment of the full amount of contribution or premium due by the payment due date or before the end of the 30-day grace period for payment (as reflected on the

invoice or payment coupon). Payments rejected due to insufficient funds (e.g., “bounced” checks) are also considered not timely paid.

Urgent/immediate care

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

Unproven Service, Supply or Treatment

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

Usual and prevailing fee limits

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

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

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

Information from this FairHealth database is utilized by American’s medical administrators in determining the eligible expense for medical or dental services and supplies provided by non-participating and out-of-network providers.

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

Archives

Prior versions of your Employee Benefits Guide are available at http://www.aacareers.com/ebg/Archive/default.asp.