

American Airlines, Inc.
Health & Welfare Plan for Active Employees

Summary Plan Description

Effective January 1, 2017

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Introduction

American Airlines, Inc. (the “Company”) provides you with a comprehensive benefits package designed to help you meet the health, life, accident, disability, and dependent care needs of you and your eligible family members. To help you make the most of those benefits, this Summary Plan Description (“SPD”) describes the provisions of the American Airlines, Inc. Health & Welfare Plan for Active Employees (the “Plan”) effective January 1, 2017.

This SPD provides a comprehensive overview of the benefits available under the Plan as well as limitations, exclusions, Deductible and Co-Insurance requirements. A detailed list of benefit types provided under the Plan, along with contact information, can be found in the chapter [“Benefits under the Plan and Contact Information.”](#)

The terms and conditions of the Plan are set forth in this Summary Plan Description, the formal Plan Document, and insurance policies/evidence of coverage related to the benefits under the Plan. Together, these documents are incorporated by reference into the formal Plan Document and constitute the written instruments under which the Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Plan.

This summary should be read in connection with any applicable insurance policy/evidence of coverage provided by the insurers listed in the section [“Benefits under the Plan and Contact Information.”](#) Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and an insurance policy/evidence of coverage, or this Summary Plan Description, the Plan Document controls. If the Plan Document is silent, then the Summary Plan Description controls, except where the Summary Plan Description refers to an insurance policy/evidence of coverage. If both the Plan Document and Summary Plan Description are silent, the terms of the applicable insurance policy/evidence of coverage controls. However, with respect to fully insured benefits, the terms of the certificate of insurance coverage or insurance policy/evidence of coverage control when describing specific benefits that are covered or insurance-related terms. See the section [“Benefits under the Plan and Contact Information”](#) to determine whether a particular benefit is self-funded by the Company or fully insured by the insurer.

The Company, or its authorized delegate, reserves the right to modify, amend or terminate any of the Plans, any program described in this SPD, or any part thereof, at its sole discretion, except as otherwise specified in the Collective Bargaining Agreements. You will be notified of any changes that affect your benefits, as required by federal law.

There is a “Glossary” at the end of this SPD that defines capitalized terms and how they apply to the benefits described in this SPD.

Eligibility and Enrollment

[Employee eligibility](#)

[Dependent eligibility](#)

[Employees married to other employees](#)

[When coverage begins](#)

[Benefits continuation if you go on a leave of absence](#)

[Making changes during the year](#)

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Employee Eligibility

Please note that some eligibility criteria are different depending on the Plan Option in question, and the location of the employee. These differences are noted in this SPD and could have a material effect on the eligibility of the employee and his or her spouse and dependents, and/or impact when coverage may become effective.

Eligible Employees

Generally, all active, full-time or part-time employees on U.S. Payroll of American Airlines, Inc. are eligible for the Plan, except for any individual or employee specifically listed as ineligible in the “Ineligible Employees” section below.

Ineligible Employees

The following individuals are not eligible to participate in the Plan:

- Except as otherwise noted in the “Employee Eligibility for Medical Benefit Options,” (1) Employees of American Airlines, Inc. in the fleet and maintenance and related groups who are covered by collective bargaining agreements entered into between US Airways, Inc. and the IAM; and (2) Employees of American Airlines, Inc. in the flight simulator engineer and flight crew training instructor groups who were covered by collective bargaining agreements entered into between US Airways, Inc. and the TWU.¹
- **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 (“IRS”), 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 Plan without a break in service, the time worked as a full-time temporary worker will be credited solely toward the eligibility requirement for the Plan. Under no circumstances will time worked as a temporary worker entitle the individual to retroactive coverage under the Plan.
 - **Provisional employee.**
 - **Associate employee.**
- **An independent contractor.**
- **Any person:**

¹ This guide serves as the Summary Plan Description for legacy US Airways IAM and TWU represented employees who are eligible for and/or enroll in the CORE medical option.

- 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; or
- Who tells the Company he/she is an independent contractor, or is employed by another company while providing services to the Company, even if the worker is, or may be reclassified at a later date as, an employee of the Company by the courts, the IRS or the DOL.

Employee Eligibility for Medical Benefit Options

Residence

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

If your alternate address (benefits address for U.S. Airways, Inc. employees) is not in an area with a Network/Claim Administrator or HMO, then the Company will advise you on your eligibility for the Out-Of-Area Medical Benefit Option.

You are allowed to list two addresses:

- a permanent address (legal payroll address for U.S. Airways, Inc. employees) (for tax purposes or for your permanent residence)
- an alternate address (benefits address for U.S. Airways, Inc. employees) (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 (or a benefits address listed in MyHR for U.S. Airways, Inc. employees (http://wings.usairways.com/uswings/human_resources/myhr), your benefit eligibility is based on your permanent address (legal payroll address for U.S. Airways, Inc. employees).

CORE Medical Benefit Option

Mechanics and related fleet service and maintenance employees of American Airlines, Inc. who were employed by US Airways, Inc. and are represented by the Transport Workers Union ("TWU") or the International Association of Machinists and Aerospace Workers ("IAM") are only eligible for the CORE Medical Benefit Option. They are not eligible for any other Medical Benefit Option under the Plan.

Eligibility in the Plan for Active Employees After Age 65

As long as you are working as an active employee for American Airlines, Inc., you are eligible for health and welfare benefit plan coverage irrespective of your age—even if you're age 65 or older. 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 Eligible Dependents. If your Spouse elects Medicare as his or her only coverage, only your Spouse's Company-sponsored active medical coverage will terminate. Please see the [Retiree Benefit Guide](#) for information about retiree medical benefit coverage under the American Airlines, Inc. Group Retiree Health and Life Benefits Plan.

Dependent Eligibility

Dependent Eligibility by Benefit

[Dependent eligibility requirements](#) are different depending on the benefit coverage you elect. See "[Dependent Eligibility Requirements](#)" for general dependent eligibility rules that apply to all dependent benefits.



Effective January 1, 2017, Company-recognized Domestic Partners and their Children are no longer Eligible Dependents under the Plan, except as mandated by state laws for HMOs. The decision to offer coverage to Domestic Partners is made by individual HMO plan provisions, not by American Airlines.

Medical, 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:

- Spouse or Common Law Spouse.
- Child until the end of the month he/she turns 26 (as defined below in the Determining a Child's Eligibility section).
- 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.

Note for HMO Medical Benefit Option: 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.

Coverage for an Incapacitated Child — Medical, Dental, and Vision Coverage

**Below you will find the critical steps that you, as the employee, are required to take to request 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](#).
- You inform your Network/Claim Administrator within 31 days prior to the date coverage would otherwise end.
 - For HMOs: Contact your HMO for the time limit.
- Your Network/Claim 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/Claim Administrator from time-to-time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your Network/Claim 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.

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

An Eligible Dependent is a Child as defined below (other than the employee covered by the Benefit Option) 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:

- Child until the end of the month he/she turns 26 (as defined below in the Determining a Child’s Eligibility section)
- A Child age 26 or older, if all of the following criteria are met:
 - The Child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law.
 - You provide proof of such handicap to the insurance carrier (listed in the chapter [Benefits under the Plan and Contact Information](#)) within 31 days after the date the child attains the age limit and at reasonable intervals after such date.

- The Child continues to meet the criteria for dependent coverage under this Plan.

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 an employer group plan as an employee.

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

- 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 Benefit Option) 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 Spouse or Common Law Spouse not employed by the Company.

Dependent Eligibility Requirements - Generally (All Benefits)

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 or Common Law Spouse as defined by the Plan
- Stepchild
- 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 American Airlines Benefits Service Center and American Airlines Benefits Service Center must approve the form. (Complete and return the form to American Airlines Benefits Service Center, along with copies of the official court documents awarding you custodianship or guardianship of the

- child.) You must receive confirmation from American Airlines Benefits Service Center notifying you of its determination.
- American Airlines Benefits Service Center 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 31 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 American Airlines Benefits Service Center. If you submit the request after the 31 day time frame, the child will not be added to your coverage.
 - QMCSO Dependent: A 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.

Parents or Grandchildren

Neither your parents nor grandchildren (except as noted above in the Child Life Insurance section) 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). Note that 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.

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, Dental, and Vision coverage for up to 36 months under COBRA Continuation Coverage at the full COBRA rate, if they had these benefits at the time of your death. See the "[COBRA](#)" chapter. If your covered dependents elect COBRA Continuation Coverage, the 90 days of coverage provided at no contribution cost immediately after your death are part of the 36 months of COBRA coverage.

If you are over age 55 but not yet 65 and over age 50 but not yet 65 (for Pilots) and working as an active employee with 10 or more years of seniority, your surviving Spouse may be eligible for retiree medical benefits if you would have been eligible for retiree medical benefits if you had retired on your date of death. See the [Retiree Benefit Guide](#) for further information.

Determining a Spouse (SP) or Common Law Spouse Eligibility (CLSP)

The Plan will cover as your Eligible Dependent only one of the following at any given time: Spouse or Common Law Spouse.

Throughout this document, references to “Spouse” include both references to “Spouse” and to “Common Law Spouse” (discussed directly below).

- **Spouse (SP).** Your Spouse means an individual who is lawfully married to the employee as recognized by the state, possession, or territory of the U.S. in which the marriage is entered into, regardless of domicile, and who is not legally separated. You and your spouse must not be married to, or have a domestic partner, common law, or other spouse-like relationship with any other person(s) at the same time you are married to each other.
- **Common Law Spouse.** Common Law Spouses are eligible for enrollment in Plan benefits only if the 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.

Proof of Dependent Eligibility

If you:

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

you must submit proof of the dependents’ eligibility to [American Airlines Benefits Service Center](#) within 31 days of the date the documentation is requested by the [American Airlines Benefits Service Center](#). Examples of proof demonstrating your dependents’ eligibility for coverage include: official government-issued birth certificates, adoption papers, marriage licenses, etc.

Important: Coverage will not be in place until you have timely requested their enrollment and provided satisfactory proof of eligibility. Coverage will be retroactive to the date of the event (i.e. Marriage, Birth, New hire date)

American Airlines, Inc. reserves 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 may result in termination of Benefit Option or Plan coverage and efforts to recover any overpaid benefits will be made.

Married Employees and Dependent Children Whose Parents are Employees

When two employees are married to each other they are referred to as “Married Employees” for this section. Employees cannot be covered under more than one medical, dental, and vision Option sponsored by American Airlines, Inc. Therefore, Married Employees have the option of being covered either: (1) as an employee and a dependent Spouse under one Medical, Dental and/or Vision benefits; or (2) separately as individual employees each without a dependent Spouse under their own Medical, Dental and/or Vision benefits.

For the first option listed above, Married Employees choose in their discretion which Married Employee is designated as the employee and which is designated as the dependent Spouse. Married Employees may elect to be covered under one of the Married Employee’s benefits during Annual Enrollment or at the time of a Life Event. During Annual Enrollment:

- First, the Married Employee who will be covered as the dependent Spouse must elect “No Coverage”;
- Next, the Married Employee who will be designated as the employee will elect to cover both Married Employees for Medical, Dental and/or Vision benefits, and must add his or her Spouse as a dependent (and any other Eligible Dependents) in the “Dependents” area of the online [Benefits Service Center](#).

The following Benefit Options must still be maintained independently:

- Accident Insurance
- Employee Term Life Insurance
- Health Reimbursement Accounts

Change in employment: If Married Employees choose to maintain separate benefits and one of them ends his or her employment with the Company, the individual who terminates his or her employment is eligible for coverage as a dependent Spouse.

Active employees married to retiree dependents: Retiree dependents married to active employees are only eligible for coverage as dependents of active employees if they are *not* enrolled in retiree medical benefits sponsored by the Company. The

benefits available and benefit limits, if any, are defined by the active employee's coverage.

Married Employee on leave of absence: The start of a leave of absence and the termination of coverage after 12 months of leave are Life Events (see the [Life Events](#) section). When Company-provided benefits terminate for a Married Employee's Spouse on a leave of absence, the Married Employee on leave may elect COBRA continuation coverage or be covered as the Dependent of his or her actively working Married Employee, but not both.

If the second option above is selected, then the actively working Married Employee's health coverage determines the health benefit coverage for all dependents, including the Married Employee on leave. Because the termination of the Spouse's coverage is a Life Event (see the [Life Events](#) section), the actively working Married Employee may make changes to his or her other coverages.

The actively working Married Employee 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 the Spouse on leave is covered as a dependent during the leave of absence, the following conditions apply:

- Optional coverages (Life, Short-term disability, etc.) the Spouse elected as an active employee end, unless payment for these coverages is continued while on leave.
- Proof of Good Health may be required to re-enroll or increase optional coverages upon the Spouse's return to work.
- Provided the Spouse on leave makes Timely Payments for benefits, Company-provided coverage (where the Company pays its share of the cost and the Spouse on leave pays his/her share) will continue for the first twelve months of leave of absence for family, sick, injury-on-duty or maternity leaves.

Eligible Dependent Children:

- Children cannot be covered under both parents' Medical, Dental, or Vision Benefit Options.
- If one Spouse is covered under the Medical Benefit Option, the Children are covered under the parent who participates in the Medical Benefit Option.

Contributions: If Married Employees choose to be covered under one employee, the contributions for the employee covering both will reflect either "Employee plus Spouse" or "Employee plus Family," if the employee also elects to cover dependent Children. This applies to contributions for the Medical and Vision Benefit Options. 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 Married Employee's paycheck.

Family Deductibles: If the parents choose to each be covered as individual employees and neither one is covered as a dependent Spouse, the family Deductible applies to the employee covering the Children and the individual Deductible applies separately to the other parent.

Accident coverage: Married Employees cannot be covered both as an employee and as a dependent. For Married Employees without Children, both you and your Spouse must enroll separately as employees.

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 federal 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 to \$2,550 per employee.

When Coverage Begins

New Employees

New Employee Enrollment

As a new employee, you will receive information shortly after you begin working regarding enrollment in the Plan. You have **31 days from your date of hire** to enroll in the Plan and you may elect coverage for yourself and your Eligible Dependents (see the [General Eligibility](#) section).

Note regarding Voluntary Term Life Insurance: Upon being hired, you also 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 a form online via a single sign on to MetLife's site when he/she elects the Voluntary Term Life Insurance coverage or increase. If you would like coverage on the life of your Spouse, he/she will need to complete the Statement of Health form online within seven days after your enrollment deadline. If you do not complete the form online within seven days after your enrollment deadline, a Statement of Health form will be mailed to you. You will then 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.

If you do not enroll for coverage when you are first solicited for benefits, you will receive "default coverage," as described in the "Default Coverage" section below and you will be required to pay the respective contributions, if any, for the default coverage.

Waiving Coverage

You may choose to waive medical coverage if you wish. If you wish to waive medical coverage, you **MUST** take action to waive the coverage at the time you are first eligible by using the online enrollment tool — the [American Airlines Benefits Service Center](#). Your dependents will not receive medical coverage if you waive such coverage. If you waive coverage for any Plan Year, 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 for New Employees

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

NEW EMPLOYEE DEFAULT TABLE		
Benefit Option	Default	Comments
Medical	CORE Medical Option (Employee only)	If the CORE Medical Benefit Option is not available, you will automatically default into another Medical Benefit Option selected by the Plan Administrator.
Dental	No coverage	N/A
Vision	No coverage	N/A
Optional STD	No coverage	This benefit only applies to TWU and employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT and Flight Attendants.
STD	STD Coverage – Taxable Benefit or Non-Taxable Benefit	This benefit applies only to Officer, Management, Specialist and Support Staff workgroups
Basic Term Life Insurance	2 times pay	Up to a maximum of \$70,000
Basic AD&D Insurance	2 times pay	Up to a maximum of \$70,000 This benefit applies only to Officer, Management, Specialist and Support Staff workgroups
Basic AD&D Insurance	\$10,000	This benefit applies only to Flight Employees.
Voluntary Term Life Insurance	No coverage	N/A
Voluntary AD&D Insurance	No coverage	This benefit applies only to Ground Employees.
Voluntary Personal Accident Insurance	No coverage	This benefit applies only to Flight Employees.
Spouse Life Insurance	No coverage	N/A
Child Life Insurance	No coverage	N/A
Flexible Spending Accounts (FSAs)	No coverage	Your Flexible Spending Accounts will default to \$0.00 unless you take action to establish the accounts and enter a dollar amount for

NEW EMPLOYEE DEFAULT TABLE		
Benefit Option	Default	Comments
(Health Care FSA and Dependent Care FSA and Limited Purpose FSA)		the accounts

When Coverage Begins as a Newly Hired Employee

If you enroll by the enrollment deadline, your selected coverage (if different from default coverage) is retroactive to your Hire Date and your paycheck is adjusted as necessary. However, if a death or accident occurs before your enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance coverage that will be paid is the amount under “Default Coverage for New Employees.” If you do not enroll by the enrollment deadline, you will default into the coverages listed in “Default Coverage for New Employees,” and your default coverage will be retroactive to your Hire Date.

Coverage under the Plan will not begin until: (i) you have reported to your first day of work, and (ii) except as otherwise noted, you are “actively-at-work.” Unless otherwise provided in the applicable insurance policy/evidence of coverage, “actively-at-work” means you are at work and performing all of the regular duties of your job.

The “actively-at-work” requirement does not apply to the Medical Benefit Options if the reason you are not actively-at-work is due to a health condition; in that event, your coverage under the Medical Benefit Option is effective on your Hire date as long as you have reported to your first day of work.

Current Employees

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 from coverage - you have 31 days to submit required documentation to verify your dependents to the American Airlines Benefits Service Center after such information is requested,
- Make changes to your prior elections, or
- Continue your previous elections at the applicable new rates (if available), excluding Spending Accounts (you must make an election during each annual enrollment period if you wish to utilize your Spending Accounts since elections for Spending Accounts do not automatically carry over from year to year).

Once Annual Enrollment ends, your benefit elections for the upcoming Plan Year are recorded and “locked in” – you are not allowed to make changes to these elections until the following year unless you experience a Life Event that would enable you to make such changes.

Default Medical Coverage for Current Employees

If you do not affirmatively make an election during the Annual Enrollment Period:

- **Medical Coverage:** You will default into your previous elections (if still available) if you previously elected benefits coverage during a prior Annual Enrollment, or you will default into the CORE Medical Benefit Option if you have not previously elected benefits coverage for the following year, at the applicable rates for the following year. If the CORE Medical Benefit Option or your previous election is not available, you will automatically default into another Medical Benefit Option selected by the Plan Administrator.
- **Health Care FSA and Limited Purpose FSA**
 - ❖ If you do not make a HCFSA or LPFSA election during the Annual Enrollment Period in 2016, up to \$500 of any amount remaining in your 2016 HCFSA will be credited to a 2017 HCFSA for you, and up to \$500 of any amount remaining in your 2016 LPFSA will be credited to a 2017 LPFSA for you. During the last two months of the current benefit year, an employee cannot change or enroll in his/her HCFSA or LPFSA elected amounts even if you experience a Life Event. This does not include the elections you make during the Annual Enrollment Period for the next benefit year.
 - ❖ Employees enrolled in the CORE Medical Benefit Option are only eligible to elect the Limited Purpose FSA.
- **Dependent Care FSA**
 - ❖ If you do not make a DCFSA election during the Annual Enrollment Period, your current DCFSA election will not continue for the following year.
 - ❖ During the last two months of the current benefit year, an employee cannot change or enroll in his/her DCFSA elected amounts even if you experience a Life Event. This does not include the elections you make during the Annual Enrollment Period for the next benefit year.

When Coverage Begins as a Current Employee

When you enroll during the Annual Enrollment Period, your selected coverage (or default coverage) begins on January 1 and continues through December 31 (the Plan Year) as long as you continue to be eligible for the Plan as described in the “Employee Eligibility” section above and satisfy other Plan requirements, such as Timely Pay premiums. 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).

How to Enroll

All employees enroll using the online enrollment tool — the [American Airlines Benefits Service Center](#). Visit my.aa.com for information on enrolling.

The American Airlines Benefits Service Center

The [American Airlines 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 [American Airlines Benefits Service Center](#) is updated by Annual Enrollment with your Benefit Options and the new rates for the upcoming Plan Year – January 1 through December 31.

Benefits continuation if you go on a leave of absence

Eligibility During Leaves of Absence and Disability

You may be eligible to continue certain 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. The due date will be noted on your billing statement.

Your leave of absence begins on the effective date indicated on your payroll transaction record or HR records, which is submitted to reflect that you are on a leave of absence.

A leave of absence is considered a Life Event (see the [Life Events](#) section), and you may make changes to your coverage. Once you record your Life Event and benefit elections on the American Airlines [Benefits Service Center](#), it will display a confirmation statement showing your choices, the monthly cost of benefits, covered dependents, etc.

If you elect not to continue your benefits during your leave of absence or if you fail to Timely Pay for your benefits, 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 (e.g., Voluntary Term Life Insurance, Disability).

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 perform 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.

While you are on military leave, your benefit coverage or the cost of that coverage will not change, unless due to an increase applicable to your workgroup.

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, which is available at newjetnet.aa.com.

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.

Making Changes During the Year

After Annual Enrollment is completed each year, and when the new benefit year begins on January 1, you may only change your elections if you experience one of the following events described below: HIPAA Special Enrollment Events, Special Enrollment for Medicaid and CHIP, and Life Events.

HIPAA Special Enrollment Events – 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 31 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 eligibility for other medical coverage for reasons that include legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
- The employer contributions to the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.
- You and/or one of your dependents exhaust a lifetime maximum in another employer's health plan or other health insurance coverage, where permitted by law.
- 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 or common law marriage, your child's birth, adoption or placement for adoption with you. In that event, 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 or Common Law Spouse and any new dependents within 31 days of your marriage or declaration. You may request enrollment for a new child within 31 days of his or her birth, adoption or placement for adoption. If you miss the 31 day deadline, you are not able to enroll and you will have to wait until the next annual enrollment period to enroll yourself and/or your dependent.

You must already be enrolled or enroll yourself in benefits in order to elect coverage for your dependents. If your spouse is not enrolled in medical benefits on the date of birth, adoption, or placement for adoption of a dependent, you may enroll yourself and request enrollment for your spouse or Common Law Spouse in the medical benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage or common law marriage, coverage will be effective on the date of the event. To request special enrollment or obtain more information, contact Benefits Service Center (see "[Contact Information](#)" in the *Reference Information* section).

Special Enrollment for Medicaid and CHIP

An employee and/or Eligible Dependent may enroll in the Plan if he or she is no longer eligible for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act, if the employee and/or Eligible Dependent requests coverage under the Plan within 60 days after the date of termination from this coverage. Such coverage shall be effective on the date of the event.

In addition, an employee and/or Eligible Dependent may enroll in the Plan if he or she becomes eligible for assistance under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act, where such assistance will be provided through the Plan, if the employee and/or Eligible Dependent requests coverage under the Program within 60 days of the date that he or she is determined to be eligible for assistance. Such coverage shall be effective on the date of the event.

Life Events

You also may change certain elections mid-year 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.

You must register the Life Event within 31 days of the event with the American Airlines Benefits Service Center. You must submit proof of the dependent's eligibility to the American Airlines Benefits Service Center within 31 days of the date the documentation is requested. Proof of eligibility cannot be submitted until you receive the request from the American Airlines Benefits Service Center. **If you miss the 31 day deadline, your Life Event change will not be processed.** You will have to wait until the next Annual Enrollment Period or experience another Life Event, whichever happens earlier, to make changes to your benefits.

When you experience a Life Event, remember these guidelines:

- Most Life Events are processed online through the [American Airlines 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 31 days of the event (as applicable), your changes are retroactive to the date the Life Event occurred (or the date Proof of Good Health is approved, as applicable).
- American Airlines, Inc. reserves 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 may result in termination of benefits coverage.
- 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.

If You Experience the Following Life Event...	Then, You May be Able to...
You become eligible for Company-provided benefits for the first time	Enroll online through the American Airlines Benefits Service Center .
Your Spouse or Eligible Dependent Child dies	Medical, Dental, and Vision: <ul style="list-style-type: none"> You lose a Spouse/ Eligible Dependent Child: Stop coverage for your lost Spouse/ Eligible Dependent Child (dependent coverage may be subject to QMCSO). Start coverage for yourself or your Eligible Dependent Child if the loss of your Spouse results in loss of eligibility under your Spouse's plan You gain a Spouse/Eligible Dependent Child: Start coverage for yourself, your Spouse, and/or your Eligible Dependent Child. Stop coverage for yourself and/or your Eligible Dependent Child if you gain coverage under new Spouse's plan. Change in your, your Spouse's or your Eligible Dependent Child's employment: If you/your Spouse or your Eligible Dependent Child gain eligibility under the other employer's plan, you can drop yourself, your Spouse, and/or your Eligible Dependent Child. If you/your Spouse or your Eligible Dependent Child lose eligibility or employer contribution under the other employer's plan, you can add yourself, your Spouse, and/or your Eligible Dependent Child. If you change Medical Benefit Options, your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option. Contact your HMO for eligibility – eligibility is determined by the HMO. Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT): <ul style="list-style-type: none"> Start/Stop coverage for yourself only. If you enroll for the first time, coverage is for a duration of 2 years Company-provided Short-Term Disability (for OMSSS): <ul style="list-style-type: none"> No changes allowed
You or your Spouse gives birth to or adopts a Child or has a Child placed with you for adoption or you gain an Eligible Dependent(s) <ul style="list-style-type: none"> 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 31 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. 	
You get legally married (including common law marriage), divorced or legally separated	
Change in your employment with an employer other than the Company OR Change in Spouse's/Eligible Dependent Child's employment or other health coverage OR Your Spouse's Eligible Dependent Child's employer no longer contributes toward health coverage OR Your Spouse's Eligible Dependent	

If You Experience the Following Life Event...	Then, You May be Able to...
<p>Child's employer no longer covers employees in your Spouse's/Eligible Dependent Child's position</p>	<p>Voluntary Term Life Insurance:</p> <ul style="list-style-type: none"> • Increase/Decrease your coverage (for increase, you must provide Proof of Good Health) <p>Spouse Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Child Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself <p>Spouse AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for eligible Spouse/ • Increase/Decrease for eligible Spouse <p>Child AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage • Increase/Decrease coverage <p>Health Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • If you lose a Spouse/Eligible Dependent Child: Stop/Decrease contributions • If you gain a Spouse/Eligible Dependent Child: Start/Increase contributions (if incentives or contributions have been deposited to an HSA, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision, regardless of the plan selection) • If you, your Spouse or your Eligible Dependent Child gain eligibility under another employer's Health FSA plan: Stop/Decrease contributions • If you, your Spouse or your Eligible Dependent Child lose eligibility under another employer's Health FSA plan: Start/Increase contributions. • Cannot reduce to an amount less than what has already been deducted or paid <p>Dependent Care Flexible Spending Account:</p> <ul style="list-style-type: none"> • Increase/Decrease contributions

If You Experience the Following Life Event...	Then, You May be Able to...
<p>Your covered Eligible Dependent Child no longer meets the Plan's eligibility requirement, i.e.:</p> <ul style="list-style-type: none"> • If the dependent attains the age at which he/she is no longer eligible to be covered as your Eligible Dependent • 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 	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Stop coverage for your Eligible Dependent Child (dependent coverage may be subject to QMCSO). • You may change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO. <p>Optional Short-Term Disability (for FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Short-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Term Life Insurance:</p> <ul style="list-style-type: none"> • Increase/Decrease your existing coverage (for increase, you must provide Proof of Good Health) <p>Spouse Term Life Insurance:</p> <ul style="list-style-type: none"> • Start or stop coverage. <p>Child Term Life Insurance:</p> <ul style="list-style-type: none"> • Start or stop coverage. <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself <p>Spouse AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for eligible Spouse <p>Child AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Health Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Stop/Decrease contributions • Cannot reduce to an amount less than what has already been deducted or paid <p>Additionally:</p> <ul style="list-style-type: none"> • Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible Dependent's address.

If You Experience the Following Life Event...	Then, You May be Able to...
<p>Your dependent Child attains age 13 or he or she or no longer requires Dependent Day Care OR Your elderly parent or Spouse who is incapable of caring for himself/herself no longer meets the definition of “dependent” under the Dependent Care FSA or no longer requires Dependent Day Care.</p>	<p>Dependent Care Flexible Spending Account:</p> <ul style="list-style-type: none"> • Reduce/Stop Dependent Care Flexible Spending Account contributions. • No other changes to benefits are allowed
<p>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”)</p>	<p>Make changes to the applicable Benefit Options:</p> <ul style="list-style-type: none"> • 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.
<p>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</p>	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Start coverage for yourself • Start coverage for your Eligible Dependent Child named in the QMCSO • If required by the terms of the QMCSO, you must change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO • You can start Dental/vision coverage for yourself and/or your Eligible Dependent Child ONLY if the QMCSO specifically orders it. <p>Health Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start/Increase as long as it is not within 60 days of the end of the Plan Year

If You Experience the Following Life Event...	Then, You May be Able to...
You, your Spouse, or your Eligible Dependent Child enroll in Medicare or Medicaid or CHIP coverage	Medical, Dental, and Vision: <ul style="list-style-type: none"> • Stop coverage for the affected Spouse or Eligible Dependent Child.
You, your Spouse, or your Eligible Dependent Child lose Medicare, Medicaid or CHIP coverage	Medical, Dental, and Vision: <ul style="list-style-type: none"> • Start coverage for yourself and the affected Spouse or Eligible Dependent Child
You, your Spouse, or your Eligible Dependent Child become eligible for a state premium assistance program	Medical, Dental, and Vision: <ul style="list-style-type: none"> • Start coverage for yourself and the affected Spouse or Eligible Dependent Child. • If you're adding a Spouse or Eligible Dependent Child, you can change your Medical Benefit Option. If you change, your Deductible and Out-of-Pocket amounts will transfer to your newly elected Medical Benefit Option.
You, your Spouse or your Eligible Dependent Child become eligible for/lose eligibility for and become enrolled/dis-enrolled in government-sponsored Tricare coverage	Medical: <ul style="list-style-type: none"> • Start coverage for yourself if you lose eligibility • Stop coverage for yourself if you gain eligibility • Start coverage for your Spouse if he/she loses eligibility • Stop coverage for your Spouse if he/she gains eligibility • Start coverage for your Eligible Dependent Child if he/she loses eligibility • Start coverage for your Eligible Dependent Child if he/she gains eligibility
You move to a new home address: <ul style="list-style-type: none"> • Update both your permanent AND alternate addresses on the Update MY Information page of Jetnet. US Airways, Inc. employees should update their legal payroll address and benefits address on MyHR: http://wings.usairways.com/uswingshuman_resources/myhr • Submit a revised Federal Form W-4 Form for payroll tax 	Medical, Dental, and Vision: <ul style="list-style-type: none"> • You may change Medical Benefit Options if your existing Medical Benefit Option is unavailable in your new location, or if your new location offers a new Medical Benefit Option not available in your old location. • No changes allowed for Dental and/or Vision Benefit Options. Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):

If You Experience the Following Life Event...	Then, You May be Able to...
<p>purposes. The form is available online through the Pay and Compensation page of American Airlines Benefits Service Center</p> <ul style="list-style-type: none"> • 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. • If you are enrolled in the STANDARD, VALUE or CORE Medical Benefit Option and you move to a location where the STANDARD, VALUE or CORE Medical Benefit Option is available, you will stay enrolled in STANDARD, VALUE or CORE Medical Benefit Option. If you were enrolled in an HMO that is not offered in your new location, you may elect a self-funded Medical Benefit Option or an HMO if it exists in your new location. • If a STANDARD, VALUE or CORE Medical Benefit Option Network is not available, you must choose another Medical Benefit Option (OUT-OF-AREA), or you may waive coverage if you have other coverage (such as your Spouse's employer-sponsored plan). • Contact American Airlines Benefits Service Center and a representative will assist you with your election. If you are enrolled in an HMO or in the STANDARD, VALUE or CORE Medical Benefit Option and you do not process your relocation Life Event within 31 days of your move, you will 	<ul style="list-style-type: none"> • Start coverage for yourself only if you had no access to this coverage in your prior state • Stop coverage for yourself if your new state prohibits OSTD coverage <p>Company-provided Short-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Term Life Insurance:</p> <ul style="list-style-type: none"> • No changes allowed <p>Spouse Term Life:</p> <ul style="list-style-type: none"> • No changes allowed <p>Child Term Life:</p> <ul style="list-style-type: none"> • No changes allowed <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • No changes allowed <p>Spouse AD&D/VPAL:</p> <ul style="list-style-type: none"> • No changes allowed <p>Child AD&D/VPAL:</p> <ul style="list-style-type: none"> • No changes allowed <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • no changes allowed

If You Experience the Following Life Event...	Then, You May be Able to...
<p>stay in your selected Medical Benefit Option. If your selected Medical Benefit Option is not available, you will automatically be enrolled in the default Medical Benefit Option, which is CORE.</p> <p>If you move or relocate to a new location within the last two months of the year, contact American Airlines Benefits Service Center so they can ensure your elections are filed for this current year and for next year.</p>	
<p>You become disabled</p>	<p>Notify: Your manager/supervisor can download a Disability Claim Form.</p> <p>Complete and submit: Your claim for disability benefits.</p>
<p>You start an unpaid leave of absence</p>	<p>Access the American Airlines Benefits Service Center to register your “Going on Leave of Absence” Life Event and update your benefit elections.. A confirmation statement showing your choices, the monthly cost of benefits, etc. will display.</p> <p>Your cost depends on: The type of leave you are taking</p> <p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Stop coverage • Stop Spouse coverage • Stop Eligible Dependent Child coverage <p>Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):</p> <ul style="list-style-type: none"> • Stop coverage <p>Company-provided Short-Term Disability (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Term Life Insurance:</p> <ul style="list-style-type: none"> • Stop coverage <p>Spouse Term Life:</p> <ul style="list-style-type: none"> • Stop coverage <p>Child Term Life:</p>

If You Experience the Following Life Event...	Then, You May be Able to...
	<ul style="list-style-type: none"> • Stop coverage <p>AD&D/VPAL Insurance Benefit:</p> <ul style="list-style-type: none"> • Stop coverage <p>Spouse AD&D/VPAL:</p> <ul style="list-style-type: none"> • Stop coverage <p>Child AD&D/VPAL:</p> <ul style="list-style-type: none"> • Stop coverage <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Stop/Decrease Health FSA contributions • Stop/Decrease Dependent Care FSA contributions • Cannot reduce any FSA to amount lower than what has been deducted or paid
<p>You return from an unpaid leave of absence</p>	<p>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 (e.g., Voluntary Term Life Insurance, Short Term Disability, etc.) Go to the American Airlines Benefits Service Center, register your “Return to Work” Life Event and make selections or changes to your benefits. If you return within 30 days, you will be placed back in the elections you were in prior to your leave unless you experience another change in status event.</p> <p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Resume/Start coverage for yourself • Start coverage for your Spouse • Start coverage for your Eligible Dependent Child <p>Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself; Proof of Good Health is required <p>Company-provided Short-Term Disability (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself; Proof of Good Health is required

If You Experience the Following Life Event...	Then, You May be Able to...
	<ul style="list-style-type: none"> • Increase/Decrease coverage for yourself; for increase, Proof of Good Health is required <p>Spouse Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage; Proof of Good Health is required • Increase/Decrease coverage; for increase, Proof of Good Health is required <p>Child Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself • Stop/Decrease coverage for yourself <p>Spouse AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage • Increase/Decrease coverage <p>Child AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start/Increase contributions • Stop/Decrease contributions • Special rules apply to the Health FSAs if your leave was FMLA leave <ul style="list-style-type: none"> ○ You can resume contributions without making up contributions you missed (coverage will be correspondingly reduced), or ○ You can resume contributions plus make up contributions you missed (coverage will resume at the level you elected).

If You Experience the Following Life Event...	Then, You May be Able to...
<p>You change from part-time to full-time employment or full-time to part-time employment</p>	<p>Optional Short-Term Disability Insurance (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):</p> <ul style="list-style-type: none"> • Start coverage for yourself; Proof of Good Health is required • Minimum duration of enrollment is 2 years <p>Company-provided Short-Term Disability (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself; Proof of Good Health is required • Stop coverage for yourself • Increase/Decrease coverage for yourself; for increase, Proof of Good Health is required <p>Spouse Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage; Proof of Good Health is required • Stop coverage <p>Child Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage • Stop coverage <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself <p>Spouse AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage • Increase/Decrease coverage <p>Child AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • No changes allowed
<p>You die</p>	<p>Continuation of Coverage: Your Eligible Dependents should contact your manager/supervisor, who will coordinate with a survivor support representative at the American Airlines Benefits Service Center to assist with all benefits and privileges, including the election of continuation of coverage, if applicable.</p>

If You Experience the Following Life Event...	Then, You May be Able to...
You end your employment with the Company or you are eligible to retire	<p>Review: “When Coverage Ends” in the <i>General Enrollment</i> section.</p> <p>Review: The information you receive regarding continuation of coverage through COBRA.</p> <p>Contact: American Airlines Benefits Service Center for information on retirement.</p>
You transfer to another workgroup	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Changes are allowed only to the extent that the change in workgroup affects benefit eligibility • Start/Stop coverage for yourself, your Spouse and/or your Eligible Dependent Child (dependent coverage may be subject to QMCSO). • You may change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO. <p>Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself only. If you enroll for the first time, coverage is for a duration of 2 years. <p>Company-provided Short-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Term Life Insurance:</p> <ul style="list-style-type: none"> • Increase/Decrease your coverage with Proof of Good Health <p>Spouse Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Child Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself <p>Spouse AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for eligible Spouse • Increase/Decrease for eligible Spouse

If You Experience the Following Life Event...	Then, You May be Able to...
	<p>Child AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Health Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Changes are allowed only to the extent that the change in workgroup affects Health Flexible Spending Account eligibility Start/Stop Health Flexible Spending Accounts • Increase/Decrease contributions (if incentives or contributions have been deposited to an HSA, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision, regardless of the plan selection) • Cannot reduce to an amount less than what has already been deducted or paid <p>Dependent Care Flexible Spending Account:</p> <ul style="list-style-type: none"> • Increase/Decrease contributions
<p>You, your Spouse, and/or your Eligible Dependent Child declined the Company's medical coverage because you or they had coverage elsewhere (external to the Company), and any of the following events occur:</p> <ul style="list-style-type: none"> • 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 	<p>Medical Coverage:</p> <ul style="list-style-type: none"> • Start coverage for yourself <ul style="list-style-type: none"> ○ Note that you must enroll in the coverage in order to elect coverage for your Spouse and/or Eligible Dependent Child. • Start coverage for your affected Spouse • Start coverage for your affected Eligible Dependent Child • You may change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option.

If You Experience the Following Life Event...	Then, You May be Able to...
<ul style="list-style-type: none"> 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 	
The cost of dependent care changes (only if the change is imposed by a dependent care provider who is not your relative)	Dependent Care Flexible Spending Account: <ul style="list-style-type: none"> Increase/decrease contributions

If Your Dependent(s) Lose Eligibility Under the Plan

If your dependent(s) lose eligibility under the Plan (e.g. divorce), you must file a Life Event or contact American Airlines Benefits Service Center to remove the ineligible dependent(s) from your coverage — even if you have missed the 31 day deadline.

If you contact American Airlines Benefits Service Center after the 31 day deadline you will be able to remove your dependent(s) from coverage, but the effective date is the loss of eligibility (e.g. legal effective date of the divorce).

You will receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified American Airlines Benefits Service Center of their ineligibility. In addition, the coverage for your dependent(s) will be retroactively terminated and any claims paid under the Plan will be reversed.

Important: If you do not file a Life Event, notify American Airlines Benefits Service Center 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 31 day deadline and the event occurred in the current year, you must wait until the next Annual Enrollment Period to add your dependents.

If you miss the 31 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 Option changes. (Adding the

dependent to your file lists the dependent as eligible to be enrolled at the next Annual Enrollment, but does not enroll him or her in benefits currently.)

When Coverage Ends

Coverage for you and your dependents will automatically terminate on the earliest of:

- The date a Plan or Benefit Option terminates;
- The last day for which required contributions were paid;
- The date you or a dependent is 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 surviving Spouse will be ineligible for coverage on the date your surviving Spouse remarries.

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, Dental, and Vision coverage for up to 36 months under COBRA Continuation Coverage at the full COBRA rate, if they had these benefits at the time of your death. See the "[COBRA](#)" chapter. The 90 days of coverage are part of the 36 months of COBRA coverage.

Expenses incurred after the date your coverage (or your dependents' coverage) terminates are not eligible for reimbursement under a Plan or Benefit Option.

In addition to the above rules, if you are covered under an HMO, 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 Aon Hewitt, the COBRA administrator.
- **You leave the service area.** You must register this move as a Life Event on the Benefits Service Center, and enroll in another HMO (if available) or self-funded Medical Benefit Option. Contact American Airlines Benefits Service Center within 31 days of your move. If you do not notify American Airlines Benefits Service Center of your move, you will be enrolled the default Medical Benefit Option for your workgroup and will receive a confirmation statement indicating your new coverage.

- **You retire.** If you retire while covered by an HMO, your coverage will change. See the [Retiree Medical Benefit Guide](#) for your workgroup eligibility. HMO membership is not currently available to retirees unless you live in Puerto Rico. Retirees in Puerto Rico may enroll in the Triple S HMO.

However, you may continue coverage in an HMO through COBRA for a period of 18 months at the time of your retirement. You will automatically be solicited for continuation of your HMO coverage under COBRA by Aon Hewitt, the COBRA administrator.

Note: If you or your covered Eligible Dependent 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).

Medical Benefits

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Medical Benefit Options Overview

The Company offers you the opportunity to enroll in medical coverage for you and your Eligible Dependent(s) that provides protection in the event of illness or injury. You may choose from several Medical Benefit Options or you may waive coverage completely. If you do not enroll in or waive medical coverage, you will be automatically enrolled in the default coverage described in the “Default Coverage” section above and you will be responsible for the respective contributions.

You may choose one of the following Medical Benefit Options:

- **The STANDARD, VALUE or CORE Medical Benefit Options.**
- **The OUT-OF-AREA (OOA) Medical Benefit Option.**
- **Health Maintenance Organization (HMO) Medical Benefit Option.**

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

You may choose from the following coverage levels:

- Employee Only
- Employee + Spouse/Common Law Spouse
- Employee + Child(ren)
- Employee + Family

Your dependents must be enrolled in the same Medical Benefit Option that you are enrolled in. If you waive coverage, your dependents cannot be enrolled in coverage. See the [eligibility](#) section for additional rules.

How the STANDARD, VALUE, and CORE Medical Benefit Options Work

The STANDARD, VALUE, CORE, and OUT-OF-AREA Medical Benefit Options offer 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, VALUE, CORE, and OUT-OF-AREA Medical Benefit Options 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.

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.

If you choose to use an Out-of-Network Provider, the payment will be calculated based on the Maximum Out-of-Network Charge (MOC), and the STANDARD, VALUE, and CORE Medical Benefit Options will pay your expenses at a lower level of benefit compared to the In-Network rate. If you are in the OUT-OF-AREA Medical Benefit Option, your Co-Insurance percentage remains the same for In-Network or Out-Of-Network services. After you meet the annual Out-of-Network Deductible, the STANDARD, VALUE, and CORE Medical Benefit Options pay 60% of Out-of-Network eligible expenses, up to the MOC, for most Medically Necessary services. The MOC is a percentage of the rate that the federal Medicare program would pay for the service. Generally, the MOC for Out-of-Network Providers and facilities will be limited to 140% of the amount the federal Medicare program would have paid for the same service. Your Network/Claim Administrator will determine the MOC based on this formula. In addition to the percentage of coinsurance you must pay under the terms of the Plan, you may be responsible for any amount your Out-of-Network Provider or facility charges over 140% of the Medicare fee schedule for the service rendered.

In the following rare instances, the payment is determined according to the following rules, as long as the covered person has received prior approval from the Network/Claim Administrator:

- 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, VALUE, CORE, and OUT-OF-AREA Medical Benefit Options will treat 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/Claim Administrator's Network gap mile limit), and the covered person has received prior approval from the Network/Claim Administrator, the Medical Benefit Option will treat the Out-of-Network Provider's full billed charge as an eligible expense.
- If the claim is for care in a "clinical gap", the Medical Benefit Option will allow the Out-of-Network Provider's full billed charge as an eligible expense, as long as In-Network Providers in the area with the same credentials cannot provide the specific treatment that a patient needs.
- If the Network/Claim Administrator is unable to determine the MOC based on Medicare reimbursements, the STANDARD, VALUE, CORE, and OUT-OF-AREA Medical Benefit Option will treat 50% of the Out-of-Network Provider's full billed charge as an eligible expense.

The following rule applies to services rendered by an anesthesiologist, radiologist, or pathologist:

- If you receive care from an Out-of-Network anesthesiologist, radiologist, or pathologist at an In-Network facility, and you have no control over choosing the anesthesiologist, radiologist, or pathologist, then the Plan will reimburse the Out-of-Network anesthesiologist, radiologist, or pathologist using the In-Network benefit level.

Go online or call your Network/Claim Administrator for more information and to access a list of In-Network Providers.

How the Out-of-Area Medical Benefit Option Works

Employees who do not have access to Network Providers that meet the guidelines determined by the Network/Claim Administrator will have OUT-OF-AREA coverage as a Medical Benefit Option. 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 negotiated rate discount if you use a preferred Provider. This negotiated rate is automatic when you present your medical ID card to a preferred Provider. In addition to negotiated rates, preferred 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 preferred 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.

The following rules apply to hospital, lab, or X-ray services:

- If you go to an In-Network hospital but receive services from a Provider who is not a preferred 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.

When you use a Physician, hospital, or other medical service Provider that does not have a contract with your Network/Claim Administrator, your eligible expenses are based on MOC.

How the HMO Medical Benefit Option Works

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

- Choose a Primary Care Physician (PCP) who coordinates all your medical care, and
- Obtain a referral from your PCP before receiving care from a Specialist.

HMOs are entities separate from the Company that contract with the Company to provide medical benefits under the Plan. 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 Benefit Options 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, you will not receive medical covered through the CORE, STANDARD, VALUE, or OUT-OF-AREA Medical Benefit Options (i.e., the self-funded Medical Benefit Options). Your benefits, including Prescription drugs and mental health care, are covered according to the rules of your HMO.

Cost-Sharing by Medical Benefit Options











The following chart describe cost-sharing under the Medical Benefit Options. As you review the chart, keep the following in mind:

Important Facts For You To Know About The Medical Benefit Options 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 chart, it is the Co-Insurance that is your financial responsibility. Medical Co-Insurance applies once the Deductible has been met.

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 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	<p>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 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.</p> <p>For some of the Medical Benefit Options, some types of In-Network expenses that are subject to Co-Pay (such as preventive care, certain Physician visits, and certain Prescription drugs) are paid by the Medical Benefit Option <i>even if you've not yet satisfied your Deductible</i>.</p> <p>Co-Pays for covered expenses (for Physician visits, emergency room, maternity care), and Prescription drug coinsurance amounts do NOT count toward your satisfaction of the Deductible for the calendar year.</p> <p>Facts about the family annual Deductible:</p> <ul style="list-style-type: none"> • The family Deductible limits apply if more than one person is covered in the Medical Benefit Option. • STANDARD/VALUE/OOA Medical Benefit Option: <ul style="list-style-type: none"> ❖ The family Deductible is satisfied when you have paid all your, and your covered dependents', covered expenses equal to the individual Deductible for each covered person. ❖ If there are two people covered under family coverage then, each person must reach the individual Deductible amount before the family Deductible is satisfied. ❖ If there are three or more people covered under your family coverage, a maximum of three

	<p>members of your family have to reach the individual Deductible amount before the family Deductible is satisfied.</p> <ul style="list-style-type: none"> ❖ Once a minimum of two members and a maximum of three members of your family have met their individual Deductibles, the family Deductible is deemed satisfied and then the Medical Benefit Option will begin to pay its percentage of the covered expenses. ❖ You do not have to meet the family Deductible amounts under the STANDARD, VALUE or OOA Medical Benefit Options in order for your Medical Benefit Option to begin paying its percentage for a family member that has met his/her individual Deductible. <ul style="list-style-type: none"> • CORE Medical Benefit Option: If more than one person is covered under the CORE Medical Benefit Option, the Family Deductible must be met before the CORE Medical Benefit Option starts to pay benefits. Covered expenses from any and all covered persons can be used to meet the family annual Deductible.
<i>Medical Necessity</i>	<p>ALL of the medical services and supplies described in the Medical Benefit Options 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. See the Glossary for the definition of Medical Necessity.</p>
<i>Out-of-Pocket/Out-of-Pocket Maximum</i>	<p>This is the portion of covered expenses that you have to pay each Plan Year before expenses are payable at 100%. Out-of-Pocket Maximum never includes expenses that are excluded from coverage, and expenses that exceed the Maximum Out-of-Network Charge limits for Out-of-Network services.</p> <p>For the STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options, medical and prescription Out-of-Pocket expenses include your Co-Pays, Co-Insurance, and Deductible. In-Network and Out-of-Network Out-of-Pocket Maximums are accumulated separately.</p> <p>For the CORE Medical Benefit Option, Out-of-Pocket expenses that count toward your Out-of-Pocket Maximum include the Deductible and your medical and Prescription</p>

	<p>Co-Insurance. In-Network and Out-of-Network Out-of-Pocket Maximums are accumulated separately.</p> <p>Facts about the individual Out-of-Pocket Maximum:</p> <ul style="list-style-type: none"> • Only each covered individual's portion of covered expenses can be used to meet his/her individual annual Out-of-Pocket Maximum. <p>Facts about the family Out-of-Pocket Maximum:</p> <ul style="list-style-type: none"> • In families consisting of 3 or more members, if the family out-of-pocket maximum is met cumulatively, expenses are payable at 100% for all members of the family even if the individual Out-of-Pocket Maximums have not been met by each member.
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Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit 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							
Individual Annual Deductible	\$850 	\$3,000	\$2,000	\$4,000	\$400 	\$1,550	\$850 
Family annual Deductible	\$2,550 	\$9,000	\$4,000	\$8,000	\$1,200 	\$4,650	\$2,550 
Individual annual Out-of-Pocket Maximum	\$2,000	\$6,000	\$4,000	\$12,000	\$2,000	\$6,000	\$2,000
Family Out-of-Pocket Maximum	\$5,000	\$15,000	\$8,000	\$24,000	\$5,000	\$15,000	\$5,000
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	40%	No cost to you	40%	No cost to you
Well-Child care	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you
Medical Care							
Physician's office visit (including X-ray and lab work)	\$30 per visit; Deductible does not apply	40%	20%	40%	\$20 per visit; Deductible does not apply	40%	20%
Telehealth office visit	\$20 per visit; Deductible does not apply 	Not covered	\$40 per visit 	Not covered	\$20 per visit; Deductible does not apply 	Not covered	\$20 per visit 
Specialist's office visit	20%	40%	20%	40%	\$40 per visit; Deductible does not apply	40%	20%
Retail/	20%	40%	20%	40%	\$40 per	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
Convenience Clinic visit (i.e., clinics inside of CVS, Walgreens, Wal-Mart, etc.) Including lab, x-ray and other charges					visit; Deductible does not apply		
Urgent Care clinic, lab, x-ray, and other charges made by the Urgent Care clinic	20%	40%	20%	40%	\$40 per visit; Deductible does not apply	40%	20%
Gyne-cological care (see Mammogram for coverage information on routine screening or diagnostic mammograms, 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; Deductible does not apply	40% for treatment of illness/ injury and preventive exam	No cost to you for annual preventive exam 20% for treatment of illness/injury	40% for treatment of illness/ injury and preventive exam	No cost to you for annual preventive exam \$20 per visit to an OB/GYN diagnostic; Deductible does not apply	40% for treatment of illness/ injury and preventive exam	No cost to you for annual preventive exam; 20% for an OB/GYN diagnostic
Preventive Pap tests: routine screening	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you
Diagnostic Pap tests: test performed for a medical problem	No cost to you if performed in the doctor's office. Otherwise 20%	40%	20%	40%	No cost to you if performed in the doctor's office. Otherwise 20%	40%	No cost to you if performed in the doctor's office. Otherwise 20%
Preventive Mammo-gram/Colonoscopy: routine screening	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
done according to national age specific guidelines and regardless of where the service is performed							
Diagnostic Mammo-gram/Colonoscopy: test performed for a <u>medical</u> problem	No cost if part of office visit or at an independent facility. 20% if performed in Outpatient hospital	40%	No cost after deductible is met if part of an office visit or at a non-hospital facility. Otherwise, 20% after deductible	40%	No cost to you if part of office visit or at an independent facility. 20% if performed in Outpatient hospital	40%	No cost if part of office visit or at an independent facility. 20% if performed in Outpatient hospital
Pregnancy and Maternity Care: <u>OB-GYN's Charges Only.</u> <i>Includes prenatal and postnatal care, and delivery charges</i>	Routine prenatal care, no cost to you. All other services, 20%	40%	Routine prenatal care, no cost to you. All other services 20%	40%	Routine prenatal care, no cost to you. All other doctor's services, \$150 per pregnancy	40%	Routine prenatal care, no cost to you. All other services, 20%
Pregnancy and Maternity Care: <u>Hospital and Other Ancillary Charges Only.</u> <i>Includes labor/delivery and postnatal expenses</i>	20%	40%	20%	40%	20%	40%	20%
Second surgical opinions No cost if ordered by the Plan or	20% if elected by participant	40% if elected by participant	20% if elected by participant	40% if elected by participant	\$40 per visit if elected by participant ; Deductible	40% if elected by participant	20% if elected by participant

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
Network/ Claim Administrator					does not apply		
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%	20%	40%	\$40 per visit; Deductible does not apply	40%	20%
Speech, physical, occupational, restorative and rehabilitative therapy, if Medically Necessary <i>Educational Services are not covered</i>	20%	40%	20%	40%	\$40 per visit; Deductible does not apply	40%	20%
Allergy Care							
Physician's office visit for allergy care	If PCP: \$30 per visit; Deductible does not apply If Specialist: 20%	40%	20%	40%	If PCP – \$20 per visit; Deductible does not apply If Specialist – \$40 per visit; Deductible does not apply	40%	20%
Allergy testing, shots or serum	20% No cost for Allergy testing performed in the	40%	20%	40%	No cost to you if administered in Physician's office. \$20 per	40%	20% No cost for Allergy testing performed

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
	doctor's office				visit if PCP office visit is charged, If Specialist – \$40 per visit; Deductible does not apply		in the doctor's office
Outpatient Services							
Diagnostic X-ray and lab (for non-urgent, non-immediate and non-emergent care)	No cost to you if performed at doctor's office or non-hospital imaging center/lab 20% if at hospital	40%	20%	40%	No cost to you if performed doctor's office or non-hospital imaging center/lab; 20% if at hospital	40%	No cost to you if performed at doctor's office or non-hospital imaging center/lab 20% if at hospital
Outpatient surgery in Physician's office Pre-authorization is recommended to ensure Medical Necessity; see "CheckFirst"	PCP – \$30 per visit; Deductible does not apply If Specialist – 20%	40%	20%	40%	PCP – \$20 per visit. If Specialist – \$40 per visit; Deductible does not apply	40%	20%
Outpatient surgery in a hospital or free standing surgical facility Pre-authorization is recommended to ensure Medical Necessity; see "CheckFirst"	20%	40%	20%	40%	20%	40%	20%
Pre-admission testing	No cost if performed at lab or in	40%	20%	40%	No cost if performed at lab or in	40%	No cost if performed at lab or in

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
	doctor's office; 20% if at hospital				doctor's office; 20% if at hospital		doctor's office; 20% if at hospital
Hospital Services – Preauthorization required for Out-of-Network Hospitalization. If you fail to get preauthorization you will pay a \$250 penalty.							
<i>Inpatient room and board</i>	20%	40%	20%	40%	20%	40%	20%
<i>Intensive care unit and special care unit</i>	20%	40%	20%	40%	20%	40%	20%
<i>Ancillary services, including radiology, pathology, operating room and supplies</i>	20%	40%	20%	40%	20%	40%	20%
<i>Newborn Nursery care</i>	20%	40%	20%	40%	20%	40%	20%
<i>Surgery and related expenses</i> (such as anesthesia and Medically Necessary assistant surgeon)	20%	40%	20%	40%	20%	40%	20%
<i>Blood transfusions</i>	20%	40%	20%	40%	No cost to you if performed in doctor's office; 20% if at hospital	40%	20%
<i>Organ transplants</i> <i>Preauthorization required</i> <i>(no coverage without</i>	20%	40%	20%	40%	20%	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
<i>preauthoriz- ation)</i>							
Emergency ambulance	20%	20%	20%	20%	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	20% on full amount allowed of the bill	20% on full amount allowed of the bill Non Emergency- 40% on full amount allowed of the bill	\$100 copay, PLUS 20% on full amount allowed on the bill	\$100 copay, PLUS 20% on full amount allowed of the bill Non Emergency- \$100 copay PLUS 40% on full amount allowed	\$100 copay, PLUS 20% on full amount allowed of the bill
FACTS ABOUT EMERGENCY ROOM CLAIMS STANDARD, VALUE, and OUT-OF-AREA Medical Benefit 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							
Out-of-Hospital Care							
Conval- escent and Skilled Nursing Facilities following hospital- ization Within 15 days of hospitaliz- ation. Maximum of 60 days per illness/injury for In-Network and Out-of- Network facilities combined	20%	40%	20%	40%	20%	40%	20%
Home Health Care	20%	40%	20%	40%	No cost to you when approved by your Network admin- istrator	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
Hospice Care	20%	40%	20%	40%	20%	40%	20%
Other Services							
Tubal ligation (Reversals are not covered, except under the CORE Medical Benefit Option)	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you
Vasectomy (Reversals are not covered, except under the CORE Medical Benefit Option)	If PCP - \$30; If Specialist - 20%	40%	20%	40%	If PCP - \$20; If Specialist - \$40; otherwise, 20%	40%	20%
Erectile Dysfunction Medications	Covered under the Prescription Drug benefit, up to six (6) pills per month.						
Infertility medications	Fertility Prescription medications are covered under the Prescription Drug benefit. The maximum benefit is \$15,000 for the entire time the person is covered under the Plan. Any other fertility treatment services are not covered by any of the self-funded Medical Benefit Options.						
Infertility Treatment (see Covered Expenses section for details)	Not covered	Not covered	20%. The maximum benefit is \$25,000 for the entire time the person is covered under the Plan.	Not covered (unless due to a "network gap." See the section "How the STANDARD, VALUE, AND CORE Medical Benefit Options Work.")	Not covered	Not covered	Not covered
Radiation therapy and chemotherapy	20%	40%	20%	40%	No cost to you if in Physician office; otherwise, 20%	40%	20%
Kidney dialysis (If the dialysis continues more than 12 months,	20%	40%	20%	40%	No cost to you if in Physician office; otherwise, 20%	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
participant must apply for Medicare)							
Supplies, equipment and Durable Medical Equipment (DME)	20%	40%	20%	40%	20%	40%	20%
FACTS ABOUT SUPPLIES, EQUIPMENT, DME Your cost is the percentage shown above, regardless of where the device is purchased, and is <i>in addition to</i> any Physician's visit costs you're required to pay.							
Gender Reassignment Benefit (Cumulative maximum benefit for travel is \$10,000). These are the maximum benefits payable for the entire time the person is covered under the Plan. See "Travel and Lodging Reimbursement" for information about when travel and lodging expenses may be reimbursed.							
Surgery One bilateral mastectomy or bilateral augmentation mammoplasty AND One genital revision surgery	20%	Not Covered	20%	Not Covered	Not Covered	Not Covered	Not Covered
Non-Surgical Treatments Physician's visits Specialist visits Outpatient mental health care X-rays and lab work Retail Prescription drugs Mail order Prescription drugs	Covered as mental health care benefits described above	Not Covered	Covered as mental health care benefits described above	Not Covered	Not Covered	Not Covered	Not Covered
Travel and Lodging Reimbursement							
Gender Reassignment Surgery Travel Expenses For yourself and one caregiver to	No cost to you, up to \$10,000—see Covered Expenses section for details	Not covered	No cost to you, up to \$10,000—see Covered Expense section for details	Not covered	Not covered	Not covered	Not covered

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
travel to the Network facility and for time while you're hospitalized/receiving Medically Necessary Outpatient care following surgery							
Travel Expenses for Surgery at Center of Excellence for Transplant, Cancer, Congenital Heart Disease, or Bariatric For yourself and one caregiver to travel to the Center of Excellence and for time while you're hospitalized/receiving Medically Necessary Outpatient care following surgery	No cost to you, up to \$10,000—see Covered Expenses section for details	Not covered	No cost to you, up to \$10,000—see Covered Expenses section for details	Not covered	No cost to you, up to \$10,000—see Covered Expenses section for details	Not covered	No cost to you, up to \$10,000—see Covered Expenses section for details
Mental Health Benefits							
Inpatient mental health care	20%	40%	20%	40%	20%	40%	20%
Alternative Mental Health Care Center — residential treatment	20%	40%	20%	40%	20%	40%	20%
Alternative Mental Health Care Center –	20%	40%	20%	40%	20%	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
<i>intensive Outpatient and partial hospital- ization</i>							
<i>Outpatient mental health care</i>	No cost (100% coverage) for PCP or Specialist Office Visits; 20% for all other Outpatient services	40%	20%	40%	\$20 per visit for PCP, Deductible does not apply; \$40 per visit for Specialist; 20% Outpatient hospital	40%	No cost (100% coverage) for PCP or Specialist Office Visits; 20% for all other Outpatient services
<i>Marriage/ relationship/ family counseling</i>	Not covered by any of the self-funded Medical Benefit Options						
Chemical Dependency Benefits							
<i>Inpatient chemical dependency rehabilitation</i>	20%	40%	20%	40%	20%	40%	20%
<i>Outpatient chemical dependency rehabilitation</i>	No cost (100% covered) for PCP or Specialist Office Visits; 20% for all other Outpatient services	40%	20%	40%	\$20 per visit PCP; \$40 per visit Specialist; 20% Outpatient facility	40%	No cost (100% covered) for PCP or Specialist Office Visits; 20% for all other Outpatient services

Covered Expenses

This section contains descriptions of the Eligible Medical Expenses (listed alphabetically) that are covered under the self-funded Medical Benefit Options when Medically Necessary. Benefits for some of these eligible expenses vary depending on the Medical Benefit Option you have selected and whether or not you use In-Network Providers. See the [Medical Benefit Options](#) chart for information on how most services are covered. For covered expenses under an HMO, check with the HMO directly. For a list of items that are excluded from coverage, see “[Excluded Expenses](#)”.

- **Applied Behavior Analysis (ABA) Therapy:** ABA Therapy is an Educational Service under the Plan. The Plan covers ABA Therapy for autism spectrum disorder under the CORE benefit option only. Even though these are educational in nature, these services must be medically necessary. In the case of ABA Therapy covered under the CORE benefit option, the Plan will cover services that are provided by a licensed ABA provider, that are habilitative in nature and that are backed by credible research demonstrating that the services have a measurable and beneficial effect on the patient’s health outcomes. To determine whether your case meets this definition, use the CheckFirst pre-determination procedure. You are required to use CheckFirst for ABA Therapy.
- **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 to be 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.
- **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 Benefit Option and your Network/Claim Administrator authorizes the transfer

Note: 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.
- **Bariatric Surgery:** The Plan covers Bariatric Surgery. This is a limited, one-time benefit for the entire time the patient is covered under the Plan. Bariatric Surgery includes Gastric Bypass (Roux-en- Y), Lap band, Gastric Sleeve and Duodenal Switch. To be eligible for Bariatric Surgery, the patient must be 18 years of age or older, or have achieved greater than 95% of estimated adult height and a minimum Tanner Stage of 4. In addition, the patient must have one of the following:
 - BMI of 40 or greater; or
 - BMI over 35, with at least one complicating comorbidity that is directly related to, or exacerbated by, morbid obesity. The following comorbidities will satisfy this requirement:
 - ❖ Type 2 diabetes;
 - ❖ Cardiovascular disease (e.g., stroke, myocardial infarction, poorly controlled hypertension);
 - ❖ History of coronary artery disease with a surgical intervention such as cardiopulmonary bypass or percutaneous transluminal coronary angioplasty;
 - ❖ Cardiopulmonary problems (e.g., documented obstructive sleep apnea); or
 - ❖ History of cardiomyopathy.
- **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 visits.



- **Clinical Trials.** Routine patient costs otherwise covered by the Plan that are associated with participation in phases I-IV of Approved Clinical Trials (i.e., clinical trials that are federally funded and certain drug trials) to treat cancer or other Life-Threatening Conditions, as determined by the Third Party Administrator and as required by law. These costs will be subject to the Plan's otherwise applicable deductibles and limitations and do not include items that are provided for data collection or services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis or otherwise payable or reimbursable by another party.
- **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/Claim 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,
 - Dental treatment due to Accidental Injury must begin within 12 months of the date of the accident
 - If the Accidental Injury requires that you have Dental implants, the maximum benefit is \$15,000 for the entire time the person is covered under this Plan
 - 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 a chemical dependency condition. Contact your Network/Claim Administrator for details.
- **Dietician services:** Dietician services are covered under the STANDARD Medical Benefit Option, CORE Medical Benefit Option, VALUE Medical Benefit Option or OUT-OF-AREA Medical Benefit Option.
- **Durable Medical Equipment (DME):** Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Medical Benefit Option may, in its discretion, 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/Claim Administrator for QuickReview approval within 48 hours of an Emergency resulting in admission to the hospital.
- **Erectile Dysfunction Medication:** Medications are covered up to a maximum of 6 pills per month.
- **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](#) Option 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 and CORE Medical Benefit Options. It is not covered under VALUE Medical Benefit Option, or OUT-OF-AREA Medical Benefit Option.
 - The Gender Reassignment Benefit (GRB) provides coverage for gender reassignment. The GRB only offers benefits on an In-Network basis. There are no GRB benefits offered Out-of-Network. The GRB offers reimbursement for travel expenses as outlined below.
 - Effective January 1, 2016, this benefit is available to employees and their Eligible Dependents age 18 and over.
 - This GRB is available to the employee and their Eligible Dependents age 18 and over only one time during the entire time the employee/Eligible Dependent is covered under the Plan.
 - An employee who receives the benefit 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, not to exceed a combined \$10,000 travel reimbursement.
 - **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.
 - **GRB Benefit Determinations.** 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.
 - **GRB Prescription Drug and Mental Health Treatment.** 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.** See “[Travel and Lodging Reimbursement](#)” for information about when travel and lodging expenses may be reimbursed.
- **Preauthorization for the GRB.** You must have approval from the Network/Claim 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)” for additional information.
- **Hearing care:** Covered expenses include Medically Necessary hearing exams performed by an audiologist or Physician and Medically Necessary hearing aids, subject to a maximum benefit of \$3,500 per hearing aid. Replacement hearing aids are allowed once every 36 months and the maximum benefit 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/Claim 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/Claim Administrator. You should contact your Network/Claim Administrator to initiate the QuickReview process.
- **Infertility Testing and Diagnosis:** Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease.
- **Infertility Treatment services (other than testing and diagnosis)**
 - Certain Infertility Treatment services are covered under the CORE Medical Benefit Option only (subject to the limitations and exclusions described in this Summary Plan Description). They are not covered under the STANDARD Medical Benefit Option, VALUE Medical Benefit Options, or OUT-OF-AREA Medical Benefit Option.
 - This benefit is subject to a \$25,000 maximum for the entire time the person is covered under the Plan.

- Infertility Treatment includes the following services and procedures, if prescribed by your attending physician:
 - Artificial Insemination (AI), Intrauterine Insemination (IUI), In-vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), Assisted Reproductive Technologies (ART), Intra Cytoplasmic Sperm Injection (ICSI) and other similar infertility procedures that are recommended by your attending physician.
 - Egg, embryo, and sperm cryopreservation, thawing, transfer and storage, as requested by the member. There is to be no limit on the number of months of storage, subject to the \$25,000 maximum for the entire time the person is covered under the Plan. Coverage is to be available for these services whether or not medically necessary.
 - Reversal of a tubal ligation or vasectomy.
 - The following limitations apply:
 - ❖ The service or procedure must be medically necessary, unless otherwise noted above.
 - ❖ The service or procedure must be prescribed by the patient's in-network physician.
 - ❖ The service or procedure must be performed by an in-network provider (unless a network gap exception has been approved by the Network/Claim Administrator).
 - ❖ The benefit requires pre-certification. However, prior claims may be paid once pre-certification has been approved by the Network/Claim Administrator.
 - ❖ Expenses incurred by a donor or surrogate who is not the covered employee or the covered Eligible Dependent under the Plan are not Eligible Medical Expenses.
 - ❖ There is no coverage for Pre-implantation Genetic Screening (PGS). However, there is coverage for Pre-implementation Genetic Diagnosis (PGD).
 - See the "[Excluded Expenses](#)" section for Infertility Treatment services that are excluded from coverage.
- **Infertility medications:** Medications used to treat infertility or to promote fertility are covered by the self-funded Medical Benefit Options, subject to an overall maximum of \$15,000 per person, for the entire time such person is covered under the Plan.
 - **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. Precertification is required for all Out-of-Network Hospitalizations. Failure to do so will result in a \$250 penalty.

- **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 (including 3-D mammograms) (diagnostic - required as part of a work-up for symptoms or a medical condition):** Diagnostic mammograms are covered, regardless of age, under all Medical Benefit Options both In-Network and Out-of-Network.
- **Mammograms (including 3-D mammograms) (routine screening or preventive):** In-Network, routine screening mammograms are covered under all Medical Benefit Options at 100%, as described in the U.S. Preventive Services Task Force A or B recommendations. Please click here to view those recommendations:
<https://www.uspreventiveservicestaskforce.org/BrowseRec/Index>
- **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.
- **Mental health and chemical dependency care:** 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.** Residential treatment is covered if:
 - ❖ The stay satisfies the criteria for Medical Necessity; or
 - ❖ The stay is required for successful completion of a program designed to satisfy FAA Regulations (14 CFR 67.401) pertaining to special issuance of medical certificate.
 - **Outpatient mental health care**
 - **Chemical dependency rehabilitation**
 - ❖ Medically Necessary chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be Inpatient, Outpatient or a combination. There are no limits on the number of chemical dependency rehabilitation programs a participant may attend (regardless of whether the program is Inpatient or Outpatient).
 - ❖ You must obtain approval from the American Airlines On-Site Employee Assistance Program for all cases resulting from regulatory or Company policy violations. In all other instances, On-Site Employee Assistance Program approval is not required for an Inpatient or Outpatient chemical dependency rehabilitation treatment.
 - ❖ The Medical Benefit Options do not cover expenses for a family member to accompany the patient being treated, although many Chemical Dependency Treatment Centers include family care at no additional cost.
 - **Detoxification:** Under the STANDARD, VALUE, CORE and OUT-OF-AREA Medical Benefit Options, such treatment is covered in the same way that other mental health and chemical dependency benefits are covered depending upon the type of services (i.e., Outpatient, In-Network; Outpatient, Out-of-Network; Inpatient, In-Network; Inpatient, In-Network; Inpatient, Out-of-Network; emergency services and pharmacy services).

- **Multiple Surgical Procedures:** Reimbursement for simultaneous 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 Maximum Out-of-Network Charge (MOC) Fee Limits. To determine the amount of coverage, contact your Network/Claim 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. Therefore, the baby must be enrolled in coverage for his/her newborn claims to be covered. 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 31 days of the birth. If you miss the 31-day deadline you will not be able to add your baby to your coverage until the next Annual Enrollment Period unless you experience another qualifying life event, 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 Benefit Option will pay room and board, anesthesia and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the Medical Benefit Options. However, they may be covered under the Dental Benefit Options.
- **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/Claim 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," below.

- **Pregnancy:** Charges in connection with pregnancy, for female employees, female Spouses, Common Law Spouses, and covered female dependent of the employee. 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 your Network/Claim Administrator to participate in their pregnancy programs if you are enrolled in the self-funded Medical Benefit Options. United Healthcare's program is the "Healthy Pregnancy Program (HPP)", and Blue Cross Blue Shield of Texas' program is "Special Beginnings". This is offered at no cost to employees and their covered dependents. See the [Contacts](#) section for information on how to contact these programs.
 - 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.

- **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 Over-the-Counter covered with a Prescription if required by PPACA.
 - Prescriptions for the treatment of obesity or weight control are covered only for the diagnosis of morbid obesity.
 - Oral contraceptive drugs, patches, implants, transdermal, and intravaginal contraceptives are covered if purchased through mail order or at any local CVS or Safeway-owned retail pharmacies.
 - 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 up to 100% if you or your covered dependents are participating in the StayWell Prescription Program, and you purchased them from ESI mail order or the ESI Smart 90 Program.
 - Medications or products used for smoking or tobacco. All Participants under the Plan are eligible to receive two, 90-day courses of tobacco cessation medication, with a prescription from your doctor (either for drugs that are only available with a prescription or drugs that are available over-the-counter). When this benefit is exhausted, additional benefits are available under the Knock Out Nicotine program.
 - Prescription medications that treat infertility are covered, subject to a \$15,000 per person the entire time the person is covered by the Plan.
 - Certain types of medicines and drugs that are not covered by the Medical Benefit Options 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.
 - The Company provides non-grandfathered group health plans that comply with the PPACA preventive care requirements.
 - Preventive care focuses on evaluating your current health status when you are symptom free.
 - Preventive services include those performed on a person who:
 - ❖ has not had a preventive screening done before and does not have symptoms or other a documented related existing care related to the outcomes of the screening
 - ❖ has had diagnostic screenings that were normal after which your Physician recommends future preventive screening
 - ❖ has a preventive service done that results in a therapeutic service done at the same time (e.g. polyp removal during a preventive colonoscopy)
 - The Company follows the USPSTF Grade A & B recommendations, CDC and HRSA guidelines for preventive care. To get a full list of In-Network preventive care covered at no cost to you visit

<https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/> or <https://www.healthcare.gov/preventive-care-benefits/>

- Some preventive services have age and frequency limitations. These limitations can be based on Medical Necessity, medical review boards of the carriers in which we partner with to provide health care services and PPACA. Call your Network/Claim Administrator for details on coverage.
 - If you receive preventive care at any location other than a Physician's office such as Urgent Care or emergency room, or from an Out-of-Network Provider, services may not be covered at 100%.
 - Your health care Provider determines how you are billed for all health plan expenses. When a service is performed for the purpose of preventive screening and is appropriately billed as such by your Provider, then it will be covered under preventive services.
- **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 Wal-Mart, etc.) and you are enrolled in the STANDARD or OOA Medical Benefit Option 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, 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.

- **Stand-by Surgeon:** Only covered when the procedure makes it Medically Necessary to have a stand-by surgeon, and when the stand-by surgeon is physically present at the facility. To determine whether a stand-by surgeon is considered Medically Necessary, use the CheckFirst pre-determination procedure.

- **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.)

- **Telehealth:** The Plan will cover live face to face video consultations for medical benefits for participants enrolled in one of the self-funded benefit options. These medical benefits are offered by Doctor on Demand, a telehealth service offering video medical visits through a secure mobile app. Doctor on Demand's contracted providers can diagnose, treat and write prescriptions for a wide range of non-emergency medical issues. The Plan has contracted with Doctor on Demand to include these medical providers as network providers. The Doctor on Demand service is available 24 hours a day, seven days a week by computer,



tablet or smartphone. These medical services may not be available everywhere due to state law restrictions; check with Doctor on Demand for a list of states where medical services are not available. Doctor on Demand cannot provide treatment for chronic conditions like diabetes, or medical emergencies like chest pain or severe burns. The Plan has contracted with Doctor on Demand for medical benefits only. For more information about services and technological requirements, visit Doctor on Demand online at doctorondemand.com or call 800-997-6196.

- **Temporomandibular joint dysfunction (TMJD):** Eligible expenses under the Medical Benefit Options 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
 - Note that 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. Keep in mind that transplants must be preauthorized. The transplant will not be covered if preauthorization is not obtained.
 - 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/Claim Administrator can help you locate a transplant facility. These facilities specialize in transplant surgery and may have the most experience, the leading techniques and a highly qualified staff. Using an In-Network transplant facility is not required. However, use of an Out-of-Network facility will be covered at the Out-of-Network rate.
- It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria — not all transplant situations will be eligible for benefits. Therefore, you must contact your Network/Claim Administrator to initiate the QuickReview process as soon as possible for pre-authorization before contemplating or undergoing a proposed transplant.
 - **Travel Reimbursement.** See "[Travel and Lodging Reimbursement](#)" for information about when travel and lodging expenses may be reimbursed.
 - **Artificial Cervical Disc Implantation.** Although disc implantation uses artificial disc materials, it is replacing the damaged natural disc tissue in the space between vertebrae in the spine and is categorized here as a transplant. It is subject to the same requirements as all other covered transplants. All of the following criteria must be met for the procedure to be covered:
 - ❖ The patient must use an FDA-approved prosthesis (if a two adjacent level implantation is planned, the prosthesis must be FDA-approved for use in a two-level procedure);
 - ❖ Implantation must be either a single level in the cervical spine or two adjacent levels in the cervical spine;
 - ❖ Patient must be diagnosed with Degenerative Disc Disease with intractable radiculopathy (nerve root pain with weakness, numbness, movement difficulties) and/or myelopathy (inflammation causing neural deficit in the spinal cord);
 - ❖ Patient must be skeletally mature;
 - ❖ Patient must have either a herniated disc OR osteophyte formation;
 - ❖ Patient must have documented history of neck and/or arm pain and/or functional impairment at the corresponding cervical level; and
 - ❖ Patient must have failed at least six weeks of non-operative treatment.

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 Benefit Options, as determined in the sole discretion of the Plan Administrator and its delegate, the Network/Claim Administrator:

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

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

- **Transportation expenses:** Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide Inpatient treatment not locally available. Only one round-trip is covered for any illness or injury and will be covered only if medical attention is required en route.
 - For information on ambulance services, see “Ambulance” in this section.
- **Travel and Lodging Reimbursement:**
 - Travel and lodging assistance is only available if:
 - (1) You receive care at an eligible Center of Excellence (COE) for one of the following surgeries:
 - ❖ Transplant
 - ❖ Cancer
 - ❖ Congenital heart disease
 - ❖ Bariatric surgery
 - Or (2) you receive care at an In-Network surgery Provider for gender reassignment surgery.
 - These surgeries are 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 (for gender reassignment surgery) or a Center of Excellence 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 (for gender reassignment surgery) or surgery at a Center of Excellence. You are only allowed to travel In-Network (for gender reassignment surgery) or to a Center of Excellence 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/Claim Administrator for instructions on receiving reimbursement for your expenses.

- **Tubal ligation and vasectomy:** These procedures are covered; however, reversal of these procedures is not covered, except under the CORE Medical Benefit Option.
- **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/Claim 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:** The wig must be prescribed by a Physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery or severe burns. This benefit is subject to the MOC Fee Limits, Deductibles, Co-Pays, Co-Insurance and Out-of-Pocket limits of the selected Medical Benefit Option. The maximum benefit available for wigs and hairpieces is \$1,000 for the entire time that a person is covered under the Plan. Hair transplants, styling, shampoo and accessories are 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, procedures, 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.
- **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 Services:** The Plan does not pay the cost of Educational Services (except for ABA Therapy under the CORE benefit option only, if medically necessary). This exclusion applies regardless of the condition being treated.
- **Erectile Dysfunction Treatment:** Procedures or devices (not including devices used to administer prescribed medication), administered or recommended to treat erectile dysfunction or other sexual dysfunction, or for the purpose of producing, restoring or enhancing sexual performance/experience.
- **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
- **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 (GRB):** Covered under the STANDARD and CORE Medical Benefit Options only. Any expenses received from an Out-of-Network Provider will not be payable.
- **Government-paid care:** Care, treatment, services or supplies provided or paid by any governmental plan or under any 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 services:**

- STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options: 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.

- CORE Medical Benefit Option: The following Infertility Treatment services are not covered:
 - ❖ Expenses related to a donor or surrogate, unless the donor or surrogate is a covered member of the Plan.
 - ❖ Experimental or Investigational Services or Supplies.
 - ❖ Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.

- **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.
- **Non-Emergency or Non-Urgent Care While Traveling Outside the United States:** Any non-emergency or non-Urgent Care such as routine Physician care or preventive care, or care, treatment, or procedures that you arrange before you arrive in a foreign country, is not covered when you travel abroad, for employees on the U.S. payroll. Note that this exclusion does not apply to expatriates who are living abroad. Please see the section "[Care While Traveling Out of the Country](#)" for more information.

- **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."](#)

- **Over-the-Counter-medication (OTC):** Over-the-Counter medications are not covered under the Medical Benefit Options.

- **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
 - Oral contraceptive drugs, patches, implants, transdermal, and intravaginal contraceptive purchased from any other retail pharmacies that are not CVS or Safeway owned.
 - 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 PPACA.
 - Drugs prescribed for cosmetic purposes (such as Minoxidil)
 - 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 that Participants under the Plan are eligible to receive two, 90-day courses of tobacco cessation medication, with a prescription from your doctor (either for drugs that are only available with a prescription or drugs that are available over-the-counter). When this benefit is exhausted, additional benefits are available under the Knock Out Nicotine program.
 - Prescription medications not approved for the condition being treated; Prescription medications compounded with ingredients not approved by the US Food and Drug Administration (FDA); Prescription medications prescribed

and/or utilized or administered in a manner other than what has been FDA-approved for the medication; Prescription medications utilized or administered with quantities, dosages, or routes of administration not approved by the FDA

- **Preventive care:** Not all preventive care may be covered. Consult your Network/Claim 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, Child, brother, sister, parent or grandparent of you or your Spouse, including adopted and step relatives).
- **Reversal of tubal ligation and vasectomy:** Reversal of these procedures is not covered under the STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options.
- **Sleep disorders:** Treatment of sleep disorders, unless it is considered Medically Necessary.
- **Speech therapy:** Except as described in “Covered Expenses,” expenses are not covered for losses or impairments caused by conditions such as learning disabilities, developmental disorders or progressive loss due to old age. Speech therapy of an educational nature is not covered.
- **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.
- **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/Claim 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 Federal Aviation Administration exams, performance testing and work hardening programs.

- **Wilderness/adventure therapy programs, residential or non-residential:**

Programs of group and/or individual therapy (irrespective of whether the diagnosed conditions or psychiatric, substance use/abuse, relationship issues, or other behavioral issues) focused on outdoor therapy, adventure therapy, wilderness therapy, “survival” therapy, “boot camp” therapy, and/or similar type of treatment protocols and 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.

Network/Claim Administrator

A Network/Claim Administrator is the administrator for the Medical Benefit Options that processes health care claims, determines Medical Necessity, and manages a Network of health care Providers and care facilities.

Network/Claim Administrator Responsibilities

Your Network/Claim 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/Claim Administrator also processes claims, negotiates fees and contracts with care Providers.

Your Network/Claim Administrator 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/Claim 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.

Participants in the self-funded Medical Benefit Options may also have access to medical case management through their Network/Claim Administrator.

Who is my Network/Claim Administrator?

The Plan's self-funded Medical Benefit Options (STANDARD, VALUE and CORE) are administered by two Network/Claim Administrators:

- Blue Cross and Blue Shield of Texas (BCBS)
- United Healthcare (UHC)

The OUT-OF-AREA Medical Benefit Option is administered by United Healthcare.

Your Network/Claim Administrator is determined by the ZIP code of your alternate address on record (your benefits address for U.S. Airways, Inc. employees). If you do

not have an alternate address listed in the [Update MY Information](#) page of Jetnet (or for U.S. Airways, Inc. employees, a benefits address listed on MyHR, http://wings.usairways.com/uswings/human_resources/myhr), your Network/Claim Administrator is based on your permanent address. The map of the Network/Claim Administrators by state can be found on my.aa.com.

Relocation and my Network/Claim Administrator

If you relocate to a new state, your Medical Benefit Option election and contribution rates remain the same for the remainder of the Plan Year. Your Network/Claim Administrator may change based on your relocation.

When you move from one Network/Claim Administrator to another either at Annual Enrollment or due to a life event, you may have a need for transition of care. If your Network/Claim 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/Claim Administrator to evaluate your need for transition of care. This allows you to continue with your current 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/Claim Administrator. Contact your Network/Claim Administrator for more information. Go to my.aa.com to learn more.

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

When you experience one of the below changes during the year, you may have to select a different Medical Benefit Option or be assigned a different Network/Claim Administrator:

- relocate and your Medical Benefit Option is no longer available in your new location, or
- retire, or
- you or your dependents move from active coverage to COBRA coverage.

In the event that this does occur, your Deductibles and Out-of-Pocket Maximums **may or may not** carry over to your new Medical Benefit Option or Network/Claim Administrator. Please contact American Airlines Benefits Service Center for more information. 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	will not carry over

If...	Your Deductible and Out-of-Pocket Maximum...
your transfer/relocation area	
<p>You declined coverage because you or your dependents had coverage elsewhere, and then that coverage was lost</p> <p>You want to add medical coverage for yourself and/or your dependents as a result of your marriage, birth/adoption of a Child</p> <p>Your other medical coverage was COBRA and you exhausted your COBRA coverage;</p> <p>Your other coverage was lost due to that Plan Sponsor's termination of its plan or if contributions were no longer paid for the other coverage</p> <p>Your other medical coverage was lost because you no longer lived in the service area.</p>	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

Filing Claims

How to File a Claim

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](#). 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.
- Submit the completed form to your Network/Claim 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/Claim 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. In most cases, the EOB will be mailed to you and the payment mailed to your Provider. EOBs are also available on your Network/Claim Administrator's website.

If you have questions about your coverage or your claim under your enrolled Medical Benefit Option, contact your Network/Claim Administrator (see "[Contact Information](#)" in the *Reference Information* section).

Please see the "[Claims Procedures](#)" chapter for a detailed description of the claims procedures that apply to your Medical benefits.

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 HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Pre-certifying Care for Certain Medical Services

CheckFirst (Predetermination of Benefits)

CheckFirst allows you to find out if:

- **The recommended service or treatment is covered by your selected Medical Benefit Option.**
- **Your Provider's proposed charges fall within the Plan's usual fees (applies only to Out-of-Network expenses under the Medical Benefit Options).** If you are receiving discounted Provider's fees, or if you are using In-Network Providers, the Provider's fees are not subject to Maximum Out-of-Network Charge Fee Limits. However, you may want to contact your Network/Claim Administrator at the appropriate CheckFirst number for your Medical Benefit

Option to determine if the proposed services are covered under your selected Medical Benefit 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/Claim Administrator to obtain a pre-determination of benefits by phone or to request the pre-determination form.

Please note that even if you use CheckFirst, your Network/Claim 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.).

If you are having surgery, your Network/Claim Administrator (as part of your Network/Claim Administrator's hospital pre-authorization process) will determine the Medical Necessity of your proposed surgery before making a pre-determination of benefits. Your Network/Claim Administrator will mail you a written response.

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/Claim Administrator for your Medical Benefit Option for pre-authorization (see "[QuickReview](#) (Pre-Authorization)"). Although you may find CheckFirst beneficial whenever you need medical treatment, the Plan recommends that you use it in some circumstances and requires that you use it in other circumstances.

<i>CheckFirst Recommended</i>	
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.
Stand-by surgeon	A fee for a stand-by surgeon is only covered when there is a demonstrated Medical Necessity and the stand-by surgeon is physically present in the facility during the surgery. 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.
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<i>CheckFirst Required</i>	
Applied Behavioral Analysis Therapy (CORE Option Only)	The Plan requires that you pre-determine your coverage for ABA benefits because benefits are only covered for certain providers (see the CORE Benefit Option section). If you use CheckFirst after your first visit, the Plan will pay for <i>all</i> approved services, even those that occurred before you used CheckFirst. But, if you wait until after the first visit and pre-certification is denied, then you will be responsible for the full amount.
Infertility Coverage (CORE Option Only)	The Plan requires that you pre-determine your coverage for infertility benefits because benefits are only covered for certain providers (see the CORE Benefit Option section). If you use CheckFirst after your first visit, the Plan will pay for <i>all</i> approved services, even those that occurred before you used CheckFirst. But, if you wait until after the first visit and pre-certification is denied, then you will be responsible for the full amount.
Home Health Care	The Plan requires that you pre-determine your coverage for home health care benefits. If you use CheckFirst after your first visit, the Plan will only cover approved benefits after you used CheckFirst. You will be responsible for the full amount until you use CheckFirst.

QuickReview (Pre-Authorization)

You or your Provider acting on your behalf are required to request pre-authorization from your Network/Claim Administrator in the following circumstances. 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 you do not contact your Network/Claim Administrator, your expenses are still subject to review and will not be covered under the Plan if they are considered not Medically Necessary. **Failure to pre-authorize will result in a \$250 penalty per Out-of-Network Hospitalization.** If you are enrolled in one of the self-funded Medical Benefit Options, request pre-authorization by calling your Network/Claim Administrator. If you are covered by an HMO, contact your HMO before any Hospitalization.

If your Physician recommends surgery or Hospitalization, ask your Physician for the following information before calling your Network/Claim 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/Claim Administrator, any of the following may call on your behalf:

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

Your Network/Claim 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/Claim 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/Claim Administrator as far in advance as possible.

After you are admitted to the hospital, your Network/Claim 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/Claim 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/Claim Administrator again to authorize any additional Hospitalization.

QuickReview Required*	
<ul style="list-style-type: none"> • Before any hospital admission, • Within 48 hours (or the next business day if admitted on a weekend) following emergency care, • Before Outpatient surgery to ensure that the surgery is considered Medically Necessary. (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.) • Before you undergo testing or treatment for sleep disorders • Before you contemplate or undergo any organ transplant (If you do not call, your claim will be denied.) • Before you undergo any procedure that will incur a substantial expense 	<p>The Plan requires that you pre-authorize your coverage for benefits received at in-network and out-of-network facilities to ensure that these benefits are medically necessary and covered under the plan. If you do not pre-authorize an admission to an out-of-network hospital, you will be subject to a \$250 penalty, and you may be responsible for the full amount of the charges for the procedure or service.</p>
Bariatric Surgery	<p>The Plan requires that you pre-authorize your coverage for bariatric surgery to assist you in finding a qualified provider. If you do not pre-authorize you might be subject to a \$250 penalty, and you may be responsible for the full amount of the charges for the procedure or service if you do not meet the requirements for the surgery.</p>
Gender Reassignment Surgery	<p>For Gender Reassignment Surgery, the Plan requires you have approval from the Network/Claim Administrator both at the time you begin your treatment and at the time you are admitted for surgery. See the “Covered Expense” section for more information.</p>

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

Please note that 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.).

Care While Traveling Out of the Country

As part of your U.S. enrolled medical and dental coverage, emergency and Urgent Care will be covered under your elected Benefit Option when you travel out of the country. Before leaving the country, contact your Network/Claim Administrator for details on coverage and services:

- BlueCross BlueShield Worldwide Benefits 1-800-810 BLUE or collect 1-804-673-1177
- United Healthcare Out-of-Country Benefits 1-866-802-8572
- MetLife International Dental 1-888-558-2704 or collect 1-312-356-5970

Emergency Care: If you have a medical Emergency while traveling, get medical attention immediately. Your medical plan coverage can be managed after you have received the attention you need.

Urgent or Immediate Care: If you need urgent or immediate (not emergency) care, you should call your Network/Claim Administrator for a list of In-Network Providers and Urgent Care facilities. If it is after hours, seek treatment and call your Network/Claim 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.

Non-Emergency or Non-Urgent Care: Any non-emergency or non-Urgent Care such as routine Physician care, preventive care, or care, treatment, or procedures you arrange before you arrive in the foreign country, is not covered when you travel abroad. Note that this exclusion does not apply to expatriates who are living abroad.

If you have Basic AD&D coverage or Voluntary AD&D coverage (for Ground Employees) or Voluntary Personal Accident Insurance (VPAI) (for Pilots and Flight Attendants), you may also take advantage of travel assistance services through CIGNA Secure Travel, when you and your covered family members travel internationally for non-work related injuries or illness. See the [Travel Assistance Services](#) under Basic AD&D and Voluntary AD&D (for Ground Employees) or VPAI (for Pilots and Flight Attendants) section for additional information and contact details.



Expert Medical Opinion

Expert Medical Opinion program, provided by Advance Medical, is provided at no cost for employees and their Eligible Dependents enrolled in any American Airlines medical option. Note that employees and their Eligible Dependents must be enrolled in the Plan to have access to this service under the Plan.

Advance Medical at a glance

Expert Medical Opinion IS: a way to get an independent opinion from a leading medical specialist, to help you choose the best care possible.

- You register securely online and submit your medical records.
- A specialist reviews your individual situation and provides a second opinion comprehensive report, securely online.
- Physicians are available for follow-up.
- Service is voluntary, completely confidential, and offered at no cost to you.
- **Expert Medical Opinion IS NOT:** a substitute for direct medical care.
- **Expert Medical Opinion IS NOT:** a resource for confirming every medical diagnosis, a physician referral service, or an alternative means of certifying a disability.

Additional Resources:

For more information, please call (855) 212-1074 or visit www.advance-medical.net/AA.

Wellness Resources

The Plan includes a wellness program, described below. American Airlines also offers biometric screenings and wellness challenges outside the Plan, which are also described below. For more information, please call 888-383-8740 or (on or after January 1, 2016) visit www.webmdhealth.com/AmericanAirlines.

Wellness Program

American Airlines' wellness program is provided at no cost for employees and family members enrolled in the STANDARD, CORE, VALUE, or OOA medical options. The wellness program consists of the following benefits:

- WebMD Wellness
 - Health assessment: Individuals can complete a 15-minute online questionnaire to answer questions about their health habits. They will get

- “action alerts” to help them start healthy new habits. If individuals complete the assessment, they can earn \$50 in wellness rewards.
- Health coaching: The wellness program’s health coaches will help individuals develop a personal action plan to eat healthier, manage stress, stop smoking, lose weight, or attain other health goals, and provide ongoing support to keep them on track.
 - Rewards: If individuals complete health-related activities throughout the year, they can earn up to \$250 in wellness rewards. Activities include working toward wellness goals (weight, physical activity, nutrition or stress), preventive care, and biometric screenings.
 - Wellness Challenges: Individuals or groups of people can work toward common goals such as regular physical activity.
 - Online Wellness Portal: The full-service wellness e-portal provides access not only to an online health assessment, but also to online learning modules, trackers, and other exciting features to support you in your wellness journey. The e-portal is mobile accessible.
- Health Condition Management
 - Medical condition management: Individuals can work one-on-one with a personal nurse coach for help with long-term health conditions, such as heart disease, diabetes, cancer, asthma or other serious conditions. They can learn more about their serious condition and make a plan for managing their health today and in the future.
 - 24-hour nurse line: Individuals can speak with a nurse coach 24/7.
 - Enhanced care management: Individuals can get help with medical conditions that need extra care. The care management program will guide them through doctor visits, treatment programs or hospital admissions, and help them know their options.
 - Biometric Screening – wellness rewards
 - Individuals who complete the biometric screening (described in the section below) will earn \$100 in wellness rewards (if enrolled in the Core, Standard, Value, PPO, or Out-of-Area medical option).
 - StayWellRx
 - Individuals can receive a 90-day supply of diabetes and blood pressure drugs when they enroll in StayWellRx (free for generic drugs, or \$15 for brand name drugs), if the medicine qualifies. Individuals must call WebMD every 12 months to make sure the medicine qualifies.
 - Knock Out Nicotine

- All Participants under the Plan are eligible to receive two, 90-day courses of tobacco cessation medication, with a prescription from your doctor (either for drugs that are only available with a prescription or drugs that are available over-the-counter). When this benefit is exhausted, additional benefits are available under the Knock Out Nicotine program. This consists of up to two, four-week courses of over-the counter tobacco cessation medication, with a prescription from your doctor. Note that effective in June 2016, this may be increased. Please call WebMD for more information.

Biometric Screening

American Airlines offers biometric screenings outside the Plan. All U.S.-based American Airlines employees are eligible for a Bio-IQ screening at no cost, regardless of whether or not they are enrolled in an American Airlines' medical benefit option. When individuals complete their biometric screening, they receive results which contain an action plan.

Wellness Challenges

American Airlines offers wellness challenges outside the Plan. All U.S.-based American Airlines employees are eligible to participate at no cost, regardless of whether or not they are enrolled in an American Airlines' medical benefit option. Individuals or groups of people can work toward common wellness goals such as regular physical activity.

Employee Assistance Programs (EAP)

Optum Employee Assistance Program (EAP)

The Optum EAP provides private, 24/7 resources to help you and your family with change, challenges, coping or crisis. All mainline, U.S.-based employees and members of their household have free access to the EAP and can speak confidentially with a licensed counselor about personal issues, big or small:

- Personal or emotional challenges
- Mediation services
- Conflict resolution
- Care of an elderly parent
- Relationship issues
- Community resources
- Child/Parenting support services
- Concierge Services

Telephonic counseling is free and employees have the option to meet with a counselor for up to four free in-person counseling sessions. If you are covered under BCBS and

would like to continue to meet with your counselor after your four free sessions, please check with BCBS Member Services before beginning your counseling to ensure they are an in-network provider.

American Airlines On-Site Employee Assistance Program (EAP)

This program 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/Claim 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/Claim 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 on-site EAP, call 1-800-555-8810.

Additional Rules That Apply to Your Medical Coverage

Statement of Rights Under the Newborns’ and Mother’s Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending Provider (e.g., your Physician, Nurse midwife, or Physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a Provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain Providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator or Network/Claim Administrator.

Also, under federal law, plans may not set the level of benefits or Out-of-Pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the Schedule of Benefits.

If you would like more information on WHCRA benefits, call your Plan Administrator.

Prescription Drug Program

[How the Prescription Drug Benefit works](#)

[Retail Drug Coverage](#)

[Express Scripts Smart 90 Program](#)

[Express Scripts Mail Order](#)

How the Prescription Drug Benefit works

Prescription drug coverage is based upon a formulary. The amount of Co-Insurance you pay under the STANDARD, VALUE and OUT-OF-AREA Medical Benefit Options 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) is the Prescription drug vendor for the STANDARD, VALUE, CORE, and OUT-OF-AREA Medical Benefit Options. 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

Overview

To maximize your prescription drug benefit under the Plan, 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.

For the STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options, the Co-Insurance amounts are the same whether you use an In-Network or Out-of-Network pharmacy. However, if you use an Out-of- Network pharmacy the negotiated discounted rates do not apply.

For the STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options, 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. Out-of-Pocket 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.

Please see the chart below for the Co-Insurance requirements for retail drug coverage by Medical Benefit Option.

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Prescription Medication							
RETAIL Pharmacy (typically a 30-day supply)	Generic: <ul style="list-style-type: none">• 20%• \$10 min• \$40 max Preferred Brand: <ul style="list-style-type: none">• 30%• \$30 min• \$100 max Non-Pref Brand: <ul style="list-style-type: none">• 50%• \$45 min• \$150 max	Generic: <ul style="list-style-type: none">• 20%• \$10 min• \$40 max Preferred Brand: <ul style="list-style-type: none">• 30%• \$30 min• \$100 max Non-Pref Brand: <ul style="list-style-type: none">• 50%• \$45 min• \$150 max	20% after Deductible (In-Network) 40% after Deductible (Out-of-Network)		Generic: <ul style="list-style-type: none">• 20%• \$10 min• \$40 max Preferred Brand: <ul style="list-style-type: none">• 30%• \$20 min• \$75 max Non-Pref Brand: <ul style="list-style-type: none">• 50%• \$35 min• \$90 max	Generic: <ul style="list-style-type: none">• 20%• \$10 min• \$40 max Preferred Brand: <ul style="list-style-type: none">• 30%• \$20 min• \$75 max Non-Pref Brand: <ul style="list-style-type: none">• 50%• \$35 min• \$90 max	Generic: <ul style="list-style-type: none">• 20%• \$10 min• \$40 max Preferred Brand: <ul style="list-style-type: none">• 30%• \$30 min• \$100 max Non-Pref Brand: <ul style="list-style-type: none">• 50%• \$45 min• \$150 max
	Prescriptions are not subject to Deductible		Preventive medications are not subject to Deductible		Prescriptions are not subject to Deductible		

Filling Prescriptions for Retail Drugs

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
 - For the CORE Medical Benefit Option: Express Scripts will notify your Network/Claim Administrator of all amounts applied to the Deductible and Out-of-Pocket Maximum.

- For OUT-OF-AREA Medical Benefit Option: Express Scripts reports the claim for your Network/Claim Administrator. Any eligible amounts will be applied to your 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 below for more information on how to file a claim.
 - **Note:** If you purchase Prescription drugs at an Out-of-Network pharmacy, you will be reimbursed based on the Express Scripts discount price, **not** the actual retail cost of the medication, which means the amount you'll have to pay for your Prescription will be greater than if you used an In-Network retail pharmacy.
 - For OUT-OF-AREA Medical Benefit Option: Express Scripts reports the claim to your Network/Claim Administrator. Any eligible amounts will be applied to your Out-of-Pocket Maximum.

Reimbursement of Out-of-Pocket Expenses

If you are enrolled in the STANDARD, VALUE, or OUT-OF-AREA Medical Benefit Option and you participate in the Health Care Flexible Spending Account (HCFSAs), your eligible retail drug Out-of-Pocket expense is reimbursable under your HCFSAs (see “[Covered Expenses](#)” in the [Health Care Flexible Spending Account](#) section). If you have funds in your Health Reimbursement Account (HRA) (for STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options), you can use those funds to pay eligible retail drug Out-of-Pocket expenses once your HCFSAs funds have been exhausted.

Retail Refill Allowance – Long-Term Medications

You and your covered dependents will pay 50% of the drug cost for long-term Prescription medications at a retail pharmacy after your third purchase, unless you utilize retail pharmacies that are part of the ESI Smart 90 Program (see below for additional information). 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.

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.

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 Smart 90 Program

You and your covered dependents are eligible for the Express Scripts (ESI) Smart 90 Program. You may use this option to purchase a 90-day supply of the 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 can order medications on a 90-day supply basis through ESI's Smart 90 Program at a local CVS or Safeway-owned pharmacy, such as Tom Thumb, Randall's, Vons or Dominick's. Ordering medications on a 90-day supply basis will save you more money than if you fill your Prescriptions at other retail pharmacies not affiliated with the Smart 90 Program.

For the CORE Medical Benefit Option: When you fill your Prescription through the ESI Smart 90 Program, you must first satisfy your annual Deductible before benefits begin. Once you meet your Deductible, you pay 20% Co-Insurance for the cost of your Prescriptions purchased through the ESI Smart 90 Program.

Express Scripts Mail Order

Overview

You and your covered dependents are also eligible for ESI Mail Order, which is an alternative to the ESI Smart 90 Program. 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. Please see the chart below for Co-Insurance requirements.

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. As an alternative to mail order, you can utilize the ESI Smart 90 Program, discussed above.

There are no Out-of-Network mail order benefits.

For the STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options, 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, VALUE, CORE, and OUT-OF-AREA Medical Benefit Options through ESI Mail Order, when filled at a local CVS or Safeway-owned pharmacy, or if purchased from a retail pharmacy not affiliated with the Smart 90 program (for up to three fills only). If you are taking contraceptives specifically for the purpose of preventing pregnancy, please be aware some services have age and frequency limitations. These limitations can be based on Medical Necessity, which is determined by medical review boards of the carriers in which we partner with to provide health care services and PPACA. If you purchase contraceptives for reasons other than the prevention of pregnancy, the appropriate Co-Insurance will apply. If you purchase a brand name contraceptive that has a generic equivalent, you are responsible for the cost difference between the brand name and generic, unless your health care Provider determines that a generic contraceptive would be medically inappropriate.

For the CORE Medical Benefit Option only: You pay the applicable 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.

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In-Network	Out-of- Network	In-Network	Out-of- Network	In-Network	Out-of- Network	
MAIL ORDER (typically a 90 day supply)	Generic: <ul style="list-style-type: none"> • 20% • \$5 min • \$80 max Preferred Brand: <ul style="list-style-type: none"> • 30% • \$60 min • \$200 max Non-Preferred Brand <ul style="list-style-type: none"> • 50% • \$90 min • \$300 max 	Not covered	20% after the Deductible	Not covered	Generic: <ul style="list-style-type: none"> • 20% • \$5 min • \$80 max Preferred Brand: <ul style="list-style-type: none"> • 30% • \$40 min • \$150 max Non-Preferred Brand <ul style="list-style-type: none"> • 50% • \$70 min • \$180 max 	Not covered	Generic: <ul style="list-style-type: none"> • 20% • \$5 min • \$80 max Preferred Brand: <ul style="list-style-type: none"> • 30% • \$60 min • \$200 max Non-Preferred Brand <ul style="list-style-type: none"> • 50% • \$90 min • \$300 max

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,
 - ❖ Personal check or money order, or
 - ❖ Your Health Savings Account (HSA) debit card (for CORE Medical Benefit Option only).
 - 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.

Manufacturer Discount Cards/Coupons

The following expenses are not applied toward the annual network out-of-pocket maximum: Funds you may receive from drug manufacturers, state assistance programs (where permitted by law), pharmacy discount programs or other third parties to assist you in purchasing prescription drugs.

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 prescription drug 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, CORE, VALUE, or OUT-OF-AREA Medical Benefit Option. However, if you elected to participate in the Health Care Flexible Spending Account (HCFSA) (for STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options) or the Health Savings Account (HSA) (for CORE Medical Benefit Option), 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 or did not elect an HCFSA and have funds in your Health Reimbursement Account (HRA), you can receive reimbursement for your Co-Insurance from your HRA.

Dental Benefits

[Dental Benefits for Ground and Flight Employees](#)

Dental Benefits for Ground and Flight Employees

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 (PDP) Network dentists, but may benefit from cost savings when you do. You can request a customized directory of participating dentists in your area by visiting the [MetLife website](#) or calling MetLife at 1-866-838-1072.

You can request a customized directory of participating dentists in your area by visiting the [MetLife website](#) or calling MetLife at 1-866-838-1072.

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

MetLife's Role

Your Dental Benefit is self-funded by the Company. MetLife is the Network/Claim Administrator for the Dental Benefit. Visit the [MetLife website](#) or contact MetLife at 1-866-838-1072 for more information on the Dental Benefit.

Eligibility

Eligible Ground and Flight 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.

Coverage Levels – Ground Employees

These coverage levels apply to employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and Officers, Management/Specialists, and Support Staff:

- Employee
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

These coverage levels apply to TWU-represented employees:

- EE Only
- EE + 1 Dependent
- EE + 2 or more Dependents

Coverage Levels – Flight Employees

Eligible Flight Employees can elect from the following coverage levels:

Benefit Option	Coverage Levels
Dental Benefit Option 1	Employee Only Employee + One Employee + Two or more
Dental Benefit Option 2	Employee Only Employee + One Employee + Two or more
Standard Dental Option	Employee Only Employee + SP/Common Law Spouse Employee + Child(ren) Employee + Family

Cost-Sharing – Ground Employees

For Ground Employees, these are the cost-sharing 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:	
<i>Preventive Service - Services Provided by a Network Provider</i> Twice per year: exams and cleanings Once per year: routine X-rays	100% (Deductible does not apply)
<i>Preventive Service - Services Not Provided by a Network Provider</i> Twice per year: exams and cleanings Once per year: routine X-rays	80% (Deductible does apply) 100% for TWU-Represented employees

Feature	Benefit
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

Cost-Sharing – Flight Employees

For Flight Employees, these are the cost-sharing features of the Dental Benefit Option:

Feature	Dental Benefit Option 1	Dental Benefit Option 2	Standard Dental Option
Annual Deductible	\$50 per person (You pay this amount before benefits are paid)	\$50 per person (You pay this amount before benefits are paid)	\$50 per person (You pay this amount before benefits are paid)
Maximum Benefit (per person per year)	\$1,000	\$1,000	\$1,500
Dental Services All services count toward the Deductible.			
Preventive Service (2 exams and cleaning visits per year)	80% Deductible must be met before coinsurance applies	80% Deductible must be met before coinsurance applies	100% In-Network 80% Out-of-Network Deductible does not have to be met before coinsurance applies.
Complete Set of X-Rays	80% Full Mouth: One set every 36 months Bitewings: twice per calendar year Deductible must	80% Full Mouth: One set every 36 months Bitewings: twice per calendar year Deductible must	100% In-Network 80% Out-of-Network Full Mouth: One set every 60 months Bitewings: One

Feature	Dental Benefit Option 1	Dental Benefit Option 2	Standard Dental Option
	be met before coinsurance applies	be met before coinsurance applies	per calendar year for adults; twice per year for Child Deductible does not have to be met before coinsurance applies
Basic & Major Services (fillings, extractions, crowns, bridges, dentures)	80% Deductible must be met before coinsurance applies	50% Deductible must be met before coinsurance applies	80% Deductible must be met before coinsurance applies
Orthodontia			
Orthodontia Services	50% Deductible does not have to be met. Eligible Dependent Child only.	50% Deductible does not have to be met. Eligible Dependent Child only.	50% Deductible does not have to be met. Eligible adult or dependent Child.
Maximum Lifetime Orthodontia Benefit	\$1,000 (per Child)	\$1,000 (per Child)	\$1,500 (per adult or Child)

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

The Dental Benefit covers Medically Necessary Dental and orthodontic items and services for covered eligible adults and children.

There are two types of Covered Expenses:

- Preventive Services
- Basic and Major Services

Preventive Services:

- Exams twice per calendar year
- Routine X-rays
 - Ground Employees: once per calendar year
 - ❖ TWU-Represented employee adults can have bitewings twice a year
 - ❖ Children can have bitewings twice a year
 - Flight Employees: Once or twice per calendar year (depends on Dental Benefit Option)
 - ❖ Bitewings – Once or twice per calendar year (depends on Dental Benefit Option)
 - ❖ Children can have bitewings twice per calendar year
- Full mouth X-rays
 - Ground Employees: once every five years; once every three years for TWU-Represented employees.
 - Flight Employees: once every three years or five years (depends on Dental Benefit Option)
- 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:** Gold, 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 (if the tooth or teeth cannot be restored by any other means) 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.**
 - Ground Employees only: 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.
 - Flight Employees only: The Dental Benefit covers orthodontic treatment for eligible Children (including adults under Standard Dental Option) to a maximum of \$1,000 (\$1,500 under Standard Dental Option) during the entire time the individual is covered under the Dental Benefit.
 - Orthodontic coverage includes:
 - ❖ Examinations
 - ❖ X-rays
 - ❖ Laboratory tests
 - ❖ Other necessary treatments and appliances
 - There is no Deductible for orthodontic treatments, and payments for orthodontia do not reduce the annual maximum benefit for other services.

The following explains additional information about orthodontia coverage:

- **Ongoing orthodontic coverage:** To remain eligible for coverage of orthodontic treatments that extend into a new coverage period (for example,

the next calendar year), you must continue to cover the patient under your Dental Benefit during each Annual Enrollment Period.

- **Paying orthodontia claims:** Payment is made according to the following procedures (regardless of the payment method you arrange with your Provider):
 - ❖ The Provider of service (orthodontist) should submit one billing that reflects the total cost of the patient's orthodontic treatment – even if the duration of treatment moves across calendar years. The Dental Benefit will pay up to the maximum benefit of \$1,500 (for Ground Employees) or \$1,000 (for Flight Employees), 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 (for Ground Employees) or \$1,000 (for Flight Employees) 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, Children, adopted and step relatives, sisters and brothers, parents and grandparents of you or your Spouse.
- **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 Network/Claim Administrator 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.
- 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.).

Please see the “[Claims Procedures](#)” chapter for a detailed description of the claims procedures that apply to your Dental Benefits.

Spending Accounts: Certain Out-of-Pocket Dental expenses may be eligible for reimbursement from your Health Care Flexible Spending Account, Health Savings Account (CORE Medical Benefit Option), Limited Purpose Health Care Flexible Spending Account (CORE Medical Benefit Option), or Health Reimbursement Account (STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options). (See “[Covered Expenses](#)” in the [Health Care Flexible Spending Account](#) section.)

Injury by others: If you are injured by someone else and your Dental Benefit Option pays a benefit, the Company will recover payment from the third party (see “[Subrogation](#)”).

Claim Filing Deadline

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.

Vision Benefit

[How the Vision Insurance Benefit Works](#)

[Using In-Network Providers](#)

[Using Out-of-Network Providers](#)

[Covered Expenses](#)

[Claims Procedure](#)

[Complaint Procedure](#)

How the Vision Insurance Benefit Works

The vision insurance benefit, insured and administered by EyeMed, provides coverages for routine vision exams, as well as eyeglasses and contact lenses.

To locate EyeMed Vision Care providers near you, visit www.eyemed.com and choose the Insight Network. You may also call EyeMed's Customer Care Center at 1-844-714-5678. EyeMed's Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

You will receive an ID card when you enroll for the Vision benefit.

EyeMed's Role

Your Vision Insurance benefit is insured and administered by EyeMed. EyeMed is the Network/Claim Administrator for the Vision Insurance benefit. Visit the [EyeMed website](http://www.eyemed.com) or contact EyeMed at 1-844-714-5678 for more information on the Vision Insurance Benefit.

Eligibility

Eligible employees and their Eligible Dependents can enroll in Vision benefits, even if they do not elect medical coverage. You must elect Vision Insurance for yourself if you would like to cover any of your dependents under the Vision Benefit Option.

Coverage Levels

You can elect the following coverage levels:

- Employee Only
- Employee + Spouse
- Employee + Child(ren)
- Employee + Family

Using In-Network Providers

When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or plan number, located on the front of your ID card. Confirm the provider is an In-Network Provider for the network. While your ID card is not necessary to receive services, it is helpful to present your EyeMed Vision Care ID card to identify your membership in the vision insurance benefit.

When you receive services at a participating EyeMed network provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers

If you receive services from an out-of-network Provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the Covered Expenses and Cost-Sharing section (below). To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care, LLC.

Attn: OON Claims

P.O. Box 8504

Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-844-714-5678.

Covered Expenses and Cost-Sharing

The vision Insurance benefit includes the following services, at the following cost-sharing amounts:

	Your In-Network Cost	Your Out-of-Network Reimbursement*
Exam	\$10 co-pay	Up to \$40
Dilation as necessary	\$0	
Refraction	\$0	
Retinal Imaging	Up to \$39	N/A
Exam Options – Contact Lenses		
Standard Fit and Follow-Up	Up to \$55	N/A
Premium Fit and Follow-Up	10% off retail price	N/A
Frames	\$0 copay, \$140 Allowance, 20% off balance over \$140	Up to \$45
Standard Plastic Lenses		
Single Vision	\$25 copay	Up to \$40
Bifocal	\$25 copay	Up to \$60
Trifocal	\$25 copay	Up to \$80
Lenticular	\$25 copay	Up to \$80
Standard Progressive	\$25 copay	Up to \$60
Premium Progressive		
Tier 1	\$45 copay	Up to \$60
Tier 2	\$55 copay	Up to \$60
Tier 3	\$70 copay	Up to \$60
Tier 4	\$25 copay, 80% of charge less \$120 Allowance	Up to \$60
Standard Lens Options		
UV coating	\$0	Up to \$8
Tint (solid and gradient)	\$0	Up to \$8
Standard Plastic Scratch Coating	\$0	Up to \$8
Standard polycarbonate – Adults	\$0	Up to \$20
Standard polycarbonate – Kids Under 19	\$0	Up to \$20
Standard anti-reflective coating	\$40	Up to \$3

Premium anti-reflective coating		
Tier 1	\$52 copay	Up to \$3
Tier 2	\$63 copay	Up to \$3
Tier 3	80% of charge	Up to \$3
Polarized	20% off retail price	N/A
Photocromatic / Transitions Plastic	\$65	Up to \$5
Other add-ons and services	20% off retail price	N/A
Contact Lenses**		
Conventional	\$0 copay; \$150 allowance, 15% off balance over \$150	Up to \$150
Disposable	\$0 copay; \$150 allowance, plus balance over \$150	Up to \$150
Medically necessary	\$0 copay, Paid-in-Full	Up to \$210
LASIK or PRK from US Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency - based on calendar		
Exam	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 12 months	

* You must pay the out-of-network provider in full at time of service and then submit an out-of-network claim for reimbursement. You will be reimbursed up to the amount shown on the chart.

** For prescription contact lenses for only one eye, the Plan will pay one-half of the amount payable for contact lenses for both eyes.

Additional Discounts

Under the Plan, you may receive benefits for eyeglass frames, eyeglass lenses or contact lenses as outlined in the Covered Expenses and Cost Sharing section. In addition, EyeMed provides an in-network discount on products and services once your in-network benefits for the applicable benefit period have been used. The in-network discounts are as follows:

- 40% off a complete pair of eyeglasses (including prescription sunglasses)
- 15% off conventional contact lenses
- 20% off items not covered by the Plan at network providers

These in-network discounts may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed Provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Pursuant to Maryland and Texas law, discounts may not be available at all network providers. Prior to your appointment, you should confirm with your provider that discounts are offered.

Medically Necessary Contact Lenses

The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- **Anisometropia** of 3D in meridian powers
- **High Ametropia** exceeding -10D or +10D in meridian powers
- **Keratoconus** where the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses
- **Vision Improvement** for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

Retinal Imaging Benefit

The Plan provides coverage for retinal imaging, as described in the Covered Expenses and Cost-Sharing section. Retinal imaging is a diagnostic tool that provides high-resolution, permanent digital records of your inner eye. Please consult with your Provider to determine if you are a candidate for retinal imaging.

Laser Vision Correction

EyeMed, in connection with the U.S. Laser Network, owned and operated by LCA Vision, offers discounts to you for LASIK and PRK. You receive a discount when using

a network provider in the U.S. Laser Network. The U.S. Laser Network offers many locations nationwide. For additional information or to locate a network provider, visit www.eyemedlasik.com or call 1-877-5LASER6.

After you have located a U.S. Laser Network provider, you should contact the provider, identify yourself as an EyeMed member and schedule a consultation to determine if you are a good candidate for laser vision correction. If you are a good candidate and schedule treatment, you must call the U.S. Laser Network again at 1-877-5LASER6 to activate the discount.

At the time treatment is scheduled, you will be responsible for an initial refundable deposit to the U.S. Laser Network. Upon receipt of the deposit, and prior to treatment, the U.S. Laser Network will issue an authorization number to your provider. Once you receive treatment, the deposit will be deducted from the total cost of the treatment. On the day of treatment, you must pay or arrange to pay the remaining balance of the fee. Should you decide against the treatment, the deposit will be refunded.

You are responsible for scheduling any required follow-up visits with the U.S. Laser network provider to ensure the best results from your laser vision correction procedure.

Mail Order Contact Lens Replacement Program

You can save money by ordering replacement contact lenses at competitive prices through www.eyemedvisioncare.com/american. The contacts will be delivered directly to your home. Your plan allowance and discounts do not apply to this service.

Plan Exclusions

No benefits will be paid for services or materials connected with or charges arising from:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any vision examination, or any corrective eyewear required by a you as a condition of employment;
- Safety eyewear;
- Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Plano (non-prescription) lenses;
- Non-prescription sunglasses;
- Two pair of glasses in lieu of bifocals;
- Services or materials provided by any other group benefit plan providing vision care;
- Services rendered after the date you or your dependent ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to you or your dependent are within 31 days from the date of such order; or

- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when vision materials would next become available.

Sample Savings

The following examples illustrate how your benefit would be applied to the services received at an in-network provider's office or location:

If a member chooses to receive:

A comprehensive vision care examination:	you pay \$10.00
A frame up to a value of \$100:	you pay \$00.00
One pair of bifocal lenses:	you pay \$25.00
Ultraviolet coating:	you pay <u>\$00.00</u>
The total cost to the member is:	\$35.00

If a member chooses to receive:

A comprehensive vision care examination:	you pay \$10.00
A frame up to a value of \$200:	you pay \$48.00
A pair of single vision lenses:	you pay \$25.00
Standard anti-reflective coating:	you pay <u>\$40.00</u>
The total cost to the member is:	\$123.00

Claims Procedures

Please see the "[Claims Procedures](#)" chapter for a detailed description of the claims procedures that apply to your Vision benefits.

Complaint Procedure

If you are dissatisfied with an EyeMed Provider's quality of care, services, materials or facility or with EyeMed's Plan administration, you should first call EyeMed Customer Care Center at 1-844-714-5678 to request resolution. The EyeMed Customer Care Center will make every effort to resolve your matter informally.

If you are not satisfied with the resolution from the Customer Care Center service representative, you may file a formal complaint with EyeMed's Quality Assurance Department at the address noted above. You may also include written comments or supporting documentation.

The EyeMed Quality Assurance Department will resolve your complaint within thirty (30) days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than one hundred twenty (120) days after EyeMed's receipt of your complaint. Upon final resolution, EyeMed will notify you in writing of its decision.

Spending Accounts

[Overview](#)

[Health Care Flexible Spending Account \(HCFSA\)](#)

[Limited Purpose Flexible Spending Account \(LPFSA\)](#)

[Dependent Care Flexible Spending Account \(DCFSA\)](#)

[Health Savings Account \(HSA\)](#)

[Health Reimbursement Account \(HRA\)](#)

Overview

All Spending Accounts may require you to submit substantiation for claims you have made. This should be in the form of a paid receipt from the provider. Credit card receipts are not accepted as proof of payment or substantiation. EOBs are accepted as proof of payment or substantiation, as long as you supply the complete EOB, including the footnotes. Please supply the required documentation when requested to avoid the claims being reversed.

The Spending Accounts apply as follows:

Account	Applicable Medical Benefit Option	Notes
Health Care Flexible Spending Account (HCFSA)	STANDARD, VALUE, and OUT-OF-AREA	You do not have to be enrolled in an American Medical, Dental, or Vision Benefit to enroll.
Limited Purpose Flexible Spending Account (LPFSA)	CORE	It is ONLY for Dental and Vision expenses.
Dependent Care Flexible Spending Account (DCFSa)	STANDARD, VALUE, CORE, and OUT-OF-AREA	You do not have to be enrolled in an American Medical, Dental, or Vision Benefit to enroll.
Health Savings Account (HSA)	CORE	If you elect the CORE benefit option, the Plan cannot deposit earned wellness rewards UNLESS you accept the terms and conditions of the HSA when making your elections. In addition, if deposits are made to an HSA and you later change plans, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can ONLY be used for dental and vision expenses.
Health Reimbursement Account (HRA)	STANDARD, VALUE, OUT-OF-AREA	

Using Your Spending Accounts

You have three options to use the balance in your Spending Accounts:

1. YSA Health Card

If you are currently enrolled in a Flexible Spending Account (FSA) or Health Savings Account (HSA), you will use the same YSA card to access both FSA/HSA funds and your HRA. If you are not currently enrolled in an FSA or HSA, you will receive a new YSA Visa debit card in the mail to access your rewards. You must activate the card in order to use it to pay for eligible medical, dental, prescription, and vision expenses. Always be sure to save your receipts, as all Spending Accounts may require you to submit documentation.

2. Automatic Reimbursement

If you select the auto reimbursement method on the [Benefits Service Center YSA site](#), your HRA and FSAs will automatically reimburse you (via check or direct deposit) whenever you have a claim for eligible medical, dental, prescription, or vision expenses under the Plan. Note that auto reimbursement cannot be used for the HSA.

3. Submit Manual Claims

You may submit eligible medical, dental, prescription, and vision claims for reimbursement online, by mail, or by fax. Visit the [Benefits Service Center YSA site](#) or call YSA at 888-860-6178 for instructions and claim forms.

Health Care Flexible Spending Account (HCFSA)

How the Health Care Flexible Spending Account (HCFSA) 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.

Benefit Overview		
Option	Who Can Be Reimbursed	Key Features
HCFSA-Health Care FSA	<p>You can be reimbursed for expenses for:</p> <ul style="list-style-type: none">• You• Your Spouse• Your natural, step, adopted or foster children who will be below age 27 at the end of the year• Any individual:<ul style="list-style-type: none">○ who has the same principal place of abode as you○ is a member of your household, and	<ul style="list-style-type: none">• Deposit up to \$2,550 in 2017• Pre-tax contributions• Have until June 15 to file claims for previous year's eligible expenses• For your 2017 HCFSA, you have until December 31, 2017 to incur eligible claims• Up to \$500 remaining in your 2017 HCFSA will be carried over to the 2018 plan year• Eligible Dependents do not have to be covered under your

Benefit Overview		
Option	Who Can Be Reimbursed	Key Features
	<ul style="list-style-type: none"> ○ for whom you provide over half of his or her support for the year. 	<p>Medical, Dental or Vision Benefit</p> <p>Option to be eligible for reimbursement</p> <ul style="list-style-type: none"> ● If both you and your Spouse are employed by American Airlines, both employees may each deposit up to \$2,550 in an HCFSAs during 2017

Contributions

You can contribute through payroll deduction up to \$2,550 in 2017 in your HCFSAs. A minimum annual election amount of \$120 is required to complete enrollment.

At the beginning of each plan year, the full amount of your elected HCFSAs amount for the entire year is available for your use, regardless of the actual balance in your account.

Deadline to Incur Claims

For your 2017 HCFSAs, you have until December 31, 2017 to incur eligible claims and until June 15, 2018 to request reimbursement for those claims.

\$500 Carryover of Remaining Account Balance

If you have an HCFSAs in 2017, the Plan allows you to carryover up to \$500 of any amount remaining in your 2017 HCFSAs as of the end of the 2017 plan year. Such carryover amount may be used to pay or reimburse medical expenses incurred during all of 2018. Any unused amount of more than \$500 remaining in your 2017 HCFSAs at the end of the 2017 will be forfeited.

If you were a participant in the CORE Medical Benefit Option in the prior Plan Year and you do not elect to participate in the CORE Medical Benefit Option for the current plan year, and you have a remaining balance from the previous plan year in your Limited Purpose Health Care Flexible Spending Account, the remaining balance from the previous plan year (of up to \$500) will be credited to a HCFSAs for you. For example, if you are enrolled in the CORE Medical Benefit Option in year one, and have a Limited Purpose Health Care Flexible Spending Account balance of \$400, and you elect the STANDARD Medical Benefit Option in year two, \$400 will be credited to a HCFSAs for you, even if you do not elect to enroll in a HCFSAs.

If you elect to participate in the CORE Medical Benefit Option for a plan year and have a remaining balance from the prior plan year from your HCFSAs, the remaining balance from the previous plan year (of up to \$500) will be credited to a LPFSA for you, even if you do not elect to enroll in a Limited Purpose Health Care Flexible Spending

Account. For example, if you were enrolled in the VALUE Medical Benefit Option in year one, and you have a HCFSA balance of \$300, and you elect the CORE Medical Benefit Option in year two, \$300 will be credited to a LPFSA for you, even if you do not elect to enroll in a Limited Purpose Health Care Flexible Spending Account.

Account Administrator

The HCFSA administrator is Your Spending Account (YSA). The [YSA 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.

Special Provisions

Special rules apply to mid-year election changes to your HCFSA:

- 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 stop or 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. 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 have had any deposits to an HSA during the plan year, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision.

If you experience a Qualifying Event (as described in the COBRA chapter), your HCFSA terminates.

- As described in the COBRA chapter, you may elect to continue your HCFSA as part of your COBRA continuation of coverage options, for the remainder of the calendar year in which you became eligible for continuation of coverage. In addition, the Plan allows you to carryover up to \$500 of any amount remaining in your HCFSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the COBRA continuation period (i.e. 18, 29, or 36 months, as applicable). Any unused amount of more than \$500 remaining in your HCFSA at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.



- If you do not continue your HCFSAs 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

Expenses that can be reimbursed through an HCFSAs 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 medicine/drugs purchased with a Physician's written Prescription (or insulin) and used to alleviate or treat personal injuries or sickness of the employee and/or the Eligible Dependents may be eligible for reimbursement through your HCFSAs. For instance, bandages, crutches and contact lens solution, and the like. Refer to the list of eligible items by visiting the [YSA website](#).
- **Reimbursable Medical Expenses.** Some medical expenses may not be covered at all by your Medical Benefit Option. However, some of those expenses may be reimbursed under your HCFSAs. 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 Maximum Out-of-Network Charge
 - 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, including the following:

- 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 drugs/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

You have until June 15 to file claims on your previous year's eligible expenses.

Participants who have a Health Care Flexible Spending Account may file claims on the [YSA 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 [YSA website](#).

Please see the "[Claims Procedures](#)" chapter for a detailed description of the claims procedures that apply to your Health Care Flexible Spending Account benefits.

Limited Purpose Flexible Spending Account (LPFSA)

How the Limited Purpose Flexible Spending Account (LPFSA) Works

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.

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 Medical Benefit Option	You can be reimbursed for expenses for: <ul style="list-style-type: none">• You• Your Spouse• Your natural, step, adopted or foster children who will be below age 27 at the end of the year• Any individual:<ul style="list-style-type: none">○ who has the same principal place of abode as you○ is a member of your household, and○ for whom you provide over half of his or her support for the year.	<ul style="list-style-type: none">• Deposit up to \$2,550 in 2017• Pre-tax contributions• Have until June 15 to file claims for previous year's eligible expenses• For your 2017 LPFSA, you have until December 31, 2017 to incur eligible claims• Up to \$500 remaining in your 2017 LPFSA will be carried over to the 2018 plan year• If both you and your Spouse are employed by American Airlines, both employees may each deposit up to \$2,550 in an LPFSA during 2017.

Contributions

You can contribute through payroll deduction up to \$2,550 in 2017 in your LPFSA. A minimum annual election amount of \$120 is required to complete enrollment.

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.

Deadline to Incur Claims

For your 2017 LPFSA, you have until December 31, 2017 to incur eligible claims and until June 15, 2018 to request reimbursement.

\$500 Carryover of Remaining Account Balance

If you have a LPFSA in 2017, the Plan allows you to carryover up to \$500 of any amount remaining unused in your 2017 LPFSA as of the end of the 2017 plan year. Such carryover amount may be used to pay or reimburse medical expenses incurred during all of 2018. Any unused amount of more than \$500 remaining in your 2017 LPFSA at the end of the 2017 will be forfeited.

If you were a participant in the CORE Medical Benefit Option in the prior Plan Year and you do not elect to participate in the CORE Medical Benefit Option for the current plan year, and you have a remaining balance from the previous plan year in your Limited Purpose Health Care Flexible Spending Account, the remaining balance from the previous plan year (of up to \$500) will be credited to a HCFSAs for you. For example, if you are enrolled in the CORE Medical Benefit Option in year one, and have a Limited Purpose Health Care Flexible Spending Account balance of \$400, and you elect the STANDARD Medical Benefit Option in year two, \$400 will be credited to a HCFSAs for you, even if you do not elect to enroll in a HCFSAs.

If you elect to participate in the CORE Medical Benefit Option for a plan year and have a remaining balance from the prior plan year from your HCFSAs, the remaining balance from the previous plan year (of up to \$500) will be credited to a LPFSA for you, even if you do not elect to enroll in a Limited Purpose Health Care Flexible Spending Account. For example, if you were enrolled in the VALUE Medical Benefit Option in year one, and you have a HCFSAs balance of \$300, and you elect the CORE Medical Benefit Option in year two, \$300 will be credited to a LPFSA for you, even if you do not elect to enroll in a Limited Purpose Health Care Flexible Spending Account.

If you experience a Qualifying Event (as described in the COBRA chapter), your LPFSA terminates. As described in the COBRA chapter, you may elect to continue your LPFSA as part of your COBRA continuation of coverage options, for the remainder of the calendar year in which you became eligible for continuation of coverage. In addition, the Plan allows you to carryover up to \$500 of any amount remaining in your LPFSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the COBRA continuation period (i.e. 18, 29, or 36 months, as applicable). Any unused amount of more than \$500 remaining in your HCFSAs at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.

Account Administrator

The LPFSA administrator is Your Spending Account (YSA). The [YSA 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.

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 other than dental/vision.** If you are enrolled in the CORE Medical Benefit Option, you may use a Health Savings Account to pay for such expenses. See the [CORE Medical Benefit Option](#) section for more information. In addition, if deposits are made to an HSA and you later change plans, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision, regardless of the plan selection.

Filing Claims

You have until June 15 to file claims on your previous year's eligible expenses.

Participants who have a Limited Purpose Flexible Spending Account may file claims on the [YSA 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 [YSA website](#).

Please see the "[Claims Procedures](#)" chapter for a detailed description of the claims procedures that apply to your Limited Purpose Flexible Spending Account benefits.

Dependent Care Flexible Spending Account (DCFSA)

How the Dependent Care Flexible Spending Account (DCFSA) Works

The DCFSA allows you to set aside money on a pre-tax basis to help pay for eligible day care expenses for your eligible adult and Child dependents (up to age 13). Paying for these expenses with pre-tax money helps reduce your taxes.

Benefit Overview		
Option	Reimbursement	Key Features
Dependent Care FSA	You can be reimbursed for: <ul style="list-style-type: none"> • Licensed child and adult day care centers • Private kindergarten (used for day care rather than education) • Babysitters • Au pairs 	<ul style="list-style-type: none"> • Contribute up to \$5,000 a year • Pre-tax contributions • Have until March 15 of the benefit year to use your prior year's balance • Have until June 15 to file claims for previous year's eligible expenses • You cannot use your funds until they are deposited in your account

Contributions

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 DCFSAs, 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 2015, a Highly Compensated Employee is an individual who has an annual income of \$120,000 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](#).

If both you and your Spouse work for American Airlines, your combined DCFSA total contribution cannot exceed \$5,000.

A minimum annual election amount of \$120 is required to complete enrollment.

Important Note about your DCFSA: You will only be able to submit claims, and be reimbursed, for amounts up to the existing balance in your DCFSA.

Deadline to Incur Expenses

You have until March 15 of the following year to incur claims reimbursable under your DCFSA balance, and until June 15 of the following year to request reimbursement.

Account Administrator

The DCFSA administrator is Your Spending Account (YSA). The [YSA 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.

Special Provisions

As funds are deposited into your account, you can pay for eligible day care expenses. You and your Spouse (if you are married) must be employed, actively seeking employment, or a full-time student for at least five months of the year to be eligible to receive reimbursement from your DCFSA.

Special rules apply to mid-year election changes to your DCFSA:

- 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 DCFSA, you cannot stop or 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 DCFSA deposits mid-year, this will affect how your claims are paid.
- If your eligible expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your DCFSA.

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your DCFSA terminates.

Who is Covered

You may claim dependent day care expenses for your Eligible Dependents, including:

- Children under age 13
- An individual who satisfies all of the requirements to be your dependent under the Internal Revenue Code (except for the requirements pertaining to the individual’s claimed dependents, marital status and gross income), if the person meets **all** of the following criteria:
 - Lives with you for over half of the calendar year, and
 - Is physically or mentally incapable of self-care
- Your Spouse who meets the following criteria:
 - Lives with you for over half of the calendar year, and
 - Is physically or mentally incapable of self-care

Covered Expenses

Expenses that you incur may be reimbursed through your DCFSA if they are:

- Incurred for your Eligible Dependents described above under “Who is Covered,” or for related household services;
- Paid or payable to a Dependent Care Service Provider described below; and
- Incurred to enable you and your Spouse to be gainfully employed or to be in active search of gainful employment.

Expenses incurred for services outside your household for the care of an Eligible Dependent described above under “[Who is Covered](#),” may only be reimbursed through your DCFSA if the Eligible Dependent is:

- A Child under age 13; or
- Regularly spends at least eight hours each day in your household.

A Dependent Care Service Provider means a person who provides care or other services for an Eligible Dependent described above under “[Who is Covered](#)” or related household services. A Dependent Care Service Provider does **not** include:

- A facility that is paid to provide care for more than six individuals, unless such center complies with all applicable state and local laws and regulations, such as licensing requirements; or
- Your Spouse or your dependent Child under age 19.

Filing Claims

You have until June 15 to file claims on your previous year’s Eligible Expenses.

Participants who have a Dependent Care Flexible Spending Account may file claims on the [YSA 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 [YSA website](#).

If you do not have adequate funds in your DCFSA account, a partial payment of the claim will be made and the balance of your claim will pay out as payroll deposits are made.

If You Elect Both an HCFSA/LPFSA and a DCFSA

Your FSA and DCFSA funds are managed separately.

Health Savings Account (HSA)

Overview

A Health Savings Account (HSA) is a tax-favored medical savings account available only to enrollees in the CORE Medical Benefit Option, a qualifying high-deductible health plan per IRS regulations. If you are enrolled in the CORE Medical Benefit Option and you do not participate in a second health plan not considered high-deductible, per IRS regulations, then you may contribute pre-tax dollars to an HSA account. The HSA is not sponsored or maintained by the Company. Rather, it is your own account to which you can contribute pre-tax or after-tax dollars. The Company will also contribute dollars to your HSA as described below. You can use the money in your HSA on a tax-free basis to pay for any qualified medical expenses, including your annual Deductible if you choose. Furthermore, unused dollars roll over from year to year and therefore can be saved or invested and accumulate through retirement. If you use the money in your HSA to pay for any expenses that are not qualified medical expenses, the distribution is subject to income tax, and may be subject to a 20% penalty. Over-the-counter drugs are only considered to be a qualified medical expense if you obtain a Prescription for such drugs from your doctor (this rule does not apply to insulin).

Contributions

You elect to deduct pre-tax dollars from payroll when you enroll in an HSA with Your Spending Account (YSA) on the [American Airlines Benefits Service Center](#). You can change your election amount anytime during the year, except for the last 60 days of the benefit year.

Employer contributions will be made in the form of reward dollars that you earn by completing specific WebMD Wellness Program activities. See [WebMD Wellness Program](#) for more information.

The IRS sets the HSA limits, including catch-up contribution amounts for individuals age 55 or over. These limits may increase or decrease in the future.

The amounts noted below are the maximum amounts you can contribute to your HSA during 2017, including any WebMD Wellness Program rewards dollars you may earn during the year, if you are below age 55. If you are age 55 or over, your maximum annual contribution increases by \$1,000.



Coverage Options	Maximum HSA Contributions
Employee Only	\$3,400 (Including up to \$250 in earned Wellness Rewards)
Employee + Covered Spouse	\$6,750 (Including up to \$500 in earned Wellness Rewards: \$250 employee and \$250 spouse)
Employee + Family	\$6,750 (Including up to \$500 in earned Wellness Rewards: \$250 employee and \$250 spouse)
Employee + Child(ren)	\$6,750 (Including up to \$250 in earned Wellness Rewards)

HSA Funds

You must have the money in your HSA before the funds are available to pay for Eligible Expenses. In addition, 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 Benefit Option via the American Airlines [Benefits Service Center](#), you will be given the opportunity to enroll in an HSA with YSA as your 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 every 2 weeks = 26 times a year.
- My pre-tax per pay period payroll deduction = \$192.31

You do not have to open an HSA account with YSA. You can select another financial institution that manages HSAs. However, your contributions will not be pre-tax. You will need to make the contributions on an after-tax basis (you can generally then deduct those contributions on your Form 1040) instead of 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 Benefit Option, you may still access your HSA funds to pay for Eligible Medical Expenses on a tax-free basis. You may not, however, contribute to the HSA if you are not enrolled in the CORE Medical Benefit Option, or another HSA-compatible medical coverage. In addition, if deposits are made to an HSA and you later change plans, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision, regardless of the plan selection.

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 YSA 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. If you use your HSA to purchase non-Eligible Expenses, the distribution will be subject to income tax and may be subject to a 20% penalty.

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 also 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 YSA as an American employee when you initiate your HSA and continue to elect pre-tax contributions year after year without a break. 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 for each future year in which you elect not to contribute to the HSA.

Covered and Excluded Expenses

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
<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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

Health Reimbursement Account (HRA)

Overview

If you are enrolled in either the STANDARD, VALUE, or OUT-OF-AREA Medical Benefit Options and participate in the WebMD Wellness Program, dollars that you earn for completing certain activities will be credited to your HRA (up to \$250 for an eligible employee and up to \$250 for an eligible Spouse). The balance in your HRA rolls over from year to year, as long as you remain enrolled in either the STANDARD or OUT-OF-AREA Medical Benefit Options. Your HRA is an account on the Company's records; it is not funded and does not bear interest or accrue earnings of any kind.

Covered Expenses

You can use your HRA to reimburse you for the same expenses listed under the "Covered Expenses section" of the "Health Care Flexible Spending Account (HCFSA)" section of this chapter. However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. The HRA will reimburse you

for the actual amount of Covered Expenses incurred by you or your dependent, up to the amount in your HRA. No payment will be made to the extent that it would reduce your HRA below zero.

Life Insurance Benefits

[Overview](#)

[Ground Employees Life Insurance](#)

[Pilot Term Life Insurance](#)

[Flight Attendant Life Insurance](#)

[Child Term Life Insurance](#)

[Filing a Claim for Spouse or Child Term Life Insurance](#)

[Designating Beneficiaries](#)

[Coverage If You Become Disabled](#)

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Overview

The Company provides the following life insurance benefits for eligible Ground and Flight Employees:

- Basic Term Life Insurance
- Voluntary Term Life Insurance
- Pilot Additional Life Insurance (Pilots only)
- Spouse Term Life Insurance

Please note that 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.

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.

Ground Employees Life Insurance

Basic Term Life Insurance Benefit – Ground Employees

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

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

As an eligible employee, the Company provides coverage equal to two times your pay up to a maximum of \$70,000, at no cost to you. You may elect a level of coverage lower than the amount you are eligible for, and may receive a credit for this lower amount.

Benefit	Coverage Levels
Basic Term Life Insurance	<ul style="list-style-type: none">• 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

Voluntary Term Life Insurance Benefit – Ground Employees

In addition to Basic coverage, Ground Employees 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). You can complete online within 7 days after your election or a Statement of Health form will be mailed to you. 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.

This means that as a new employee you can elect any level of coverage with a Statement of Health.

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

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

Below are the available Voluntary options:

Coverage for Ground Employees
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

You pay the entire cost for any Voluntary Term Life Insurance coverage you select. You elect coverage at the rate shown in the [American Airlines Benefits Service Center](#) with after-tax contributions based on your age, your annual pay, and your selected option. The cost of coverage will increase or decrease during the year if the amount of your coverage fluctuates due to changes in your age and/or pay. If your new contribution is substantially higher after an increase in age and/or pay, you may be able to drop or adjust your election pursuant to Life Event procedures. Contact the [American Airlines Benefits Service Center](#) if you have questions.

Definition of “Pay” for Employee Term Life Insurance

The following table defines “pay” for Employee Term Life Insurance (i.e. Basic and Voluntary Term Life Insurance):

Employee Status	Definition of Pay
Regular Full-time Employees	Base annual salary or annualized hourly pay 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

Spouse Term Life Insurance – Ground Employees

You may cover your Spouse under Spouse Term Life Insurance. The Spouse Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse Term Life Insurance for Ground Employees	Option 1 – One times your pay
	Option 2 – Two times your pay
	Option 3 – Three times your pay

To add or increase Spouse Term Life Insurance, your Spouse must complete a Statement of Health Form online within seven days after your election. If you do not complete the form online within seven days after your election, a Statement of Health form will be mailed to you. 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.

You pay the entire cost of Spouse Term Life Insurance coverage that you select. You elect coverage at the rate shown on your benefits enrollment screen in the [American](#)

[Airlines Benefits Service Center](#) and pay for this coverage with after-tax contributions. Your Spouse's rate is based on your Spouse's age, your pay, and your selected option. The cost of coverage your Spouse pays will increase or decrease during the year if your contribution fluctuates due to changes in Spouse's age and/or your pay.

Pilot Term Life Insurance

Note: As required by the APA Agreement, all pilots formerly employed by US Airways, Inc. and currently covered as employees by the APA Agreement, hired on or after December 9, 2013 are eligible for the Basic Term Life Insurance, Voluntary Term Life Insurance, Spouse Life and Dependent Life benefits described in this section. However, pilots formerly employed by US Airways, Inc. and currently covered as employees by the APA Agreement who were hired *prior* to December 9, 2013 have grandfathered life insurance benefits through December 8, 2018. US Airways EAST Pilots hired *prior* to December 9, 2013 are eligible for the Spouse Life Insurance and Child Life Insurance benefits described in this section.

Basic Term Life Insurance Benefit – Pilots

The Company provides all eligible Pilot employees with Basic Term Life Insurance at no cost to you. You are auto-enrolled in this benefit and may not elect a lower amount of Basic Term Life coverage or waive this benefit.

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


The Company provides Basic Term Life Insurance coverage based on your salary, as shown in the table below. Benefit amounts may increase or decrease during the year if your salary changes.

Basic Term Life Insurance for Pilots	
Monthly Salary for Benefits*	Coverage Amounts
Up to \$2,499.99	\$49,000
\$2,500 or over	\$70,000

* Salary for benefits includes your base pay, flying pay, sick pay and minimum pay, but excludes expense allowances and reimbursement of expenses.

Up to \$10,000 of your Basic Term Life Insurance is immediately payable to your beneficiary upon your death. The remainder of the benefit will be paid after all documentation has been provided to MetLife as required. Such documentation may include, for example, a claim submission form and a copy of the death certificate.

Voluntary Term Life Insurance Benefit – Pilots

 In addition to Basic Term Life Insurance coverage, Pilot employees 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 up to and including \$400,000 of coverage without providing Proof of Good Health. You must complete a Statement of Health from [MetLife](#) if you wish to elect more than \$400,000 of coverage. You can complete online with 7 days after your election or a Statement of Health form will be mailed to you. 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.

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 Term Life Insurance options:

Coverage for Pilots
½ times Basic (up to \$35,000)
One times Basic (up to \$70,000)
One and a half times Basic (up to \$105,000)
\$200,000
\$400,000
\$600,000
\$800,000
\$1,000,000

(Age reduction does not apply to Voluntary Term Life Insurance.)

You pay the entire cost for any Voluntary Term Life Insurance coverage you select. You elect coverage at the rate shown on your benefits enrollment screen in the American Airlines [American Airlines Benefits Service Center](#) and pay for this coverage with after-tax contributions. Your Voluntary Term Life rate is based on your age, your pay, and selected option. The cost of coverage that you pay will increase or decrease during the year if the premium fluctuates due to changes in your age and/or your pay. If your new contribution is substantially higher after an increase in age and/or pay, you may be able to drop or adjust your election pursuant to Life Event procedures. Contact the [American Airlines Benefits Service Center](#) if you have questions.

Pilot Additional Life Insurance Benefit

The Company-provided Pilot Additional Life Insurance coverage was equal to 1½ times your Basic Term Life Insurance amount (up to a maximum of \$105,000). Eligibility for the Pilot Additional Life Insurance was available if you were a member of the Pilot Retirement Benefit Program and at the time of your death you are:

- Under the age of 50,
- Over the age of 50 and unmarried, or
- Over the age of 50 and married for less than 12 months before your death.

The Company provided Pilot Additional Life Insurance coverage at no cost.

Spouse Term Life Insurance – Pilots

You may cover your Spouse under Spouse Term Life Insurance. The Spouse Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse Term Life Insurance for Pilots	\$25,000
	\$50,000
	\$100,000

To add or increase Spouse Term Life Insurance, your Spouse must complete a Statement of Health form online within seven days after your election. If you do not complete the form online within seven days after your election, a Statement of Health form will be mailed to you. 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 the lowest level of coverage (\$25,000) 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.

Flight Attendant Life Insurance

Definition of “Pay” for Flight Attendant Life Insurance Options

For Flight Attendant Basic and Voluntary Term Life Insurance, “pay” is defined as follows: Base annual salary or annualized hourly pay plus market rate differentials, but excluding bonus and overtime.

Basic Term Life Insurance Benefit – Flight Attendants

The Company provides all eligible Flight Attendant employees with Basic Term Life Insurance at no cost to you. You are auto-enrolled in this benefit and may not elect a lower amount of Basic Term Life coverage or waive this benefit.

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

The Company provides Basic Term Life Insurance coverage at no cost to you based on your salary. You are eligible for 2 times your base annual salary, up to a maximum of \$70,000. Benefit amounts may increase or decrease during the year if your salary changes.

If you were a member of the Retirement Benefit Plan of American Airlines, Inc. for Flight Attendants 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 – Flight Attendants

In addition to Basic coverage, Flight Attendant employees 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 1 times your pay level of coverage without providing Proof of Good Health. You must submit a Statement of Health if you wish to elect a higher level of coverage (2 times your pay to 8 times your pay). You can complete online within 7 days after your election or a Statement of Health form will be mailed to you. 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.

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 Term Life Insurance options:

Coverage for Flight Attendants
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

You pay the entire cost for any Voluntary Term Life Insurance coverage you select. You elect coverage at the rate shown on your benefits enrollment screen in the [American Airlines Benefits Service Center](#) with after-tax contributions. Your Voluntary Term Life rate is based on your age, your pay, and your selected option. The cost of coverage that you pay will increase or decrease during the year if your contribution fluctuates due to changes in your age and/or your pay. If your new contribution is substantially higher after an increase in age and/or pay, you may be able to drop or adjust your election pursuant to Life Event procedures. Contact the Benefits Service Center if you have questions.

Spouse Term Life Insurance – Flight Attendants

You may cover your Spouse under Spouse Term Life Insurance. The Spouse Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse Term Life Insurance for Flight Attendants	Option 1 - 1 times your pay
	Option 2 - 2 times your pay
	Option 3 - 3 times your pay

To add or increase Spouse Term Life Insurance, your Spouse must complete a Statement of Health Form online within seven days after your election. If you do not complete the form online within seven days after your election, a Statement of Health form will be mailed to you. You must then forward the completed form to MetLife for review within 30 days. 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 Term Life Insurance 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.

You pay the entire cost for the Spouse Term Life Insurance coverage you select. You elect coverage at the rate shown on your benefits enrollment screen in the [American Airlines Benefits Service Center](#) with after-tax contributions. Your Spouse Term Life rate is based on your Spouse's age, your pay and selected option. The cost of coverage that you pay will increase or decrease during the year if the premium fluctuates due to changes in your Spouse's age and/or your pay.

Child Term Life Insurance

Eligible Ground Employees, Flight Attendants, and Pilots may cover your Children under 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 [American Airlines 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 for Spouse or Child Term Life Insurance

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 American Airlines Benefits Service Center of the death. You are the sole beneficiary for your Spouse or Child's term life insurance.
- After American Airlines Benefits Service Center 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 American Airlines Benefits Service Center. Upon receipt of both items, American Airlines Benefits Service Center 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](#)” in the [Plan Administration](#) section).
- When a Spouse or covered dependent dies, you may want to make changes to your benefits coverages. To process these changes, contact American Airlines Benefits Service Center within 31 days from the date of your loss. 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. For your convenience, the letter you receive includes a Beneficiary Designation Form. This can be completed online through the [American Airlines Benefits Service Center](#). You can use this form to make any necessary changes to the beneficiary designations you have on file, if appropriate and as applicable.

Designating Beneficiaries

In the event of your death, Basic and Voluntary Term Life Insurance coverage benefits are paid to the named beneficiaries on file with the American Airlines Benefits Service Center. You can designate your Term Life Insurance Benefits to go to a person, trust, estate, or organization. If you would like to designate your Term Life Insurance Benefits to a person, you can designate your Spouse, Children, or others (including other family members or friends).

When you select your beneficiary, the wording is important. If you need assistance, please contact an attorney.

You can name the same or different beneficiaries for your Basic and Voluntary Term Life Insurance coverage. When you enroll for benefits when you are first eligible as a new employee, or during Annual Enrollment, you designate your beneficiaries. You may change your beneficiary designation at any time during the year by accessing the [American Airlines Benefits Service Center](#).

Unless prohibited by law, your Term Life Insurance benefits are distributed as you indicated on your Beneficiary Designation Form on file with the American Airlines Benefits Service Center. For this reason, you should consider updating your beneficiary designation periodically, especially if you get married, you or your Spouse give birth or adopt a Child, or if you get divorced.

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
- Children or stepchildren
- Parents
- Brothers and sisters
- Estate

Coverage if You Become Disabled

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

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

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

In order for your Term Life Insurance coverage to continue at no cost to you, you must apply for a waiver of Voluntary Term Life Insurance contributions. 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 the American Airlines Benefits Service Center to request a claim form.

Ground Employees:

- If you became disabled before January 1, 1995, and are approved for this waiver, your Basic and Contributory Voluntary Life Insurance coverage continues at no cost to you as long as you remain permanently and totally disabled.
- If you became disabled on or after January 1, 1995, your life insurance coverage (Basic and Voluntary) will continue until you reach age 55. At age 55, your Voluntary coverage will terminate and your Basic Term Life Insurance will be reduced to the retiree level. If you are not eligible for a pension benefit or Retiree Life Insurance, your coverage stops at age 65.

Pilots:

- If you became disabled before January 1, 1995, and are approved for this waiver, your Basic and Voluntary Term Life Insurance coverage continues at no cost to you as long as you remain permanently and totally disabled.
- If you became disabled on or after January 1, 1995, your life insurance coverage will continue until you reach age 50. At age 50, your Voluntary Term Life Insurance coverage will terminate and your Basic Term Life Insurance will be reduced to the retiree level. The amount of your Pilot Additional Life Insurance will continue as long as you are permanently and totally disabled.
- If you become permanently and totally disabled after age 50, you will receive Retiree Life Insurance coverage only, unless you are eligible for Pilot Additional Life Insurance coverage.

Flight Attendants:

- If you became disabled before January 1, 1995, and are approved for this waiver, your Basic and Voluntary Term Life Insurance coverage continues at no cost to you as long as you remain permanently and totally disabled.
- If you became disabled on or after January 1, 1995, your life 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.

All Eligible Employees: 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 (24 months for Texas residents), 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, Voluntary, and Pilot Additional, if applicable) 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 employees who have applied for retirement benefits are not eligible for ABO benefits. See ["Assignment of Benefits"](#).

Taxation of Life Insurance

If your Basic Life plus Pilot Additional Life (if applicable) coverage is more than \$50,000, you may be taxed on the value of your coverage over \$50,000. This value is imputed to your income for tax purposes and referred to as "imputed income." (Only Basic Life and Pilot Additional Life coverage above \$50K is subject to imputed income, since Voluntary Life coverage is after-tax.) 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

The following two examples illustrate how imputed income works:

(1) Example 1

Assume a 30-year-old employee has \$70,000 in Basic Term Life coverage. The following calculations show the employee's taxable imputed income:

1. Figure the taxable amount of coverage (amount over \$50,000):
 $\$70,000 - \$50,000 = \$20,000$
2. Divide that amount by \$1,000:
 $20,000 / \$1,000 = 20$
3. Multiply the result by the IRS rate from the table above for an employee who is age 30:
 $20 \times \$0.08 = \1.60

The monthly imputed income shown on this employee's paycheck will be \$1.60. This is the amount that is subject to federal income and Social Security taxes.

(2) Example 2

The following calculations show the taxable imputed income for a 37-year-old Pilot earning \$10,000 per month:

1. Figure the total amount of Term Life Insurance coverage:

Basic Life:	= \$70,000
<u>Pilot Additional Life:</u>	<u>= \$105,000</u>
TOTAL	= \$175,000

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

$$\$175,000 - \$50,000 = \$125,000$$

3. Divide that amount by \$1,000:

$$\$125,000 / \$1,000 = 125$$

4. Multiply the result by the IRS rate from the table above for an employee who is age 37:

$$125 \times \$0.09 = \$11.25$$

The monthly imputed income shown on this employee's paycheck will be \$11.25. This is the amount that is subject to federal income and Social Security taxes.

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 Plan stops covering Term Life Insurance, and you have been covered under this insurance for at least five years, or
- Coverage for your particular job classification ends, and you have been covered under this insurance for at least five years.

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 lesser of:

- 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, or
- \$10,000.

Spouse Term Life Insurance may also be converted to an individual life insurance policy (other than term life insurance), if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for dependent Term Life Insurance coverage,
- The Plan stops covering Term Life Insurance, and your Spouse has been covered under this insurance for at least five years,
- Coverage for your particular job classification ends, and your Spouse has been covered under this insurance for at least five years;
- Upon the death of the employer; or
- The date on which the Dependent no longer meets the definition of Dependent.

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.

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 American Airlines Benefits Service Center.

Assignment of Benefits

Beginning January 1, 2015, no new assignments on your life insurance coverage will be accepted by the Company. Any existing life assignments as of December 31, 2015 will continue to be recognized by the Company. If you previously assigned 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 continue to 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 [American Airlines Benefits Service Center](#). 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 and processes all claims. The life insurance claim will be processed after MetLife receives all necessary documentation.

Please see the “[Claims Procedures](#)” chapter for a detailed description of the claims procedures that apply to your life insurance benefits.

Ground Employees – Accidental Death & Dismemberment (AD&D) Insurance Benefits

[Overview](#)

[Basic and Voluntary Accidental Death & Dismemberment Insurance \(AD&D\)](#)

[Other Accident Insurance: Special Risk Accident Insurance \(SRAI\) Benefit, Special Purpose Accident Insurance \(SPAI\) Benefit and Management Personal Accident Insurance \(MPAI\)](#)

Overview

Accident Insurance benefits may provide benefits to Ground Employees and your eligible family members in the event of an accident or injury. **NOTE: AD&D insurance does NOT cover medical and other expenses associated with an injury as a result of an accident.**

The Company provides the following Accident Insurance benefits to eligible Ground Employees:

- Basic Accidental Death & Dismemberment Insurance (AD&D)
- Voluntary Accidental Death & Dismemberment Insurance (AD&D)
- Special Risk Accident Insurance (SRAI)
- Special Purpose Accident Insurance (SPAI)
- Management Personal Accident Insurance (MPAI)

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 the [American Airlines Benefits Service Center](#) for more information.

Basic and Voluntary Accidental Death & Dismemberment Insurance (AD&D)

Basic Accidental Death & Dismemberment Insurance (AD&D)

Management and Support Staff employees are automatically eligible to receive Basic Accidental Death and Dismemberment Insurance (AD&D) from the Company, at no cost to you. The coverage is equal to your Basic Term Life Insurance coverage (typically, 2 times your pay up to \$70,000, unless you have elected a lesser amount of Basic Term Life coverage).

Voluntary Accidental Death & Dismemberment Insurance (AD&D)

As an eligible employee, you may elect to purchase Voluntary Accidental Death and Dismemberment (AD&D) Insurance benefits for yourself and your family. You pay premiums through before-tax payroll deduction.

Coverage is as follows:

- \$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.

What is Covered under Basic and Voluntary AD&D

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.

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	<i>2/3 benefit amount</i>
Loss of use of one limb	<i>1/2 benefit amount</i>

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

Special Benefit Features Under Basic and Voluntary AD&D

- **Air bag benefit:** If you or your covered dependent dies in a motor vehicle accident and the safety airbag (as defined by the Benefit Option) 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 Network/Claim Administrator 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.
- **Bereavement Counseling:** 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 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 \$20,000). 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.
- **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.

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.

- **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.
- **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 have Basic or Voluntary 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 administered by Europ Assist. Please note that CIGNA Secure Travel is not an ERISA-covered benefit.

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
- Services available while traveling abroad (or within the US if 100 or more miles from home) include:
 - Medical referrals to local Physicians, dentists and medical treatment centers in the event of an Emergency (accident or illness); you must follow your Medical Benefit Option rules to receive reimbursement for any Eligible Expenses
 - Assistance with paying for medical services (if payment is required at the time services are rendered)
 - 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
 - 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. CIGNA Secure Travel 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 more than 10 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.

CIGNA Secure Travel agents are available 24 hours per day and 7 days per week.

- Call 1-888-226-4567 (in the U.S. and Canada)
- Call collect 202-331-7635 (in other countries)
- By fax at 202-331-1528
- By e-mail at cigna@europassistance-usa.com
- Please identify yourself as a member of CIGNA Secure Travel
 - Policyholder: American Airlines, Inc.
 - Policy #: AA-GAP; or
 - Group #: 57

Basic and Voluntary AD&D 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 for Basic or Voluntary AD&D

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 the American Airlines Benefits Service Center 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.
- 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 Benefits Service Center along with documentation of the claim, such as a police report of an accident and a certified copy of the death certificate. The Benefits Service Center 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 Under Basic and Voluntary AD&D

You can convert up to \$250,000 in Accidental Death and Dismemberment (AD&D) Insurance 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.

Basic & Voluntary AD&D 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 SPD 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), Special Purpose Accident Insurance (SPAI), and Management Personal Accident Insurance (MPAI) (for Management/Specialist and Officer employees only).

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

The 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.

The 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 under SRAI Benefit, SPAI Benefit, and MPAI Benefit

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 the SRAI benefit.
- \$2,000,000 per aircraft accident under the SPAI benefit.
- \$5,000,000 per aircraft accident under the 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 under SRAI Benefit, SPAI Benefit, and MPAI Benefit

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 the 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).

SRAI Benefit, SPAI Benefit, and MPAI 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 in this SPD and the provisions of the insurance policies, the insurance policies will govern.

Flight Employees – Accidental Death & Dismemberment (AD&D) Insurance Benefits

[Overview](#)

[Basic Accidental Death & Dismemberment Insurance \(AD&D\) and Voluntary Personal Accident Insurance \(VPAI\) Insurance](#)

[Other Accident Insurance: Terrorism and Hostile Act Accident Insurance \(T&HAAI\) and Special Purpose Accident Insurance \(SPAI\)](#)

Overview

Accident Insurance benefits may provide benefits to Flight Employees and your eligible family members in the event an accident or injury. **NOTE: AD&D Insurance does NOT cover medical and other expenses associated with an injury as a result of an accident.**

The Company provides the following Accident Insurance benefits to eligible Flight Employees:

- Basic Accidental Death & Dismemberment Insurance (AD&D)
- Voluntary Accidental Death & Dismemberment Insurance (AD&D)
- Terrorism and Hostile Act Accident Insurance (T&HAAI)
- Special Purpose Accident Insurance (SPAI)

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 the [American Airlines Benefits Service Center](#) for more information.

Note: As required by the APA Agreement, all pilots formerly employed by US Airways and currently covered as employees by the APA Agreement, hired on or after December 9, 2013 are eligible for the Basic Accidental Death & Dismemberment (AD&D) Insurance described in this section. However, all pilots formerly employed by US Airways and currently covered as employees by the APA Agreement who were hired *prior* to December 9, 2013 have grandfathered Basic AD&D benefits through December 8, 2018. All pilots formerly employed by US Airways and currently covered as employees by the APA Agreement are eligible for Voluntary Personal Accident Insurance (VPAI), Terrorism and Hostile Action Accident Insurance (T&HAAI) and Special Purpose Accident Insurance (SPAI) benefits described in this section.

Basic Accidental Death & Dismemberment Insurance (AD&D) and Voluntary Personal Accident Insurance (VPAI) Insurance

Basic Accidental Death & Dismemberment Insurance (AD&D)

As an eligible employee, you automatically receive \$10,000 in Accidental Death and Dismemberment Insurance (AD&D) from the Company, at no cost to you.

Voluntary Personal Accident Insurance (VPAI)

You may also elect to purchase Voluntary Personal Accident Insurance (VPAI) for yourself in \$10,000 increments up to \$500,000. You may also elect to purchase VPAI

for yourself and your family. You pay premiums through before-tax payroll deductions. Other notable features include:

- Coverage is available without regard to previous health history.
- The Plan provides broad 24-hour protection, year-round, including coverage during travel.
- Benefits are payable in addition to any other insurance you may have.

The amount of VPAI coverage for your covered family members is a percentage of the amount of coverage you elect for yourself, as shown in the table below.

Family Covered	Amount of Benefit
Spouse only	70% of the employee's elected benefit amount
Spouse and Children	<ul style="list-style-type: none"> • Spouse: 60% of the employee's elected benefit amount • Each Child: 15% of the employee's elected benefit amount, not to exceed \$75,000 for each covered Child
Children only	Each Child: 25% of the employee's elected benefit amount, not to exceed \$125,000

What is Covered under AD&D and VPAI

In the event of an accident, the coverage may pay benefits to:

- You, in the case of certain accidental injuries/dismemberment 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 and VPAI coverages pay a benefit if you (or a covered dependent for VPAI) 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.

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)

If Injury Is to:	It Must Be:
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 and VPAI coverages pay if you (or a covered dependent for VPAI) 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	<i>2/3 benefit amount</i>
Loss of use of one limb	<i>1/2 benefit amount</i>

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

Special VPAI Benefit Features

The VPAI offers the following special features that do not apply to AD&D:

- **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 VPAI 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 VPAI, 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 VPAI, the coverage pays your dependents an additional annual benefit up to 3% of your VPAI 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 VPAI, 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 VPAI 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 VPAI 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 Network/Claim Administrator 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 VPAI 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.
- **Bereavement Counseling:** VPAI 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. VPAI will pay for up to five sessions of Medically Necessary Bereavement 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 \$250,000). 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 VPAI 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 VPAI 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.

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.

- **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.

- **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 VPAI, 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, VPAI 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 VPAI, 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 VPAI coverage for you and your dependents and you die as the result of an accident, any VPAI coverage you have elected for your Spouse and Children continues without charge for 24 months.

Travel Assistance Services

If you have Basic AD&D or Voluntary Personal Accident Insurance (VPAI) coverage for yourself, you may also take advantage of travel assistance services when you and your covered family members travel internationally. This package of services and benefits is called CIGNA Secure Travel and is administered by Europ Assist. Please note that CIGNA Secure Travel is not an ERISA-covered benefit.

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
- Services available while traveling abroad (or within the US if 100 or more miles from home) include:
 - Medical referrals to local Physicians, dentists and medical treatment centers in the event of an Emergency (accident or illness); you must follow your Medical Benefit Option rules to receive reimbursement for any Eligible Expenses
 - Assistance with paying for medical services (if payment is required at the time services are rendered)
 - 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
 - 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. CIGNA Secure Travel 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 more than 10 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.

CIGNA Secure Travel agents are available 24 hours per day and 7 days per week.

- Call 1-888-226-4567 (in the U.S. and Canada)
- Call collect 202-331-7635 (in other countries)
- By fax at 202-331-1528
- By e-mail at cigna@europassistance-usa.com
- Please identify yourself as a member of CIGNA Secure Travel
 - Policyholder: American Airlines, Inc.
 - Policy #: COA 001312 (Basic AD&D); or
 - Policy #: OK 8000 (VPAI)
 - Group #: 57

AD&D and VPAI Exclusions

AD&D and VPAI 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 for AD&D or VPAI Benefits

AD&D and VPAI are 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 VPAI and AD&D benefits:

- Contact American Airlines Benefits Service Center 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. If you have questions contact CIGNA directly. CIGNA contact information is located in Contact Information section.
- 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 American Airlines Benefits Service Center along with documentation of the claim, such as a police report of an accident and a certified copy of the death certificate. American Airlines Benefits Service Center 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.

AD&D and VPAI Conversion Rights

You can convert up to \$250,000 in VPAI coverage for you and your family and up to \$10,000 in AD&D coverage for you 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.

AD&D and VPAI Insurance Policy

The terms and conditions of these AD&D and VPAI coverages 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 SPD and the provisions of the insurance policies, the insurance policies will govern.

Other Accident Insurance: Terrorism and Hostile Act Accident Insurance (T&HAAI) and Special Purpose Accident Insurance (SPAI)

Terrorism and Hostile Act Accident Insurance (T&HAAI)

Terrorism and Hostile Act Accident Insurance (T&HAAI) provides two types of insurance coverage, at no cost to you:

- Up to \$500,000 in insurance coverage, depending on the incident, for accidental death or dismemberment resulting from terrorism or sabotage.
- Up to \$100,000 in the event of your covered Accidental Injury, permanent and total disability benefit as a result of hostile acts overseas

Special Purpose Accident Insurance (SPAI)

Special Purpose Accident Insurance (SPAI) coverage provides two types of insurance coverage, at no cost to you:

- Up to \$100,000 if you are injured while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device, while on the ground.
- **For Pilots Only:** Up to \$500,000 for injury in an accident while engaged in a flight for the Company aboard an experimental aircraft for the Company.

Policy Aggregates: T&HAAI and SPAI

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 T&HAAI
- \$2,000,000 per aircraft accident under SPAI.

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.

T&HAAI and SPAI 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
- 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 United States of America or a similar air transport service of any other country.

T&HAI and SPAI Insurance Policy

The terms and conditions of the Other Accident Insurance coverages are set forth in the group insurance policies issued by LINA. The group policies are available for review from the Plan Administrator. In the event of a conflict between the description in this SPD and the provisions of the insurance policies, the insurance policies will govern.

Ground Employees – Short-Term Disability Benefits

[Overview](#)

[Optional Short-Term Disability \(OSTD\) for certain TWU-represented employees and employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT](#)

[Management & Support Staff Short-Term Disability](#)

Note: Long-term disability benefits are provided under a separate plan, the American Airlines, Inc. Long-Term Disability Plan.

Overview

The Company provides the following short-term disability benefits for eligible Ground Employees:

- Optional-Short-Term Disability (OSTD) Insurance (for certain TWU-represented employees and employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT);
- Short-Term Disability (STD) Insurance coverage (for Management & Support Staff); and

Please note that additional details on these coverages are contained in supplemental insurance certificates. These supplemental insurance certificates are incorporated and are a part of this SPD. Please note that additional details on your Disability benefits may be contained in these documents.

MetLife's Role – OSTD/STD Pay

MetLife is the Network/Claim Administrator for Short-Term Disability. Visit the [MetLife website](#) or contact MetLife at 1-888-533-6287 for more information.

Optional Short-Term Disability (OSTD) Insurance for TWU-represented employees and employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT

[Click here to view the insurance certificate for the Optional Short-Term Disability Insurance Plan for certain TWU-represented employees and employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT.](#)

How the OSTD Insurance Benefit Works

This benefit applies to certain TWU-represented employees and employees represented by the Communication Workers of America, AFL-CIO, CLC, IBT. Dependents are not eligible for this benefit.

The Company offers 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) benefits begin. (Note that Long-Term Disability benefits are not part of this Plan.) In this case, the Company also offers Optional Short-Term Disability (OSTD) Insurance benefits to provide income protection until LTD benefits begin.

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.

The cost of OSTD Insurance is collected through after-tax 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.

When You Qualify for OSTD Insurance Benefits

In order to qualify for OSTD Insurance, you must be considered “totally disabled.” 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.

In addition, 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 Benefit

OSTD Insurance is insured through MetLife and is designed to supplement any other similar benefits to equal 50% of your “adjusted monthly salary,” for up to 26 weeks. The maximum covered salary is \$200,000.

- 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.

Your OSTD Insurance benefit will be adjusted to reflect income from other sources (see [“Benefits from Other Sources,”](#) below) 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.

If you are enrolled in LTD coverage, you will receive the full OSTD Insurance benefit, plus you will receive a minimum benefit from LTD 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 benefit will be payable. (Note that Long-Term Disability benefits are not part of this Plan.)

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.

The OSTD Insurance benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

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 OSTD Insurance 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.

Successive Periods of Disability

There is no limit to the number of times you may receive OSTD Insurance 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.

Filing a Claim for OSTD Insurance Benefits

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 benefit. (Note that Long-Term Disability benefits are not part of this 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. The completed sections may be mailed together or separately to the Network/Claim Administrator at the address on 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.

After the Network/Claim Administrator receives the form, your claim will be processed. Sometimes the Network/Claim Administrator 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 Network/Claim Administrator for the Optional Short-Term Disability Insurance benefit. The OSTD Insurance and state disability coverages are insured plans (including state plans in Hawaii, New Jersey, New York and Puerto Rico). The states of California and Rhode Island administer their own disability plans.

OSTD Insurance Return-to-Work Program

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. If you participate in the 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.

OSTD 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 receive the reimbursement, 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. Child care must be provided for your or your Spouse's Child, legally adopted Child or a Child for whom you or your Spouse is legal guardian and who is:

- Living with you as part of your household;
- Dependent on you for support; and
- Under age 13.

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 OSTD Insurance Benefits End

Your OSTD Insurance benefit payments end automatically on the earliest of the following dates:

- The date the Network/Claim Administrator 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.

OSTD Insurance 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 by the amount of the state benefit. 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 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.

Management & Support Staff Short-Term Disability (STD) Insurance

[Click here to view the insurance certificate for the Management and Support Staff Short-Term Disability Insurance Plan.](#)

Tax Consequences of STD Insurance Benefit

You may elect either of the following two options:

- You may elect to have the Company pay the entire premium for the coverage and include that amount in your gross income for the year in which the payments are made (i.e., the premiums will be reported on your Form W-2 for that year). If you elect this option, short-term disability benefits that you receive for the plan year in which you became disabled are excluded from your gross income.
- Alternatively, you may elect to have the Company pay for this coverage on a pre-tax basis, in which case the Company will not include the cost of the coverage in your gross income (i.e. the premiums will not be reported on your Form W-2 for the year). If you elect this option, short-term disability benefits that you receive for the plan year in which you become disabled will be included in your gross income.

If you do not make any election, the Company will include the amount of the premium in your gross income for the year in which the payments are made.

How the STD Insurance Benefit Works

This benefit applies to Management & Support Staff. Dependents are not eligible for this benefit.

The Company offers 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) benefits begin. (Note that Long-Term Disability benefits are not part of this Plan.) In this case, the Company also offers Short-Term Disability (STD) Insurance benefits to provide income protection until LTD benefits begin.

STD Insurance benefits replace a portion of your salary when you are unable to work as a result of a non-work related disability.

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 STD Insurance benefits.



When You Qualify for STD Insurance Benefits

To qualify for STD Insurance benefits, you must be considered “disabled.” You are considered disabled if you are:

- unable to perform the essential functions of your own occupation due to your sickness or injury;
- under the “regular care” of a doctor; and
- you are unable to earn more than 80% of your pre-disability base weekly income due to the same sickness or injury.

“Regular care” means that you:

- personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disability by a doctor whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

STD Insurance Benefits

For all employees eligible for STD Insurance, your weekly STD Insurance benefit equals 66.67% of your gross weekly income in effect just prior to your date of disability, subject to the BENEFITS FROM OTHER SOURCES section. The maximum weekly benefit is \$4,695.

The minimum STD Insurance benefit is \$15 per week. This does not apply if you are in an overpayment situation or are participating in the rehabilitation program described under “STD Insurance Rehabilitation Program.”

STD Insurance benefits are payable for a maximum of 180 days.

In some cases, STD 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.

Benefits from Other Sources

We will reduce your STD Insurance benefit by the amount of all other income. Other income includes the following:

- Any disability or retirement benefits which you, your Spouse or Child(ren) receive because of your disability or retirement under:
 - any state or public employee retirement or disability plan;

- a no-fault auto law for loss of income, excluding supplemental disability benefits;
- plan or arrangement, whether insured or not, as a result of membership in or association with any groups, associations, union or other organization, including benefits required by state law;
- any state or government retirement system.
- The gross amount that you, your Spouse and Children receive or are eligible to receive because of our disability under the Railroad Retirement Act; the Canada Pension Plan; the Quebec Pension plan; or any similar plan or act.
- The gross amount that you receive because of your disability from the Veteran's Administration, or any other foreign or domestic governmental agency. If your disability begins and you were already receiving payments from the Veteran's Administration, we will only subtract the amount of any increase in benefit that is attributed to such disability.
- The gross amount that you receive as retirement payments or the gross amount your Spouse and Children receive as retirement payments because you are receiving payments under: the Railroad Retirement Act; the Canada Pension Plan; the Quebec Pension plan; or any similar plan or act.
- The amount that you:
 - receive as disability payments under the Retirement Benefit Plan of American Airlines, Inc. for Agent, Management, Specialist, Support Personnel, and Officers;
 - voluntarily elect to receive as retirement or early retirement payments under the Retirement Benefit Plan of American Airlines, Inc. for Agent, Management, Specialist, Support Personnel, and Officers
 - receive as retirement payments when you reach normal retirement age, as defined in the Retirement Benefit Plan of American Airlines, Inc. for Agent, Management, Specialist, Support Personnel, and Officers
- The amount you receive under laws providing maritime maintenance and cure.
- The amount of loss of time benefits that you receive under any salary continuation or accumulated sick leave.
- The amount that you receive under any unemployment income act or law due to the end of employment with the Company.

MetLife will not reduce your payment by your Social Security or Canada or Quebec Pension Plan retirement payments if your disability begins after age 65 and you were already receiving Social Security or Canada or Quebec Pension Plan retirement payments.

Benefits from Other Sources – Single Sum Payment

If you receive other income in the form of a single sum payment, you must, within 10 days after receipt of such payment, give written proof satisfactory to MetLife of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When MetLife receives such proof, it will adjust the amount of your disability benefit.

If MetLife does not receive the written proof described above, and MetLife knows the amount of the single sum payment, MetLife may reduce your disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If MetLife adjusts the amount of your disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an overpayment.

If you receive other income in the form of a single sum payment and MetLife does not receive the written proof described above within 10 days after you receive the single sum payment, MetLife will adjust the amount of your disability benefit by the amount of such payment.

When STD Insurance Benefits Begin

Provided you qualify, STD Insurance benefits are payable on the eighth day of disability.

Successive Periods of Disability

If you return to active work before completing your elimination period and then become disabled, you will have to complete a new elimination period. (Note that the “elimination period” is the waiting period before STD Insurance benefits are payable. It extends until the eighth day of disability.)

If you return to active work after completing your elimination period, the following rules apply:

- If your current disability is related or due to the same cause(s) as your prior disability for which MetLife has made a payment, MetLife will treat your current disability as part of your prior claim and you will not have to complete another elimination period, if you return to active work for the Company on a full-time basis for 90 consecutive days or less. Your disability will be subject to the same terms, provisions and conditions that were used for the original disability.
- If your current disability is unrelated to your prior disability for which MetLife has made a payment, MetLife will treat your current disability as a new claim and you will have to complete another elimination period. Your disability will be subject to all of the plan provisions.

Filing a Claim for STD Insurance Benefits

Obtain a claim form from the Company and fill it out carefully. Return the completed claim form with the required proof to the Company.

If you are unable to report for active work due to a sickness or accidental injury, and you think that you may be disabled, you should contact MetLife to initiate a claim, no later than 14 days after the first day you are unable to report for active work so that your claim can be processed in a timely manner.

When you file an initial claim for STD Insurance benefits, you should send both the notice of claim and the required proof within 90 days after the end of the elimination period.

Notice of claim and proof may also be given to MetLife by following the steps set forth below:

- Call MetLife at the phone number listed in the chapter ["Benefits under the Plan and Contact Information"](#) within 20 days of the date of disability.
- MetLife will send a claim form and explain how to complete it.
- When you receive the form, you should fill it out as instructed and return it with the required proof described in the claim form. You must give MetLife proof not later than 90 days after the end of the elimination period.

When you submit proof on an initial or continuing claim for STD Insurance benefits, the following items may be required:

- Documentation of: the date your disability started; the cause of Your Disability; the prognosis of Your Disability; the continuity of Your Disability;
- Your application for other benefit sources; federal Social Security disability benefits; and workers compensation benefits or benefits under a similar law.
- Written authorization for MetLife to obtain and release medical, employment and financial information and any other items MetLife may reasonably require;
- Any and all medical information;
- The names and addresses of the physicians, medical practitioners, hospitals, or other medical facilities which have provided you with diagnosis, treatment, or consultation, and pharmacies which have filled your prescriptions within the past three years.

STD Insurance Rehabilitation Incentives

The rehabilitation program, administered by MetLife, is a program designed to assist you to return to work. As your file is reviewed, medical and vocation information will be analyzed to determine if rehabilitation services might help you to return to work. Once

the initial review is completed by MetLife, MetLife may elect to offer you and pay for a rehabilitation program. If the rehabilitation program is not developed by MetLife, you must receive written approval from MetLife for the program before it begins.

The rehabilitation program may include, but is not limited to, the following services:

- coordination with the Company to assist you to return to work;
- adaptive equipment to allow you to work;
- worksite modification to allow you to work;
- vocational evaluation to determine how your disability may impact your employment options;
- job placement services;
- resume preparation;
- job seeking skills training;
- retraining for a new occupation; or
- assistance with relocation that may be part of an approved rehabilitation program.

If you participate in a rehabilitation program, MetLife will increase your weekly benefit by an amount equal to 10% of the weekly benefit. MetLife will do so before it reduces your weekly benefit by any other income.

If you work while you are disabled and receiving weekly benefits, including self-employment, and your weekly work earnings are 80% or less of your pre-disability base weekly income, your weekly benefit will be adjusted as follows:

- 1. Add your weekly work earnings to your gross weekly benefit payment.
- 2. Compare the answer in item 1 to your pre-disability base weekly income.

If the answer from item 1 is less than or equal to 100% of your pre-disability base weekly income, MetLife will not further reduce your net weekly benefit payment. If the answer from item 1 is more than 100% of your pre-disability base weekly income, MetLife will subtract the amount over 100% from your net weekly benefit payment. MetLife may require you to send proof of your weekly work earnings. MetLife will not pay a weekly benefit for any week in which your work earnings exceed 80% of your pre-disability base weekly earnings.

When STD Insurance Benefits Ends

Your STD Insurance benefit payments end automatically on the earliest of the following dates:

- The end of the maximum benefit period of 180 days;

- If MetLife determines you are able to work under a modified work arrangement and you choose not to do so;
- When you are able to work in your own occupation by using adaptive equipment or a worksite modification that MetLife considers appropriate for your situation and that is approved by an independent doctor, but you choose not to;
- The date you are no longer disabled;
- The date you die;
- The date you choose not to participate in a rehabilitation program that MetLife considers appropriate for your situation and is approved by an independent doctor;
- The date you fail to have a medical exam requested by MetLife;
- The date your work earnings exceed the amount allowable;
- The date you fail to provide required proof of continuing disability.

STD Insurance Exclusions and Limitations

STD Insurance benefits are not payable for any disability caused or contributed to by:

- War, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
- Your active participation in a riot;
- Intentionally self-inflicted injury;
- Attempt to commit or taking part in a felony;
- Occupational sickness or injury;
- A Pre-Existing Condition: 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.
- Elective treatment or procedures, excluding organ donations, such as:
 - cosmetic surgery or treatment primarily to change appearance;
 - reversal of sterilization;
 - liposuction;
 - visual correction surgery;
 - in vitro fertilization; embryo transfer procedure; or artificial insemination (excluding disability resulting from pregnancy as a result of in vitro fertilization); and
 - laser vision corrective surgery.

Flight Employees – Short-Term Disability Benefits

[Overview](#)

[Pilot Short-Term Disability \(STD\)](#)

[Flight Attendant Optional Short-Term Disability \(OSTD\)](#)

Note: Long-term disability benefits are provided under a separate plan, the American Airlines, Inc. Long-Term Disability Plan.

Overview

It's important to note that Short-Term Disability benefits are different for the Pilot and Flight Attendant workgroups.

The Company provides Short-Term Disability (STD) benefits for eligible Pilot employees.

The Company provides Optional Short-Term Disability (OSTD) Insurance for eligible Flight Attendant employees.

MetLife's Role – OSTD/STD Pay

MetLife is the Network/Claim Administrator for Short-Term Disability. Visit the [MetLife website](#) or contact MetLife at 1-888-533-6287 for more information.

Pilot Short-Term Disability (STD)

How the Benefit Works

This benefit applies to eligible Pilot employees. Dependents are not eligible for this benefit.

As an eligible employee, 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 other benefits begin. To help bridge the gap, the Company offers Short-Term Disability (STD) pay until other disability benefits begin.

STD pay is \$50 per week (minus taxes). The STD pay you receive is part of your taxable income because it is an extension of your earnings paid by the Company. Benefits are payable only after you have used all of your accrued sick time or on the eighth day of your non-worked related disability, whichever is later. Benefits end after a period of 26 weeks or when you recover, whichever is earlier.

If you are unable to work your normal work schedule for any reason, you must address your work status with your manager/supervisor, regardless of whether or not you receive STD pay.

When You Qualify for Pilot STD

To qualify for STD benefits, you must be considered "totally disabled." 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.

The Company's approval of your sickness or injury leave of absence is separate from disability benefit determination and is not validation of your disability claim or any guarantee of benefits payable for your disability claim.

When STD Benefits Begin

Provided you qualify, you begin receiving STD pay on the eighth day of disability or when your accrued paid sick time is exhausted, whichever is later. Benefits are payable for a maximum of 26 weeks.

Successive Periods of Disability

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 one week of full-time active work are considered a single period of disability. 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.

Filing a Claim for STD Benefits

You must file a claim in order to receive STD Pay. If your disability continues for eight or more days, **you should file your claim by the eighth day of disability**. The sooner you file, the sooner your claim can begin processing.

You can file your claim up to one year 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 after the one-year deadline has passed (or the state-mandated deadline, if sooner), your claim will not be accepted and you will not be eligible for benefits.

To file a claim for disability benefits:

- You or your manager/supervisor can obtain the [Disability Claim Form](#) or request the form from Flight Administration as soon as you become disabled.
- You, your manager/supervisor and your attending Physician must each complete a part of the form. The completed sections may be mailed together or separately to MetLife at the address on the form.
 - Disability Claim Employer Statement: Your manager/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.
 - Disability Claim Attending Physician Statement: Your Physician completes this page.

After MetLife receives the form, your claim will be processed. Sometimes MetLife may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment are made directly to you.

If your disability extends beyond the maximum duration of STD payments, you must file a separate claim for Long-Term Disability benefits. (Note that Long-Term Disability benefits are not part of this Plan.) To file this claim, consult Flight Administration and refer to the claim filing information in the Pilot Long-Term Disability Plan on Jetnet. You must file a separate claim for Pilot Long-Term Disability benefits.

When STD Benefits End

Your STD pay ends automatically on the earliest of the following dates:

- The date the Network/Claim Administrator determines you are no longer disabled,
- The date you become gainfully employed in any type of job for any employer,
- The end of the maximum benefit period of 26 weeks,
- The date your employment terminates, or
- The date you die.

If and when you return to work, you or your manager/supervisor must notify MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for reimbursing the Company for any overpayments you receive.

Exclusions and Limitations

STD pay 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.
- Pay is not available if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered work-related if the claim is denied by Workers' Compensation.
- If you are based in California, Hawaii, New York, New Jersey, Rhode Island or Puerto Rico, STD pay does not apply. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. These state disability coverages are insured plans through MetLife.

Flight Attendant Optional Short-Term Disability (OSTD)

How the OSTD Insurance Benefit Works

This benefit applies to eligible Flight Attendant employees. Dependents are not eligible for this benefit.

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) benefits begin. (Note that Long-Term Disability benefits are not part of this Plan.) In this case, the Company also offers Optional Short-Term Disability (OSTD) Insurance benefits to provide income protection until LTD benefits begin.

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. 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.

When You Qualify for OSTD Insurance Benefits

In order to qualify for OSTD Insurance, you must be considered “totally disabled.” 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.

In addition, 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

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. It does not include profit sharing, bonus, overtime or incentive pay. The maximum covered salary is \$200,000.

Your OSTD Insurance benefit will be adjusted to reflect income from other sources (see ["Benefits from Other Sources,"](#) below) 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.

If you are enrolled in the Long-Term Disability (LTD) benefit, you will receive the full benefit of OSTD Insurance, plus you will receive a minimum benefit from LTD coverage (to begin the later of four months from the date of disability or when sick pay is exhausted). (Note that Long-Term Disability benefits are not part of this Plan.) Once the 26 weeks of OSTD Insurance are exhausted, the full LTD benefit will be payable.

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.

The OSTD Insurance benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

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 OSTD Insurance 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.

Successive Periods of Disability

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.

Filing a Claim for OSTD Insurance Benefits

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 benefit. (Note that Long-Term Disability benefits are not part of this 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. The completed sections may be mailed together or separately to the Network/Claim Administrator at the address on 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.

After the Network/Claim Administrator receives the form, your claim will be processed. Sometimes the Network/Claim Administrator 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 Network/Claim Administrator for the Optional Short-Term Disability Insurance benefit. The OSTD Insurance and state disability coverages are insured plans (including state plans in Hawaii, New Jersey, New York and Puerto Rico). The states of California and Rhode Island administer their own disability plans.

OSTD Insurance Return-to-Work Program

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. If you participate in the 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.

OSTD Insurance 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 receive the reimbursement, 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.

Child care must be provided for your or your Spouse's child, legally adopted child or a child for whom you or your Spouse is legal guardian and who is:

- Living with you as part of your household;
- Dependent on you for support; and
- Under age 13.

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 you 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 OSTD Insurance Benefits End

Your OSTD Insurance benefit payments end automatically on the earliest of the following dates:

- The date the Network/Claim Administrator 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 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 Care Insurance

MetLife fully insures and administers the long-term care insurance benefit under the Plan. MetLife has made the determination to no longer offer long-term care insurance under the Plan. Individuals who are already enrolled in long-term care insurance will be able to continue their coverage through MetLife. To be considered for coverage, individuals must have submitted a completed enrollment form to MetLife, and MetLife must have received it on or before January, 2, 2013.

When you enrolled in the long-term care insurance benefit, you should have received a Certificate of Coverage in the mail that describes the benefits under long-term care insurance. If you need another copy of your Certificate of Coverage or want more information, you can visit the [MetLife website](#) or contact MetLife at 1-800-438-6388 for more information.

Additional Rules That Apply to the Plan

[Overview](#)

[Qualified Medical Child Support Orders \(QMCSO\)](#)

[Coordination of Benefits](#)

[Subrogation and Reimbursement](#)

[Notice of Privacy Rights – Health Care Records](#)

[Rescission in Event of Fraud](#)

[Premium Assistance Under Medicaid and the Children's Health Insurance Program \(CHIP\)](#)

Overview

Unless otherwise stated in this SPD, the following rules apply to employees covered under the Plan.

Qualified Medical Child Support Orders (QMCSO) Procedures

The following procedures have been adopted and amended with respect to medical child support orders received by group health benefits and plans maintained for employees of American Airlines, Inc. These procedures shall be effective for medical child support orders issued on or after the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) relating to employer-provided group health plan benefits.

These procedures are for health coverage under the American Airlines, Inc. Health & Welfare Plan for Active Employees ("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 OBRA '93 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 NMSN decreed to be a QMCSO.
- The term “Plan Administrator,” as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures upon Receipt of 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:

American Airlines QMCSO
PO BOX 1542
Lincolnshire, IL 60069-1542
Fax#: 847.442.0899

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

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

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

- Must be a “medical child support order”, which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that

has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

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

American Airlines, Inc. does not provide interim coverage to any 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, the Company 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 OBRA '93, a state-ordered medical child support order is not necessarily a Qualified Medical Child Support Order. Thus, before the Plan honors the Order, the Order must meet the requirements for a QMCSO or NMSN specified above.

Procedures upon Final Determination

The Participant, Alternate Recipient and any party specified in the medical child support order shall be notified of the acceptance of the medical child support order or national medical support notice as being qualified. Once the Order is determined to be a QMCSO or NMSN, the Plan Administrator will follow the terms of the Order and shall authorize enrollment of the Alternate Recipient as well as have any payments for such coverage deducted from the payroll of the Participant. In addition, a copy of the appropriate Summary Plan Description describing applicable Medical benefit options 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 Employee Benefits Committee (EBC) or its authorized delegate 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 Summary Plan Description, shall be provided upon request.

Coordination of Benefits

This section explains how the Plan coordinates coverage between the Plan 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 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 were your only coverage.

For example, if your dependent is covered by another benefit/plan and the VALUE Medical Benefit Option is his or her secondary coverage, the VALUE Medical Benefit Option pays only up to the maximum benefit amount payable under the VALUE Medical Benefit 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 Maximum Out-of-Network Charge (“MOC”)). 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 Plan's coordination of benefits rules apply regardless of whether a claim is made under the other plan. If a claim is not made, benefits under the Plan may be delayed or denied until an explanation of benefits is issued showing a claim made with the primary plan.

The Plan will not coordinate as a secondary payer for any copays you pay with respect to another plan or with respect to prescription drug claims (except where the other plan is Medicare).

If you reside in a state where automobile no-fault coverage, personal injury protection coverage or medical payment coverage is mandatory, that coverage is primary and the Plan takes secondary status. The Plan will reduce benefits for an amount equal to, but not less than, the state's mandatory minimum requirement.

The Plan has first priority with respect to its right to reduction, reimbursement and subrogation.

The Plan will not coordinate benefits with an HMO or similar managed care plan where you only pay a copayment or fixed dollar amount.

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:

- Group insurance or other coverage for a group of individuals, including coverage under another employer-sponsored benefit plan or student coverage through an educational facility, organization, or institution
- Coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefit organization plans
- Government or tax-supported programs, including Medicare or Medicaid
- Property or homeowner's insurance or no-fault motor vehicle coverage
- Any other individual or association insurance policies that are group or individual rated

Which Plan Is Primary

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

The following determines which plan is primary:

- 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.
- The Plan is always secondary to any motor vehicle policy that may be available to you, including personal injury protection (PIP coverage) or no-fault coverage. If the Plan pays benefits as a result of injuries or illnesses resulting from the acts of another party, the Plan has a right of reimbursement or subrogation as to the benefits paid. Please see the Plan's [Subrogation and Reimbursement](#) provision.
- 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.
 - 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. If the other plan has a gender rule, that plan determines which plan is primary.

Coordination with Medicare

If you (or one of your dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare benefits for Prescription drug benefits), American Airlines, Inc. is the primary payer if:

- You are currently working for American Airlines, Inc.
- You become eligible for Medicare due to your (or your dependent) having end-stage renal disease, but only for the first 30 months of Medicare entitlement due to end-stage renal disease.
- You become eligible for Medicare due to becoming eligible for Social Security Disability and your coverage under this Plan is due to the current employment status of the employee. (For this purpose, you will only be considered to have current employment status during the first six months in which you receive

Company paid disability benefits that are subject to FICA tax. Generally, Medicare does not begin to pay benefits until after this period ends.)

If you (or one of your dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare benefits for Prescription drug benefits), the American Airlines, Inc. plan pays secondary if:

- You (or your dependent) are covered by Medicare, do not have end-stage renal disease, and you are not currently working for American Airlines, Inc. or deemed to have coverage because of current employment status.
- You become eligible for Medicare due to you (or your dependent) having end-stage renal disease, but only after the first 30 months of Medicare entitlement due to end-stage renal disease is exhausted.

If you (or your dependent) are over age 65 and the American Airlines, Inc. 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 American Airlines, Inc. plan will terminate.

Benefits for Disabled Individuals

If you stop working for American Airlines, Inc. because of a disability and you are eligible for Social Security Disability Benefits, or if you retire before age 65 and subsequently become disabled and you are eligible for Social Security Disability Benefits, 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 American Airlines, Inc. plan, the American Airlines, Inc. plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the American Airlines, Inc. plan considers eligible, the American Airlines, Inc. 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 American Airlines, Inc. 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.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement. By enrolling in the Plan and applying for benefits from the Plan, you and your covered dependents (including minor dependents) agree and acknowledge that benefits are not payable to or on behalf of a covered person or dependent when the injury or illness occurs through an act or omission of another person, party, or entity, and any such payments made or advanced by the Plan are subject to the following terms and conditions:

Subrogation applies when the Plan has paid benefits on your behalf for a sickness or injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. The Plan has the right to subrogate 100% of the benefits paid or to be paid on your behalf.

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You further agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
 - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with us. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- By accepting benefits from this Plan, you agree that the Plan has established an equitable lien by agreement and has a first priority right to receive payment on any claim against a third party before you receive payment from that third party, whether obtained by judgment, award, settlement, or otherwise. The Plan has the right to 100% reimbursement in a lump sum and has the right to recover interest on the amount paid by the Plan because of the actions of a third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's lien exists at the time the Plan pays benefits, and if you or your covered dependents file a petition for bankruptcy, you and your covered dependents agree that the Plan's line existed prior to the creation of the bankruptcy estate.
- 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 the Plan is not responsible for your attorney's fees, expenses and costs. The Plan is not subject to any state laws or equitable doctrines, including but not limited to the so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine," which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable doctrine or state law shall limit or defeat the Plan's subrogation and reimbursement rights.
- If this Section applies, the Plan will not cover either the reasonable value of the services to treat such an injury, sickness or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By accepting benefits from this Plan, you and your covered dependents automatically assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury, including another group health plan, insurer or individual. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval, or approval from the Plan's authorized or designated agent for subrogation-and-reimbursement recoveries.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent Child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

The Plan and all individuals and entities administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Notice of Privacy Rights — Health Care Records

This notice applies to all Plan participants. 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 American Airlines, Inc. Health & Welfare Plan for Active Employees (particularly, the STANDARD Medical Benefit Option, the CORE Medical Benefit Option, the VALUE Medical Benefit Option, the OUT-OF-AREA Medical Benefit Option, the HMOs, Dental, Vision Insurance, Health Care Flexible Spending Accounts, Limited Purpose Flexible Spending Account, Health Savings Account), the Supplemental Medical Plan for Employees of Participating American Airlines Group Subsidiaries, the Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group 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 American Airlines, Inc. 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 Health and Wellness, at American Airlines, Mail Drop 5126-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 Health and Wellness, at American Airlines, Mail Drop 5126-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 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 EBC 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 EBC 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 American Airlines, Inc. May Use Your Health Information

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 Plans include the health plan components of:

- The American Airlines, Inc. Health & Welfare Plan for Active Employees (Plan 501)

- The Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group 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 plans),
- 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, the Company may have personal medical information about you that is used for routine employment activities. Medical information held or used by the Company 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 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, the Company has agreed to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description, as it may be amended by the Company 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 American Airlines, Inc. and the Group Health Plans

The following employees or classes of employees or other persons under the control of the Company 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.
- The EBC, its delegated authority, due to their role in governing health plan matters, including rendering appeal decisions and other health plan administrative matters.
- Benefits Compliance and the EBC Appeals group personnel involved in receiving, researching and responding to health plan member appeals filed with the EBC.
- American Airlines Benefits Service Center 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 American Airlines Benefits Service Center personnel, and thus have access to the call center systems.
- The 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.
- American Airlines Benefits Service Center 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 the Company, including payment and health care operations.

The Company shall provide an effective mechanism for resolving any issues of non-compliance by such employees or persons.

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 American Airlines, Inc.

The American Airlines, Inc. Health & Welfare Plan for Active Employees 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 American Airlines Group Subsidiaries, the Trans World Airlines, Inc. Retiree Health and Life Benefits Plan, the Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group 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.

Rescission in Event of Fraud

Any act, practice, or omission by a Plan participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the Plan and the Plan may rescind coverage as a result. Any such fraudulent statements, including on Plan enrollment forms and in electronic submissions, will invalidate any payment or claims for services and will be grounds for rescinding coverage.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	NEVADA – Medicaid

Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicaid/serv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/ http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid

Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	WASHINGTON – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	WYOMING – Medicaid
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security
Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

COBRA

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Overview

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 Aon Hewitt, Inc., the COBRA administrator. Aon Hewitt, 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.

The STANDARD Medical Benefit Option, VALUE Medical Benefit Option, CORE Medical Benefit Option, OUT-OF-AREA Medical Benefit Option, Dental, Vision Insurance, 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
- Dental
- Vision Insurance
- Health Care Flexible Spending Account or Limited Purpose Flexible Spending Account, 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.) In addition, the Plan allows you to carryover up to \$500 of any amount remaining in your HCFSA or LPFSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the COBRA continuation period (i.e. 18, 29, or 36 months, as applicable). Any unused amount of more than \$500 remaining in your HCFSA or LPFSA at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.

The coverage under COBRA is identical to coverage provided under the benefits or plans for similarly situated employees or their dependents, including future changes.

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 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. 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 (Aon Hewitt, 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
- You become eligible for (enrolled in) Medicare benefits
- Loss of eligibility because the dependent no longer meets the Plan's definition of a dependent (for example, if a Child reaches the Plan's limiting age). The dependent loses coverage on the last day of the month in which they attain age 26.
- Your 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 Following Layoff or Termination

In the event that your employment ends through layoff or termination, you will automatically receive information from Aon Hewitt, Inc., the COBRA administrator, about electing continuation of coverage through COBRA.

Solicitation of Coverage Following a Qualifying Event

In the event of a Qualifying Event (as shown above as for your dependents only), you must notify American Airlines Benefits Service Center 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, the Benefits Service Center will advise Aon Hewitt, 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 Aon Hewitt 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 Aon Hewitt, 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 Benefits Service Center before your 60-day election period expires.

Processing Life Events After Continuation of Coverage Is in Effect

If you elect continuation of coverage for yourself and later marry, 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 American Airlines Benefits Service Center within 31 days of the marriage, 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 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 American Airlines Benefits Service Center of the newborn Child or Child newly placed for adoption within 31 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 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 Aon Hewitt, 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.

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 Aon Hewitt, 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.

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 enrolled in 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.

Keep Us Informed of Address Changes

In order to protect you and your family’s rights, you should keep both Aon Hewitt, Inc. and the Company informed of any changes in the addresses of your family members.

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 certain 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. 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 may also have the right to enroll in coverage through a state-based or federally-facilitated healthcare exchange under PPACA. 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 American Airlines Benefit Service Center.

Claims Procedures

[Time Frame for Initial Claim Determination](#)

[Appealing a Denial](#)

[When You are Deemed to Have Exhausted the Internal Claim and Appeal Process](#)

[The External Review Process](#)

[Deadline to Bring Legal Action](#)

Time Frame for Initial Claim Determination

Unless otherwise provided in the applicable insurance policy/evidence of coverage, your claim for benefits will be processed under the procedures described below.

Medical, Dental, Vision, and Long-Term Care Claims

For claims for medical, dental, vision, and long-term care 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/Claim 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); and
- 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/Claim Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For **Urgent Care claims**, if you fail to provide the Network/Claim Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Network/Claim 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/Claim 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/Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Network/Claim 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/Claim 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.

Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account Claims

For claims under the Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account, the Network/Claim Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. A 15-day extension may be allowed to make a determination, provided that the Network/Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Network/Claim 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 You Receive an Adverse Benefit Determination on a Medical, Dental, Vision, Long-Term Care, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, or Limited Purpose Flexible Spending Account Claim

The Network/Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

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

the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits.

- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim
- For Medical claims, the Network/Claim 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
- Date of service, the health care Provider, the claim amount (for Medical claims)
- The denial code and corresponding meaning (for Medical claims)
- 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) (for Medical claims)
- A description of the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for Medical claims)
- A description of [the external review process](#), if applicable (for Medical claims)
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for Medical claims).

Disability Claims

This section applies to Short-Term Disability Pay and Optional Short-Term Disability Insurance.

All Disability claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the Network/Claim Administrator. After the Network/Claim Administrator has reviewed the claim for Disability benefits and obtained any other information that it deems necessary or relevant, the Network/Claim 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/Claim Administrator for up to 30 days, provided the Network/Claim 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/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/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 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.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

All Other Claims

This section applies to the following benefits:

- Employee Term Life Insurance;
- Spouse Term Life Insurance;
- Child Term Life Insurance;
- Accidental Death & Dismemberment Insurance (Employee, Spouse, Child)
- Special Purpose Accident Insurance
- Special Risk and Accident Insurance
- Management Personal Accident Insurance (For Management, Specialist and Officer employees)
- Voluntary Personal Accident Insurance (for flight attendants and pilots)
- Terrorism and Hostile Act Accident Insurance

All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the Network/Claim Administrator. After the Network/Claim Administrator has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the Network/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/Claim Administrator for up to 90 days, provided the Network/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/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 benefits is denied, in whole or in part, the Network/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, and
- 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.

Effect of Failure to Submit Required Claim Information

If the Network/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/Claim Administrator request for information or upon a demonstration to the satisfaction of the Network/Claim Administrator that under the circumstances the Network/Claim Administrator request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the Network/Claim Administrator, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the Network/Claim Administrator deems relevant.

Appealing a Denial

Unless otherwise provided in the applicable insurance policy/evidence of coverage, you must file your appeal within the deadlines set forth below.

Appealing a Denial — For Non-Grandfathered Medical Benefit Options (STANDARD, CORE, VALUE, OUT-OF-AREA), HMO Medical Benefit Options, Dental Benefits

This contains appeal information and requirements specific to the Non-Grandfathered Medical Benefit Options and Dental Benefits.

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). However, there are other rules and provisions that the U.S. Department of Labor continues to review. Those rules may carry a later compliance date. 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 SPD 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 SPD.

However, your Network health care Providers, through their Provider contracts with the Network/Claim Administrator, also have the option to appeal adverse benefit determinations — to the extent that the adverse benefit determinations affect their benefit payments from the Network/Claim Administrator. Your Network health care Providers may appeal directly to the Network/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/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/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 SPD (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 SPD).

Procedures for Appealing an Adverse Benefit Determination

American Airlines, Inc., as Plan Sponsor and Plan Administrator of the Plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the Network/Claim Administrator or benefit vendor that rendered the adverse benefit determination. Second Level Appeals are conducted by the Employee Benefits Committee (EBC) or its delegate 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, the appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The EBC 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.) For purposes of this paragraph, "full-insured benefits" include the following:

- Employee Term Life Insurance
- Spouse and/or Child Term Life Insurance
- Voluntary Life Insurance
- Accidental Death & Dismemberment Insurance (employee, Spouse, Child, VPAI and all Company-provided Accident Insurance Benefits)
- Vision Insurance
- HMOs
- Long-Term Care Insurance

First Level Appeal

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Network/Claim 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/Claim 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/Claim 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/Claim Administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For pre-service claims – within 15 days of receipt of your First Level Appeal
- For post-service claims – within 30 days of receipt of your First Level Appeal
- For Urgent Care claims – within 72 hours of receipt of your First Level Appeal
- For Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account claims – within 30 days of receipt of your First Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If the Network/Claim 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/Claim 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, Dental, Vision, Long-Term Care, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Limited Purpose Flexible Spending Account, or Disability, within 60 days of receipt of your First Level Appeal, if the Network/Claim 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/Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Second Level Appeal

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 EBC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the EBC 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 EBC) 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 EBC, 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 EBC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within 15 days of receipt of your Second Level Appeal
- For post-service claims, within the 30 days of receipt of your Second Level Appeal
- For Urgent Care claims, within the 72-hour time period allotted for completion of both levels of appeal
- For Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account claims – within 30 days of receipt of your Second Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If the Network/Claim Administrator requires additional time to obtain information needed to evaluate your Second Level Appeal for disability, it may have an additional 45 days to complete your Second Level Appeal (the Network/Claim Administrator will notify you if this additional time period is needed to complete a full and fair review of your case).
- For all other claims for all benefits other than Medical, Dental, Vision, Long-Term Care, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Limited Purpose Flexible Spending Account, or Disability, within 60 days of receipt of your Second Level Appeal, if the Network/Claim 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 Second Level Appeal (the Network/Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

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 EBC. Appointed officers of American Airlines, Inc. are on the EBC. In some cases, the EBC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the Network/Claim Administrator, if appropriate, will be reviewed by the EBC or its designee(s).

Rights on Appeal

In the filing of appeals under the Plan, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as “relevant” to your claim if it:
 - Was relied upon in making the benefit determination
 - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
 - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
 - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony.
- Receive from the Plan Administrator or Network/Claim Administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond to 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 Administrator 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

Notice of Determination

If your appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A description of 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 (for appeals for all benefits except for those benefits listed under "All Other Claims").
- 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 (for appeals for all benefits except for those benefits listed under "All Other Claims"). 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
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures.

- Date of service, the health care Provider, the claim amount (for Medical claims)
- The denial code and correspondent meaning (for Medical claims);
- 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 external review, and will not trigger the start of external review) (for Medical claims)
- A description of the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for Medical claims);
- A description of [the external review process](#), if applicable (for Medical claims); and
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for Medical claims).

When You are Deemed to Have Exhausted the Internal Claim and Appeal Process

If the Plan Administrator or Network/Claim 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 (for Medical claims), 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/Claim 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/Claim Administrator's control).

You may request from the Plan Administrator or Network/Claim Administrator a written explanation of the violation, and such explanation must be provided to you within 10 days. This explanation should include a specific description of the bases, if any, for its assertion that the violation should not cause the internal claim and appeal process to be deemed exhausted.

If an external reviewer (for Medical claims) or court rejects your request for immediate review because it finds that the Plan Administrator or Network/Claim Administrator met the standards for exception (*de minimis* violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or Network/Claim 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/Claim 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.

The External Review Process

After you have exhausted (or 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 and Dental 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 non-quantitative 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.

Deadline to Bring Legal Action

You must use and exhaust the Plan's administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plan's 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.

Plan Administration

[Administrative Information](#)

[Other Legal Information](#)

Administrative Information

Plan Name & Number

American Airlines, Inc. Health & Welfare Plan for Active Employees (501)

Plan Sponsor

American Airlines, Inc., or its authorized delegate

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

Plan Administrator

American Airlines, Inc., or its authorized delegate

Mailing address:

Mail Drop 5141-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616
General Phone: 1-800-433-7300

American Airlines, Inc. has delegated certain administrative functions to Aon Hewitt, including answering questions on behalf of American Airlines, Inc. They can be reached at: 1-800-860-6178

Street address (do not mail to this address):

4333 Amon Carter Blvd.
Fort Worth, Texas 76155

The Plan Administrator (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the Plan described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the Plan Administrator (or its delegate(s)) made pursuant to the Plan described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The Plan Administrator may delegate this discretionary authority to selected service Providers. In certain circumstances, for all purposes of overall costs savings or efficiency, the Plan Administrator (or its delegate(s)) may, in

their sole discretion, offer benefits for services that would not otherwise be covered. The fact that the Plan Administrator (or its delegate(s)) do this in any particular case shall not in any way be deemed to require the Plan Administrator (or its delegate(s)) to do so in similar cases.

The Plan Administrator for Urgent and Second Level Claim Appeals

Employee Benefits Committee (EBC)

American Airlines, Inc.
Mail Drop 5134-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Agent for Service of Legal Process

Managing Director, Health and Wellness
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

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Plan Type

Health and welfare benefits, including medical, Dental, vision, disability, life, flexible spending account, long-term care insurance, and employee assistance benefits.

Plan Funding

Please see the chapter “[Benefits under the Plan and Contact Information](#)” for information regarding how benefits under the Plan are funded.

Collective Bargaining Agreement

Certain benefits described in this SPD are maintained pursuant to collective bargaining agreements for certain groups of eligible employees. A copy of a collective bargaining agreement applicable to you may be obtained by participants and beneficiaries upon written request to the Plan Administrator. The collective bargaining agreements are also available for review during normal business hours at the corporate offices of American Airlines, Inc. (see “[Contact Information](#)” in the *Reference Information* section, and Collective Bargaining Agreement in the *Glossary*).

Other Legal Information

Plan Amendment and Termination

The Company or its authorized delegate has the sole authority to adopt new employee benefit plans, amend existing plans, and terminate plans. The Company may at any time amend the Plan by written instrument executed by an officer of the Company. Further, the Company reserves the right to terminate the Plan at any time. On or after the effective date of a termination, no further benefits shall be payable to or on behalf of any participant to whom such terminate applies.

No Liability for Benefits

Notwithstanding any other provision of the Plan, neither the Company nor the Plan shall have any liability to provide any benefit that is to be provided through any insurance contract or health maintenance organization contract in the event that such benefit is not paid or otherwise provided by the issuer of such contract.

No Commitment to Employment

Nothing in the Plan shall be construed as a commitment or agreement upon the part of any person to continue his employment with the Company, and nothing contained in the Plan shall be construed as a commitment on the part of the Company to any rate of compensation of any person for any period, and all employees of the Company shall remain subject to discharge to the same extent as if that Plan had never been put into place.

No Precedent

Except as otherwise specifically provided, no action taken in accordance with the provisions of the Plan by the Plan Administrator or the Company shall be construed or relied upon as precedent for similar action under similar circumstances.

Severability

If a provision of the Plan is held illegal or invalid, the illegality or invalidity does not affect the remaining parts of the Plan and the Plan must be construed and enforced as if the illegal or invalid provision had not been included in the Plan.

Anti-Assignment of Benefits

You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

For information about whether you can assign Life Insurance benefits, see “[Assignment of Benefits](#)” under “[Special Provisions](#)” in the *Life Insurance* section.

Confidentiality of Claims

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

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

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see “[Notice of Privacy Rights — Health Care Records](#)”.

Payment of Benefits

Benefits will be paid to you unless you have authorized payment to your service Provider. Benefits are paid after the Network/Claim Administrator receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the Network/Claim Administrator may pay all or part of the benefit to:

- 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 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 Benefit Option under the Plan (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

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

Right to Recovery

The Plan and the Network/Claim Administrator shall have the right to recover from any participant or former participant the amount of any benefits paid by the Plan (i) for expenses incurred on behalf of a participant which were not paid by the participant and were not legally required to be paid by the participant, (ii) which exceeded the amount of benefits payable under the Plan, or (iii) for expenses which were recovered from or paid by a source other than this Plan, as described in "Subrogation." If the participant or former participant, or any other person or organization, does not repay to the Plan the amount owed in a lump sum within 30 days of receiving notice, then notwithstanding any provision in this SPD to the contrary and without limiting any other remedies available to the Plan, the Plan may reduce the amount of any benefits that become payable to the participant or the participant's service Providers to recover the amount owed to the Plan.

The Network/Claim Administrator may also 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.

Your Rights Under ERISA

Your Rights Under ERISA

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

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.

Continue Group Health Plan Coverage

Continue group health coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation rights.

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:

American Airlines Benefits Service Center
PO Box 564103
Charlotte, NC 28256-4103
1-888-860-6178

For information about your claims, contact the appropriate Network/Claim Administrator or Plan Administrator at the addresses and phone numbers located in the “[Contact Information](#)” in the *Reference Information* section.

Benefits under the Plan and Contact Information

The Network/Claim Administrator for each benefit under the Plan vary and are listed below. The chart below also describes how benefits under the Plan are funded.

Benefit Option	Network/Claim Administrator and Plan Funding
Medical and Mental Health/Chemical Dependency Coverage	
<ul style="list-style-type: none"> ○ STANDARD Medical Benefit Option ○ CORE Medical Benefit Option ○ VALUE Medical Benefit Option ○ OUT-OF-AREA Medical Benefit Option ○ Healthy Pregnancy Program ○ Special Beginnings ○ Telehealth 	<p>Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044 1-877-235-9258 Website: www.bcbstx.com/americanairlines</p> <p>UnitedHealthcare American Airlines, Inc. Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551 1-800-955-8095 Website: americanairlines.welcometouhc.com</p> <p>Please also contact the above Network/Claim Administrators for CheckFirst (Predetermination of Benefits) and QuickReview (Pre-authorization for Hospitalization).</p> <p>Please also contact United Healthcare at the number listed above for information about the Healthy Pregnancy Program.</p> <p>Please contact Blue Cross and Blue Shield of Texas for information about Special Beginnings by calling 888-421-7781.</p> <p>For more information about Telehealth services and technological requirements, visit Doctor on Demand online at doctorondemand.com or call 800-997-6196.</p> <p>Self-funded through the general assets of the Company and employee contributions</p>

Benefit Option	Network/Claim Administrator and Plan Funding
<ul style="list-style-type: none"> Health Maintenance Organizations (HMOs) 	<p>Community Care Managed Healthcare Plans of Oklahoma 1-800-777-4890 http://aa.ccok.com Group Number: C01338</p> <p>Health Plan Hawaii (HMSA) 1-808-948-6372 http://www.hmsa.com/ Group Number: C92U (Referred to as Agent Code)</p> <p>Humana Health Plans of Puerto Rico 1-800-314-3121 http://www.humana.com/ Group Number: 113262</p> <p>Kaiser Northern California 1-800-464-4000 http://www.my.kp.org/americanairlines Group Number: 8653</p> <p>Kaiser Southern California 1-800-464-4000 http://www.my.kp.org/americanairlines Group Number: 102105</p> <p>Kaiser Mid-Atlantic States (Maryland and Washington, D.C.) 1-800-777-7902 http://www.my.kp.org/americanairlines Group Number: 3381</p> <p>TRIPLE-S Inc. (Puerto Rico only) 1-787-774-6060 http://www.ssspr.com/ Group Number: SP0003447</p> <p>Fully insured, funded through the general assets of the Company and employee contributions</p>

Benefit Option	Network/Claim Administrator and Plan Funding
Prescription Drugs (Except HMOs)	
Mail Service Drug Option (Mail Order Pharmacy Service)	Express Scripts P.O. Box 3938 Spokane, WA 99220-3938 1-800-988-4125 Website: express-scripts.com
Prescriptions - Prior Authorization	Express Scripts 8111 Royal Ridge Parkway, Suite 101 Irving, TX 75063 1-800-988-4125 Website: express-scripts.com
Filing Retail Prescription Claims	Express Scripts P.O. Box 2160 Lee's Summit, MO 64063-2160 1-800-988-4125 Website: express-scripts.com
	Self-funded through the general assets of the Company and employee contributions
Expert Medical Opinion	
Expert Medical Opinion	Advance Medical 855-212-1074 www.advance-medical.net/AA
Employee Assistance Program	
American Airlines, Inc. On-Site Employee Assistance Program	EAP at American Airlines 1-800-555-8810



Benefit Option	Network/Claim Administrator and Plan Funding
Optum Employee Assistance Program (EAP)	Optum Health 800-363-7190 Website: www.liveandworkwell.com
	Self-funded through the general assets of the Company
Wellness	
<ul style="list-style-type: none"> • WebMD Wellness • Health Condition Management • Biometric Screening (Wellness rewards) • StayWellRX • Knock Out Nicotine 	WebMD For more information, please call 888-383-8740 or visit www.webmdhealth.com/AmericanAirlines . Self-funded through the general assets of the Company
Dental Coverage	
Dental	MetLife AMR American Airlines, Inc. Dental Claim Unit P.O. Box 981282 El Paso, TX 79998-1282 1-866-838-1072 Website: https://mybenefits.metlife.com/ Self-funded through the general assets of the Company and employee contributions
Vision Insurance	

Benefit Option	Network/Claim Administrator and Plan Funding
Vision Insurance	<p>EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 1-844-714-5678 Website: Please click on the following link for more information: https://www.eyemedvisioncare.com/american</p> <p>First American Administrators, Inc. will decide claims and first levels appeals. Appeals should be mailed or faxed to the following address:</p> <p>FAA/EyeMed Vision Care, LLC Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040 Fax: 1-513-492-3259</p> <p>Fully insured, funded through the general assets of the Company and employee contributions</p>
Life Insurance	
<p>Life Insurance:</p> <ul style="list-style-type: none"> • Employee Basic Term Life • Voluntary Life • Spouse Term Life • Child Term Life 	<p>MetLife American Airlines Customer Unit P.O. Box 3016 Utica, NY 13504-3016 1-800-638-6420</p> <p>The following benefits are fully insured and premiums are paid through the general assets of the Company:</p> <ul style="list-style-type: none"> ○ Employee Basic Term Life Insurance <p>The following benefits are fully insured and paid entirely by employee contributions:</p> <ul style="list-style-type: none"> ○ Voluntary Life Insurance ○ Spouse Term Life Insurance ○ Child Term Life Insurance
Accident Insurance	

Benefit Option	Network/Claim Administrator and Plan Funding
<p>Accidental Death & Dismemberment (AD&D) Insurance:</p> <ul style="list-style-type: none"> • Basic • Voluntary <p>Other Accident Insurance:</p> <ul style="list-style-type: none"> • Special Purpose Accident Insurance • Special Risk Accident Insurance • Management Personal Accident Insurance • Terrorism and Hostile Act Insurance 	<p>American Airlines, Inc. Benefits Service Center P.O. Box 564103 Charlotte, NC 28256-4103 Phone: 1-847-554-1884</p> <p>The following benefits are fully insured and premiums are paid through the general assets of the Company:</p> <ul style="list-style-type: none"> ○ Basic AD&D Insurance (Management Support Staff and Flight Employees only) ○ Special Purpose Accident Insurance ○ Special Risk Accident Insurance ○ Management Personal Accident Insurance ○ Terrorism and Hostile Act Insurance <p>The following benefits are fully insured and paid entirely by employee contributions:</p> <ul style="list-style-type: none"> ○ Voluntary AD&D (Ground Employees only) ○ Voluntary Personal Accident Insurance (Flight Employees only)

Benefit Option	Network/Claim Administrator and Plan Funding
Disability Coverage for Ground Employees: Employees represented by the Communications Workers of America, AFL-CIO, CLC, and Officers, Management/Specialists and Support Staff	
<ul style="list-style-type: none"> ○ Short-Term Disability (Management/Specialists and Support Staff only) ○ Optional Short Term Disability (OSTD) Insurance (Employees represented by the Communications Workers of America, AFL-CIO, CLC only) 	<p>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://mybenefits.metlife.com/</p> <p>The following benefits are fully insured and premiums are paid through the general assets of the Company:</p> <ul style="list-style-type: none"> ○ Short-Term Disability (Management /Specialists and Support Staff only) <p>The following benefits are fully insured and paid entirely by employee contributions:</p> <ul style="list-style-type: none"> ○ Optional Short-Term Disability Insurance (Employees represented by the Communications Workers of America, AFL-CIO, CLC only)
Disability Coverage for Ground Employees: TWU-Represented Employees	
Optional Short Term Disability (OSTD) Insurance	<p>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://mybenefits.metlife.com/</p> <p>Fully insured and paid entirely by employee contributions</p>
Disability for Flight Attendants	

Benefit Option	Network/Claim Administrator and Plan Funding
<ul style="list-style-type: none"> Optional Short Term Disability (OSTD) Insurance 	<p>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://mybenefits.metlife.com/</p> <p>This benefit is fully insured and paid entirely by employee contributions.</p>
Disability for Pilots	
Short-Term Disability (STD)	<p>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://mybenefits.metlife.com/</p> <p>This benefit is self-funded through the general assets of the Company.</p>
Flexible Spending Accounts (FSAs), Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA)	
<ul style="list-style-type: none"> HSA (applies to Core Medical Benefit Option Only) HRA (applies to Standard, Value, and Out-of-Area Medical Benefit Options Only) Health Care FSA (for Standard, Value, and Out-of-Area Medical 	<p>AonHewitt : Your Spending Account Services P.O. Box 785040 Orlando, FL 32878-5040 Fax: 1-888-211-9900</p> <p>Please note that the HSA is not Company-sponsored.</p> <p>HRA: Reimbursements are paid from the Company's general assets.</p> <p>Health Care FSA, Limited Purpose Health Care FSA, and</p>

Benefit Option	Network/Claim Administrator and Plan Funding
<p>Benefit Options Only)</p> <ul style="list-style-type: none"> ○ Limited Purpose Health Care FSA (applies to Core Medical Benefit Option Only) ○ Dependent Care FSA 	<p>Dependent Care FSA: These benefits are self-funded and paid entirely by employee contributions.</p>
Long-Term Care Insurance	
Long-Term Care Insurance	<p>MetLife Long-Term Care 57 Greens Farms Road Westport, CT 06880 1-800-438-6388 Website (claims tracking and coverage information): https://mybenefits.metlife.com/</p> <p>Fully insured (Policy 96659) and paid entirely by employee contributions</p>
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 Added Benefits Program:	
Added Benefits Program	<p>Added Benefits 855-550-0706 www.AAaddedbenefits.com</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Hyatt Legal Plan • Group Homeowner's and Automobile Insurance • LifeLock Identity Theft Protection • Veterinary Pet Insurance (VPI) • MetLife Group Accident Insurance • MetLife Critical Illness Insurance • Group Prepaid Legal Services • Group Homeowners' and/or Automobile Insurance

Glossary of terms

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 Alternative and/or Complementary 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).

American Airlines Benefits Service Center or Benefits Service Center: The online enrollment tool, available on my.aa.com.

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.


Annual Enrollment or Annual Enrollment Period: The period, usually in the fall of each year, during which employees make benefit elections for the next Plan year.

APA Agreement: The most recent Agreement between American Airlines, Inc. and the Airline Pilots in the service of American Airlines, Inc. as represented by the Allied Pilots Association.

Appropriate Care and Treatment: 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.

Approved Clinical Trial: A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and meets any of the following three conditions:

- 
- (1) *Federally funded trials.* The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - (a) The National Institutes of Health.
 - (b) The Centers for Disease Control and Prevention.
 - (c) The Agency for Health Care Research and Quality.
 - (d) The Centers for Medicare & Medicaid Services.
 - (e) Cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - (g) Any of the following if certain conditions are met:
 - The Department of Veterans Affairs.
 - The Department of Defense.
 - The Department of Energy.

The conditions for this clause (g) are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines: to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- (2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

- (3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Benefit Options: The employee welfare benefits offered as part of this Plan, identified in the chapter “[Benefits under the Plan and Contact Information](#).”

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

Child: Your:

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Spouse or Common Law Spouse as defined by the Plan
- Stepchild
- Special Dependent, if you meet all of the requirements listed in the section “[Dependent Eligibility Requirements](#) – Generally (All Benefits)” in the chapter “Eligibility and Enrollment.”

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

Co-Insurance: A percentage of Eligible Expenses. You pay a percentage of the cost of Eligible Expenses and the Medical Benefit Option pays the remaining percentage.

Collective Bargaining Agreement(s): The labor agreements entered into between American Airlines, Inc. and its union-represented employees, listed as follows:

- Joint Collective Bargaining Agreement (JCBA) Between American Airlines, Inc. and the Airline Pilots in the Service of American Airlines, Inc. and US Airways, Inc. as Represented by the Allied Pilots Association
- Agreement Between American Airlines, Inc. and the Flight Attendants in the Service of American Airlines, Inc. as Represented by the Association of Professional Flight Attendants, and
- Letter of Agreement Between American Airlines, Inc. and the Flight Attendants in the Service of American Airlines, Inc. as Represented by the Association of Professional Flight Attendants
- Agreement Between American Airlines, Inc. and the Flight Dispatchers and Dispatcher's Assistants in the Service of American Airlines, Inc. as Represented by the Transport Workers Union of America, AFL-CIO
- Agreement Between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Fleet Service Employees
- Agreement Between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Ground School and Pilot Simulator Instructors
- Agreement Between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Aviation Maintenance Technicians and Plan Maintenance Employees of American Airlines, Inc.
- Agreement Between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Material Logistics Specialists and Crew Chief Material Logistics Specialists Employees of American Airlines, Inc.
- Agreement Between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Maintenance Control Technician Employees of American Airlines, Inc.
- Agreement Between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Flight Simulator Technicians, Associate Simulator Technicians, Technical Coordinators
- Passenger Service Agreement Between American Airlines, Inc. and the CWA-IBT Association

Common Accident: 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: American Airlines, Inc. and any successor thereto.

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 or Co-Payments: 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 Option or the 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 Options. The services are delivered under a defined set of Physician-approved policies and procedures or clinical protocols.

Durable Medical Equipment (DME): Medical equipment intended for use solely by the participant for the treatment of his or her illness or injury. DME is considered to be lasting and would have a resale value. DME must be usable only by the participant and not the family in general. The equipment must be Medically Necessary and cannot be primarily for the comfort and convenience of the patient or family. A statement of Medical Necessity from the attending Physician and a written Prescription must accompany the claim. DME includes (but is not limited to): prosthetics, casts, splints,

braces, crutches, oxygen administration equipment, wheelchairs, hospital beds and respirators.

Educational Services: A service is considered to be an Educational Service if:

- It is a service for learning and educational disorders (which include, but are not limited to, services for reading disorders, alexia, developmental dyslexia, dyscalculia, spelling disorders and other learning difficulties).
- It is an early intensive behavioral intervention for autism and pervasive developmental disorders (which include, but are not limited to, development delay services and Applied Behavior Analysis (ABA)).
- It involves testing or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded).

Eligible Dependent: Dependent eligibility requirements are different depending on the benefit coverage you elect. See the section “[Dependent Eligibility](#)” in the chapter “Eligibility and Enrollment” for information on dependent eligibility requirements by Benefit Option.

Eligible Medical Expenses or Eligible Expenses: The Benefit Option or the Plan covers the portion of regular, Medically Necessary services, supplies, care and treatment of non-occupational injuries or illnesses up to the 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. See MOC definition below for more information.

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.

Hire Date: The first date that you were on the U.S. payroll of American Airlines, Inc. as a Regular Employee.

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

- It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.
- Reliable Evidence shows that the drug, device, procedure or medical treatment is the subject of ongoing phase I, II or III clinical trials or under study (or that the

consensus of opinion among experts is that further studies or clinical trials are necessary) to determine its maximum tolerated dose, toxicity, safety or efficacy, both in diagnosis and treatment of a condition and as compared with the standard means of treatment or diagnosis.

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

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

Flight Employees: Pilots and Flight Attendants employed by the Company.

Flexible Spending Accounts (FSAs): The Health Care Flexible Spending Account (HCFSA), Limited Purpose Flexible Spending Account (LPFSA), and Dependent Care Flexible Spending Account (DCFSA).

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

Gender Reassignment Benefit (GRB): Provides coverage for gender reassignment under the STANDARD and CORE Medical Benefit Options. For more information, see the section “[Covered Expenses](#)” in the chapter “Medical Benefits.”

Ground Employees: The below group of American Airlines, Inc. employees:

- Agents/Representatives/Planners (ARP) employees of the Company who are represented by the Communications Workers of America and the International Brotherhood of Teamsters (“CWA-IBT”)
- Officers, Management/Specialists, Support Staff (OMSS) employed by the Company;
- Dispatchers who are represented by the Transport Workers Union (“TWU”).

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.

In-Network: Refers to benefits and services you receive from Providers that contract with the Network/Claim Administrators. Generally, your benefits under the Plan are higher (and your Out-of-Pocket expenses lower) when you use In-Network services.

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 Benefit Option will start reimbursing you. After you satisfy the Deductible, your selected Medical Benefit Option pays the appropriate percentage of eligible covered medical services.

Infertility Treatment: 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.

Life-Threatening Condition: Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Loss or Impairment of Speech or Hearing: Loss or damage of verbalization or hearing, or 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.

Married Employees: Employees of the Company who are married (legal or common law) to other employees of the Company.

Maximum Out-of-Network Charge (MOC): The MOC is the amount that your claims administrator will use in determining how much the Plan will pay toward out of Network services. The MOC applies to the STANDARD, CORE, VALUE, and OUT-OF-AREA Medical Benefit Options. The MOC is a percentage of the rate that the federal Medicare program would pay for the service. The MOC for Out-of-Network Providers and facilities will be limited to 140% of the amount the federal Medicare program would have paid for the same service. Your claims administrator will determine the MOC based on this formula.

Medical Benefit Option: The medical coverage offered by the Company to eligible employees to provide benefits for eligible employees and covered dependents in the event of an illness or injury. The Company offers the following Medical Benefit Options:



- STANDARD
- CORE
- VALUE
- OUT-OF-AREA
- HMO

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 Option 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 inpatient 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
- 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. Services that are educational, Experimental or Investigational, or Unproven in nature are not considered to be Medically Necessary unless otherwise covered by the Plan.

In the case of inpatient 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.

Network/Claim Administrators: The third-party organizations with which the Company maintains contracts to process benefit claims, determine Medical Necessity, and manage a Network of Providers and care facilities.

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, B, and D.

Out-of-Network: Refers to benefits and services received from Providers that are not part of the Network/Claim Administrators' networks. Generally, your benefits under the Plan are lower (and your Out-of-Pocket expenses higher) when you use Out-of-Network services.

Out-of-Pocket/Out-of-Pocket Maximum: Out-of-Pocket is the portion of covered expenses that you have to pay during the Plan Year. Out-of-Pocket Maximum is the most you will pay for covered expenses during the Plan Year.

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 or certified practitioner of the healing arts acting within the scope of his or her license or certification. The term includes (but is not limited to) 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

The term does not include:

- You
- Your Spouse
- A parent, Child, sister or brother of you or your Spouse

Plan Administrator: American Airlines, Inc., or its authorized delegate, is the Plan Administrator. The Plan Administrator maintains sole responsibility for the Plan and the benefits it provides. The Plan Administrator has the sole discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, including entitlement to benefits. The Plan Administrator also has the sole discretion to determine all matters relating to interpretation and operation of the Plan and may contract with third parties to provide some or all of these services to participants.

Plan Document: A written document or documents that establish the terms of employer sponsored group coverage. The Welfare Plan Document serves as the Plan Document for each of the plans listed under “Plan Information” in the “Plan Administration” section.

Plan Sponsor: American Airlines, Inc. is the Plan Sponsor.

PPACA: The Patient Protection and Affordable Care Act.

Pre-Existing Condition or Pre-Existing Condition Limitation (applies to Optional Short-Term Disability Insurance in the American Airlines, Inc. Health & Welfare Plan for Active Employees). 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 Benefit Options and Dental Benefit Options): A group of Physicians, hospitals and other health care Providers who have agreed to provide medical services at negotiated rates.

Prescriptions: Drugs and medicines that must, by federal law, be requested by a Physician's written order and dispensed only by a licensed pharmacist. Prescription drugs also include injectable insulin and prenatal vitamins during pregnancy and general vitamins as prescribed to treat a medical condition.

Primary Care Physician (PCP): 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. (An OB/GYN can also be considered a PCP.)

Primary Surgical Procedure: The principal surgery prescribed based on the primary diagnosis.

Prior Authorization for Prescriptions: Authorization by the Prescription drug program administrator that a Prescription drug for the treatment of a specific condition or diagnosis meets all of the Medical Necessity criteria.

Proof of Good Health or Statement of Health (also referred to as Evidence of Insurability or EOI): Some Benefit Options require you to provide Proof of Good Health when you enroll for coverage at a later date (if you do not enroll when you are first eligible), or when you increase levels of coverage. Proof of Good Health (or a Statement of Health) is a form you must complete and return to the appropriate Plan Administrator when you enroll in the Optional Short-Term Disability Insurance or increase levels of Life Insurance for you or your Spouse. Life Insurance coverage amounts will not increase, nor will you be enrolled in the Optional Short-Term Disability Insurance, 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 Option.

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.

Qualifying Event: A change in your status that causes you to lose eligibility for Medical, Dental, Vision and Health Care Flexible Spending Account coverages and would qualify you to be eligible for COBRA Continuation of Coverage. Qualifying Events are defined by COBRA. For examples, see "[Continuation of Coverage](#)" in the Additional Health Benefit Rules section of this SPD.

Qualified Medical Child Support Order (QMCSO): An order, decree or judgment from a court or administrative body, which directs the Plan to provide coverage to the Child of a participant under the Plan.

Regular Employee: An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, or a Flexible Work Arrangement, depending on the business needs of the organization or the terms of the applicable labor agreement. A Regular Employee is eligible for the benefits and privileges that apply to his or her workgroup or as outlined in his or her applicable labor agreement.

Reliable Evidence: Reliable Evidence includes:

- Published reports and articles in the authoritative peer reviewed medical and scientific literature including: American Medical Association (AMA) Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Dispensing Information and National Institutes of Health, U.S. Food and Drug Administration
- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment or procedure

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

Reliable Evidence does not include articles published only on the Internet.

Residential Treatment Center: A facility that offers 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The center must be licensed or certified by the state as a psychiatric and/or substance abuse Residential Treatment Center, or accredited by one of the following entities: the Commission on Accreditation of Rehabilitation Facilities (“CARF”), the Joint Commission on the Accreditation of Health Care Organizations, or the Council on Accreditation (“COA”).

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.

Retiree Benefit Guide: Retiree Health and Life Benefits Guide for Retirees of Participating American Airlines Group Subsidiaries.

Return-to-Work Program: A voluntary program offered under certain of the Plan’s Disability Benefit Options that allows you, as a disabled employee collecting disability benefits, to work in an occupation or job for wage or profit for a trial period without losing your disability benefits.

School: A school or 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).

Social Security Disability Benefits (SSDB): Disability benefits paid by the Social Security Administration to individuals and their families who qualify.

Sound Natural Teeth: Teeth that satisfy all of the following criteria:

- Both deciduous teeth and permanent teeth that developed in your own mouth.
- Teeth free of active or chronic clinical decay or disease.
- Teeth that have at least 50% bone support, and have at least 50% tooth structure in the crown portion of the teeth.
- Teeth which are functional in the dental arch.



- Teeth that have any type of restorations (including but not limited to, fillings, crowns, inlays, onlays, bridges, veneers) are not sound natural teeth.

Specialist: A Specialist is any Provider or entity, other than a Primary Care Physician.

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

Spending Accounts: Refers to the Health Care Flexible Spending Account (HCFSA), Limited Purpose Flexible Spending Account (LPFSA), Dependent Care Flexible Spending Account (DCFSA), Health Savings Account (HSA), and Health Reimbursement Account (HRA).

Spouse: An individual who is lawfully married to the employee as recognized by the state, possession, or territory of the U.S. in which the marriage is entered into, regardless of domicile, and who is not legally separated. See the section “[Determining a Spouse](#) (SP) or Common Law Spouse Eligibility (CLSP)” in the “Eligibility and Enrollment” chapter for more information.

Summary Plan Description: A document provided to participants outlining terms of employer sponsored group coverage. This document serves as the Summary Plan Description for the Plan, along with any other benefits summary published by the Company that contains a description of these plans. 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. If there is any discrepancy between the online version and the official hard copy of this document, then the official hard copy, plus official notices of Plan changes/updates will govern.

Telehealth: Live face to face video consultations for medical benefits offered by Doctor on Demand for participants enrolled in one of the self-funded medical benefit options.

Timely Pay or Timely Payment: 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. This term applies to Benefit Options for which you are required to pay ongoing contributions or premiums in order to maintain coverage under the Benefit Options.

Urgent Care or 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 (U&P). The maximum amount that the Plan will consider as an Eligible Expense for *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

Usual and Prevailing Fee Limits can also be impacted by the number of services or procedures you receive during one dental 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.

Workers’ Compensation: Insurance that provides cash benefits and/or medical care for employees who are injured or become ill as a direct result of their employment.

For more information

For Information About:	Contact
<ul style="list-style-type: none"> • General questions • Dependent eligibility • Information updates 	American Airlines, Inc. Benefits Service Center P.O. Box 564103 Charlotte, NC 28256-4103 Phone: 1-847-554-1884
Online Help from a Benefits Service Center Representative	American Airlines, Inc. Benefits Service Center Chat my.aa.com or newjetnet.aa.com Click on Employee Services, then Healthand Benefits, click Benefits Service Center, click on “chat” on the upper right portion of the screen.
Forms, Guides and Contact Information	my.aa.com (Benefits page)
Qualified Medical Child Support Orders (QMCSO)	American Airlines QMCSO P.O. Box 1542 Lincolnshire, IL 60069-1542 Fax: 1-847-442-0899 (Include a cover sheet with the employer name and employee name)
Provider Directories	If your Network/Claims Administrator is: Blue Cross and Blue Shield of Texas http://www.bcbstx.com/americanairlines UnitedHealthcare http://americanairlines.welcometouhc.com/
<ul style="list-style-type: none"> • Continuation of Coverage (COBRA) • Direct billing while on Leave of Absence 	COBRA Administrator: Aon Hewitt P.O. Box 1345 Carol Stream, IL 60132-1345 Phone: 1-800-860-6178 Fax: 1-847-554-1884
Appeals (Urgent Care and Second Level Appeals)	Employee Benefits Committee American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616 ICS or 1-817-967-1412