American Airlines, Inc. Health Benefit Plan

for Certain Legacy Employees

Summary Plan Description

Effective January 1, 2018

Revised March15, 2018

SUMMARY PLAN DESCRIPTION

This document summarizes the main provisions of the American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees (Plan), effective as of January 1, 2018, and serves as the Summary Plan Description (SPD) for Medical, Prescription Drug, Employee Assistance Program, Dental, Voluntary Vision Care, and Voluntary Long-Term Care program benefits under the Plan. This document replaces the SPD dated January 1, 2013 and incorporates the changes to that SPD that are set forth in the Summaries of Material Modification dated January 1, 2014, January 1, 2015, January 1, 2016, and January 1, 2017, as well as other changes and clarifications.

In this SPD you will find descriptions of those benefits as they apply to eligible employees and their eligible Dependents. This SPD also covers retirees and their eligible Dependents. The information in this SPD about the benefits available under the Medical, Prescription Drug, and Employee Assistance Program applies to both active employees and retirees (and their eligible Dependents) unless specifically stated otherwise.

This SPD provides a comprehensive overview of the benefits available under the Plan as well as limitations, exclusions, deductible and coinsurance requirements. Additional Plan details are contained in the legal Plan document. If there is any difference between the information in this SPD and the legal Plan document, the legal Plan document will govern. American Airlines, Inc. ("American Airlines" or "the Company") sponsors the Plan and reserves the right to amend or terminate the Plan at any time, subject to the terms of an applicable collective bargaining agreement. You will be notified of any changes that affect your benefits, as required by federal law.

Throughout this SPD, you will find “information boxes” indicated by this symbol:  When you see the symbol, read what’s inside the accompanying information box to learn more about the highlighted topic in that section of the SPD. Terms used to describe your benefits are generally defined when the term is first introduced. There is also a “Glossary” at the end of this SPD that defines certain additional terms and how they apply to the benefits described in this SPD.

Please read this SPD carefully and share it with your family members who are eligible for coverage or for whom you've elected coverage. If you have any questions about the benefits information contained in this SPD, contact American Airlines Benefit Service Center.at 1-888-860-6178. When you hear the telephone prompts, select 1.

Grandfathered Health Plan Notice

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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About Your Participation – Active Employees

This section includes important information about:

- Eligibility to participate in the Plan;
- When coverage begins;
- An overview of Life Events;
- When coverage ends.

Eligibility

Eligibility for YOU

You are eligible to participate in the Plan if you are:

- An active, full-time or part-time employee of American Airlines, Inc. in the maintenance and related groups who are covered by collective bargaining agreements entered into between Legacy US Airways, Inc. and the IAM.
- A former employee of the Company who was eligible for coverage under the Plan the day before a separation or inactive status from the Company and is subject to a written separation agreement, collectively bargained agreement or Company policy that includes coverage for a pre-determined period of time following the separation.

Please note: For purposes of eligibility, "employees" are individuals who are classified by the Company as employees under Section 3121(d) of the Internal Revenue Code. In the event the classification of an individual who is excluded from eligibility under the preceding sentence is determined to be erroneous or is retroactively revised by a court, administrative agency or other administrative body, the individual shall nonetheless continue to be excluded from the Plan and shall be ineligible for benefits for all periods prior to the date that it is determined that its classification of the individual is erroneous or should be revised.

For eligibility provisions relating to retirees and their eligible Dependents, please see the "Retiree Health Coverage" Section.

Eligibility During a Leave of Absence or Furlough

If you take a Company-approved leave of absence, you may continue, start or stop participation in the Plan, within 31 days of the start of your unpaid leave of absence and also within 31 days of your return from the leave of absence provided you are still

eligible to participate in the Plan at that time. If you make no changes to the elections in place for you (and your Dependents) within 31 days your elections will remain in place until the earliest of (a) the date you make an election change due to a Life Event *(see the "An Overview of Life Events" Section of this SPD for more information on Life Events)* or during an annual enrollment in which you are eligible to participate, (b) the date you stop making any required premium payments, or (c) the date you (or your Dependents) are no longer eligible for coverage under the Plan. You may not enroll additional Dependents for coverage under the Plan unless you experience a Life Event (*see the "An Overview of Life Events Section of this SPD for more information on Life Events*). If you waive coverage at the beginning of or during a leave of absence or furlough, you will not be able to re-enroll for coverage until you return to active status or retire.

At any time during a leave of absence or furlough, you may contact American Airlines Benefit Service Center at 1-888-860-6178 to reduce your level of coverage or cancel coverage. Please note, however, that if you reduce your coverage level or cancel your coverage while on leave of absence or furlough, you may not increase or reinstate that coverage until you return to active status. If you go on furlough, you are eligible to continue your participation in the Plan according to the terms specified in your collective bargaining agreement. Please see the collective bargaining agreement applicable to you for more details. You can obtain a copy of your collective bargaining agreement by contacting your local management or union representative.

To change or revoke your medical and/or dental elections during a leave of absence or while on furlough, contact American Airlines Benefit Service Center at 1-888-860-6178.

Eligibility for Your Dependents

You may elect coverage for your eligible Dependents under the Plan, provided you enroll them and supply the necessary documentation to verify eligibility. Eligible Dependents include:

- Your Spouse;
- Your children who are age 26 and under at any time in a calendar year;
- The children of your Spouse who are age 26 and under at any time in a calendar year;
- The unmarried children of you or your Spouse following the calendar year in which they attain age 26 who are not self-supporting because of a permanent physical, or mental disability and are dependent upon you, as defined by the Internal Revenue Code for income tax purposes, provided that such children were physically or mentally disabled and covered by the Plan on the day before the end of the calendar year in which they attained age 26. Any child who satisfies these conditions will continue to be eligible for coverage as long as the disability remains. The Plan Administrator may require documentation that confirms such child's ongoing disability. "Disability" for dependent eligibility

purposes will have the meaning used by the Internal Revenue Service for income tax purposes.

- Children, for purposes of determining those dependents who are your "eligible Dependent children" under the Plan, include your:
    - Natural child
    - Legally adopted child
    - Natural or legally adopted child of a covered Spouse as defined by the Plan
    - Stepchild


Supporting documentation for eligible Dependent children

The Company will require you to provide supporting documentation for eligible Dependent children and for other Dependents. This information includes verification of relationship. If you fail to provide this information at the time Dependents are added, they will not be eligible to receive coverage under the Plan. When your Dependent children are no longer eligible to participate in the Plan, you must notify the American Airlines Benefit Service Center.

If You and Your Spouse Both Work for or are Retired from the Company

In the case where you and your Spouse are both employed by or are retired from the Company, provided you meet all other eligibility requirements, you may participate in the Plan in one of the following ways:

- You and your Spouse may each elect coverage separately; or
- One of you can elect employee coverage and enroll the other as a Dependent.

If you both elect separate coverage, you may either enroll your eligible children as Dependents under your coverage, or enroll them under your Spouse's coverage. You may not, however, enroll them under both your coverage and your Spouse's coverage.

Surviving Spouses and Other Eligible Surviving Dependents

In the event you die while covered under the Plan, your surviving spouse, and your surviving dependent children may be eligible to continue participation per company policy or collective bargaining agreement, if applicable. If they are eligible and they are not enrolled in the Plan, they may choose to enroll within 31 days of your date of death. Information will be provided to your surviving spouse and eligible Dependent children upon notification of your death.

When Coverage Begins

Making Your Initial Elections

If you are a new employee enrolling during the year, coverage for you and any eligible dependents you elect to enroll will begin as of your date of hire. You have 31 days from your date of hire to enroll in the Plan. For example, if your hire date is March 15 and you enroll on April 1, your coverage begins as of March 15. Your initial coverage will remain in effect, as long as you are eligible and have provided the required documentation for eligible dependents, until you make an annual enrollment change, or until you experience a change in status. If you do not enroll within 31 days of your date of hire, you cannot enroll in the Plan until the next annual enrollment or if you experience a change of status event *(See the "An Overview of Life Events" Section of this SPD for further details.)*

Annual Enrollment

You may elect coverage or make changes to your existing elections during the annual enrollment period, provided coverage remains available under this Plan and you continue to be eligible. New elections and any changes made during annual enrollment will be effective on January 1 immediately following the annual enrollment period and remain in effect through December 31. Aside from this annual enrollment period, Internal Revenue Service rules specify that you can only make changes to your elections during the year if you experience a Life Event. *(See the "An Overview of Life Events" Section of this SPD for further details.)*

During the annual enrollment period, you may make changes to your Plan elections. For example, you may:

- Add or drop medical and/or dental coverage; or
- Increase or reduce the number of eligible Dependents you enroll for medical coverage (however, you must provide the required documentation to verify their eligibility for coverage as your Dependent).

During a leave of absence or furlough, you may participate in annual enrollment if you are current on your direct bill payments and are enrolled in medical, dental and/or vision coverage. Changes will only be allowed for medical, dental and/or vision coverage. Unless you make such changes during the annual enrollment period, coverage under the Plan will continue based on your existing elections. (S*ee the "An Overview of Life Events" Section of this SPD for more information on Life Events*).

Coverage Levels

When you enroll in the Plan, you may choose from one of the following medical, dental and/or vision coverage levels for you and/or your verified eligible Dependents:

- Employee only;
- Employee and Spouse;
- Employee and child or children with no Spouse; or
- Employee and family, which includes you, your Spouse and your eligible Dependent children.

If You Do Not Enroll for Coverage

If you do not enroll in the Plan within 31 days of your date of hire, you will **not receive coverage under the Plan**. You will not be eligible to enroll in the Plan until the next annual enrollment period, unless you experience a Life Event. *(See the "An Overview of Life Events" Section of this SPD for more information on Life Events.)*

Paying for Coverage

If you are an active employee, you will pay for the coverage that you elect under the Plan by payroll deduction on a pre-tax basis, before Federal—and, in most cases, state—income taxes and Social Security (FICA) taxes are withheld. The amount of your monthly contributions for coverage under the Plan is based on a group rate — that is, it is based on the cost of providing medical dental and/or vision coverage to all participants.

If you are on an unpaid Company approved leave of absence or furlough, your payment will be made to a third party administrator on an after-tax basis.

Benefits continuation in the event that your required contributions for benefits exceed your paycheck

Generally, your contributions for benefits elected under the Plan are taken from your paycheck on a pre-tax basis automatically, without any required action from you. However, in certain circumstances, such as if you reduce your hours, your paycheck may not be sufficient to pay the required contributions. In order to continue your benefits when your paycheck is not sufficient to pay required contributions, you must Timely Pay the required contributions for your benefits through another method (e.g., a personal check). You will receive a billing statement if this occurs, and the due date will be noted on your billing statement.

If you fail to Timely Pay for your benefits, your benefits may terminate and you may not resume participation in the Plan until the earliest of: (i) a HIPAA Special Enrollment Event, Special Enrollment for Medicaid and CHIP Life Event that allows you to enroll, (ii)

the next Plan year, or (iii) sufficient continuous paychecks from which to deduct benefits contributions.

An Overview of Life Events

The following table provides a detailed look at various circumstances that may be considered Life Events under the Plan, as well as what changes to medical, dental, and vision may be permitted, according to IRS regulations. For further information regarding health care spending account and change of status events, please refer to your Flexible Benefit Plan Summary Plan Description. Similar rules may apply to other benefits under other plans, such as life and accidental death and dismemberment ("AD&D").

- You must register the Life Event within 31 days of the event (60 days for Medicaid or CHIP) 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 (60 days for Medicaid or CHIP), 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.

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:** • 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 gains
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) • 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.	

If You Experience the Following Life Event…	Then, You May be Able to…
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 child's employer no longer covers employees in your Spouse's/Eligible Dependent child's position	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 loses 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.
Your covered eligible Dependent child no longer meets the Plan's eligibility requirement, i.e.: • If the dependent attains the age at which he/she is no longer eligible to be covered as your 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	**Medical, dental, and vision:** • 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. **Additionally:** • Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible Dependent's address.
Your benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant") *OR* Your contribution amount is significantly increased or decreased by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")	Make changes to the applicable benefit options: • The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.

If You Experience the Following Life Event…	Then, You May be Able to…
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMCSO) that requires you to provide health care coverage for a child	**Medical, dental, and vision:** • 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.
You, your Spouse, or your eligible Dependent child enroll in Medicare or Medicaid or CHIP coverage	**Medical, dental, and vision:** • 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:** • 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:** • 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/disenrolled in government-sponsored Tricare coverage	**Medical:** • 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

If You Experience the Following Life Event…	Then, You May be Able to…
You move to a new home address: • 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. • Submit a revised Federal Form W-4 Form for payroll tax purposes. The form is available online through the Pay and Compensation page of American Airlines Benefits Service Center • Provide your new address and current emergency contact numbers to your manager/supervisor, as well. • If you are enrolled in a PPO Medical Benefit Option and you move to a location where a PPO Medical Benefit Option is available, you will stay enrolled in the PPO 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 PPO Medical Benefit Option Network is not available, you must choose an Out-of-Area Medical Benefit Option, 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 a PPO Medical Benefit Option and you do not process your relocation Life Event within 31 days of your move, you will 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. 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.	**Medical, dental, and vision:** • 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.
You become disabled	**Notify:** Your manager/supervisor can download a Disability Claim Form. **Complete and submit:** Your claim for disability benefits.

If You Experience the Following Life Event…	Then, You May be Able to…
You start an unpaid leave of absence	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. **Your cost depends on:** The type of leave you are taking **Medical, dental, and vision:** • Stop coverage • Stop Spouse coverage • Stop eligible Dependent child coverage
You return from an unpaid leave of absence	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. 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 Life Event. **Medical, dental, and vision:** • Resume/Start coverage for yourself • Start coverage for your Spouse • Start coverage for your eligible Dependent child
You die	**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.
You end your employment with the Company or you are eligible to retire	**Review: "***When Coverage Ends*" in the *General Enrollment* section. **Review:** The information you receive regarding continuation of coverage through COBRA. **Contact:** American Airlines Benefits Service Center for information on retirement.

If You Experience the Following Life Event…	Then, You May be Able to…
You transfer to another workgroup	**Medical, dental, and vision:** • 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.
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: • Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) • Employer contributions for the other coverage stopped • Other coverage was COBRA and the maximum COBRA coverage period ended • Exhaustion of the other coverage's lifetime maximum benefit • Other employer-sponsored coverage is no longer offered • Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your eligible Dependents no longer reside, live, or work in its service area	**Medical coverage:** • Start coverage for yourself o 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.

Special Enrollment Periods

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you will be able to enroll yourself, your Spouse or your Dependents in this Plan if any of three special enrollment periods apply, as described below.

Special Enrollment for Loss of Coverage

A special enrollment period applies if you or a Dependent did not enroll during the annual enrollment period or initial enrollment period (for newly hired employees), provided that you request enrollment within 31 days after your other coverage ends, and the following requirements are satisfied:

- you or your Dependent had existing health coverage (also known as creditable coverage) under another plan at the time of the initial enrollment period or annual enrollment period.
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including without limitation, divorce or death).
  - The prior employer or policyholder stopped paying the contribution.
  - In the case of COBRA continuation coverage, the coverage ended.

Coverage will become effective as of the first day following the loss of coverage. Failure to notify the Company of your loss of coverage within 31 days of the loss will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

Special Enrollment for Addition of a Dependent

A special enrollment period applies if you **add a Dependent due to** marriage, birth, adoption, or placement for adoption**,** provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Coverage added due to marriage, birth, adoption or placement for adoption will become effective as of the date of the event.

Failure to notify the Company of your marriage, birth, adoption, or placement for adoption within 31 days of the event will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

Special Enrollment for Medicaid and CHIP

The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") requires the Plan to permit you and your Dependent(s) to enroll (or disenroll) in the Plan following the occurrence of either of the following events:

- Loss of coverage under Medicaid or a state child health plan: If you or your Dependent(s) lose coverage under Medicaid or a state child health plan, you may

request to enroll yourself and/or your Dependent(s) in the Plan not later than 60 days after the date coverage ends under Medicaid or the state child health plan.

- Gaining eligibility for coverage under Medicaid or a state child health plan: If you and/or your Dependent(s) become eligible for financial assistance (such as a premium subsidy) from Medicaid or a state child health plan, you may request to enroll yourself and/or your child(ren) under the Plan, provided that your request is made no later than 60 days after the date that Medicaid or the state child health plan determines that you and/ or your Dependent(s) are eligible for such financial assistance. If you and/or Dependent(s) are currently enrolled in the Plan, you have the option of terminating the enrollment of you and/or your child(ren) in the Plan and enroll in Medicaid or a state child health plan. Please note that, once you terminate your enrollment in the Plan, your children's enrollment will also be terminated.

Coverage will become effective as of the first day following the loss of coverage or the date of gain in eligibility.

Failure to notify the Company of your loss or gain of eligibility for coverage under Medicaid or a state children's health plan within 60 days will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

When Coverage Ends

In general, your Plan coverage will end for you and your Dependents:

- The end of the month in which your employment ends;
- When you stop making required contributions;
- When you or your Dependents are no longer eligible to participate in the Plan (for instance, due to a change in your employment status); or
- When the Plan is terminated.

You may be able to continue your Plan coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). (*See the "Qualifying Events for Continuation Coverage Under Federal Law (COBRA)" section of this SPD for further details.*) You may also be able to continue coverage if you are on an approved Family and Medical Leave Act (FMLA) leave or are on military leave. (*See the "Qualifying Events for Continuation Coverage Under Federal Law (COBRA)" section of this SPD for further details*.)

Note: Rules and rates for benefit continuation vary by group and are subject to the terms of your collective bargaining agreements. You can obtain a copy of the respective collective bargaining agreement by contacting your local management or union representative.

Your Medical Options

The Plan includes medical coverage for a wide range of covered health services and supplies your doctor prescribes to treat an illness or injury. Both in-network and out-of-network benefits are available.

This section provides important information about each of the medical coverage options offered under the Plan and the benefits those options include. In this section you will find the following information on your medical coverage under the Plan:

- The claims administrator's responsibilities;
- A detailed summary of each medical coverage option;
- Information about pre-certifying your care for certain medical services;
- How to file a claim;
- Medical services covered under the Plan;
- Medical services not covered under the Plan; and
- Additional rules that apply to your medical coverage.

Claims Administrator Responsibilities

One or more Claims Administrators are responsible for all medical coverage options under the Plan. The carrier(s) maintain medical plan networks, process medical claims, and provide member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for these administrators.

Wellness Program

American Airlines' wellness program is provided at no cost for all employees. Some aspects of the Wellness Program, such as health coaching, are only available to employees enrolled in a self-funded Medical Benefit Option and covered Spouses. The wellness program consists of the following benefits:

- WebMD Wellness
  - Activities include health assessments, health coaching, biometric screenings, and community and charity events.
    - Health assessment: Individuals can complete a 15-minute online questionnaire to answer questions about their health habits.
    - 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.

- ❖ Individuals can receive a preventive care exam, annual physical or biometric screening.
- ❖ Get Involved: Individuals can participate in certain community or charity events and log their participation.

- o 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
  - o 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.
  - o 24-hour nurse line: Individuals can speak with a nurse 24/7.
  - o 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.

- StayWellRx
  - o Individuals can receive a 90-day supply of asthma, 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
  - o 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. 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 a 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 a Medical Benefit Option. Individuals or groups of people can work toward common wellness goals such as regular physical activity.

The PPO Plan

The Plan offers medical benefits through a Preferred Provider Organization, referred to as "PPO" or "PPO Plan." Preferred providers are those who participate in the PPO network of doctors, hospitals, and other health care facilities.

The PPO Plan includes three coverage options from which to choose that vary based on the amounts of your annual deductible and out-of-pocket maximum, and coinsurance levels. The amount of the premium that you will be required to pay also varies based on the PPO option you elect. Current information about the premium costs will be provided each year during annual enrollment.

The PPO Plan provides coverage in nearly all the areas where American Airlines employees reside. If you live within a PPO Plan network service area and choose to enroll for medical coverage under the Plan, the PPO Plan Program will provide your medical coverage. If, however, your primary residence is outside all PPO Plan network service areas and you choose to enroll for medical coverage under the Plan, your medical coverage will be provided through an Out-of-Area Program *(See "The Out-of-Area Program" section of this SPD for more information.)*

The chart included in the *"Schedule of PPO Plan Benefits"* section of this SPD provides a detailed summary of the medical benefits available through the PPO Plan.

Using Preferred and Non-Preferred Providers

Under the PPO Plan, each time you need care, you can choose to receive care from a preferred provider who is part of the network (in-network provider) or a non-preferred provider outside the network (out-of-network provider).

When You See In-Network Program Providers

When you receive care from an in-network provider, your out-of-pocket costs are less than they would be if you received care from an out-of-network provider. For example, when you use an in-network provider, your annual deductible for covered services is lower than the amount required for such services from an out-of-network provider. In addition, after you pay any applicable co-pays and/or coinsurance, you will not be subject to any balance billing for charges from in-network providers.

When You See Out-of-Network Providers

When you receive care from an out-of-network provider, you must pay 100% of charges for medical services until you have met the applicable annual deductible amount for your coverage option. After you meet the annual deductible amount, you share the cost of the services you receive with the Plan. Your out-of-pocket costs are higher than they would be if you received care from an in-network provider because the Plan pays benefits based on reasonable and customary (R&C) charges. R&C charges are based on the typical amounts charged by most providers in your geographic area for specific medical services. If an R&C charge is more than the limit set by the Plan, you must pay the amount that exceeds the limit, in addition to any applicable deductible and coinsurance amounts.

The PPO Plan includes separate annual out-of-pocket maximum amounts for in-network and out-of-network care. When you reach these out-of-pocket maximums, the Plan will pay 100% of your eligible expenses for the rest of the calendar year (excluding charges above the R&C limit or charges not otherwise covered by the Plan).

More about Co-pays, Annual Deductibles and Out-of-Pocket Maximums

Please note that your co-pays for medical services do not count toward satisfying the annual deductible or the annual out-of-pocket maximum.

Finding In-Network Providers

You can find an in-network provider by:

- Visiting my.aa.com;
- Calling your medical plan administrator.

Groups of Providers

Please note that groups of providers (such an association of physicians or clinics) may have some providers that are in-network providers and other providers that are out-of-network providers. Just because some providers in the group are in-network, does not mean all providers in the group are in-network. To determine whether a particular provider is in-network, go online or call your medical plan administrator.

Behavioral Health Providers and Facilities

When you contact your Claims Administrator, you will be referred to an in-network, local participating provider or facility. If you choose to receive care outside the network, you can use the following eligible licensed behavioral health care providers:

- Mental health counselors;

- Psychiatrists and osteopaths with a psychiatric specialty;
- Psychiatric nurses; and
- Licensed Clinical Social Workers (LCSWs).

Facilities you use (whether in-network or out-of-network) must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in order for your services to be covered under the Plan.

Schedule of PPO Plan Benefits

An Overview of PPO Plan Benefits

The following chart is an overview of the key features of the PPO Plan, including the benefits for PPO 80/60, PPO 90/70, and PPO 100/80. The chart is an overview only and does not list every covered service. For more information on how services are covered under the PPO Plan, contact your Claims Administrator.

Schedule of PPO Plan Benefits						
Feature	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible (1 person/2 or more people)	$450/$900	$900/$1,800	$225/$450	$450/$900	$225/$450	$450/$900
Coinsurance	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of reasonable and customary (R&C) charges, after annual deductible	The Plan pays 90% of discounted in-network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Annual Out-of-Pocket Maximum (1 person/2 or more people)	$3,000/$6,000	$6,000/$12,000	$1,500/$3,000	$3,000/$6,000	$225/$450	$3,000/$6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Medical Office Services						
Doctor's Office Visits	$25 co-pay for primary doctors; $40 co-pay for specialists	The Plan pays 60% of R&C charges, after annual deductible	$25 co-pay for primary doctors; $40 co-pay for specialists	The Plan pays 70% of R&C charges, after annual deductible	$25 co-pay for primary doctors; $40 co-pay for specialists	The Plan pays 80% of R&C charges, after annual deductible
Telehealth	$20 co-pay for Telehealth visit	Not covered	$20 co-pay for Telehealth visit	Not covered	$20 co-pay for Telehealth visit	Not covered

Schedule of PPO Plan Benefits						
Feature	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive Care *includes routine physicals and well child care* (no limit on visits until attaining age 5, then one routine physical per year)	$25 co-pay	Not covered	$25 co-pay	Not covered	$25 co-pay	Not covered
OB/GYN Exams	$25 co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to deductible and coinsurance	$25 co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to deductible and coinsurance	$25 co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to deductible and coinsurance

Schedule of PPO Plan Benefits						
Feature	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
X-Rays and Lab Tests (pathology and other diagnostic testing)	The Plan pays 100% of discounted in-network fees if performed in doctor's office as part of office visit. If performed in outpatient facility, the Plan pays 100% of discounted in-network fees for lab charges, 80% of discounted in-network fees after annual deductible for x-rays and related services, except mammograms performed in outpatient facility $25 co-pay, no deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees if performed in doctor's office as part of office visit; If performed in outpatient facility, the Plan pays 100% of discounted in-network fees for lab charges, 90% of discounted in-network fees after annual deductible for x-rays and related services, except mammograms performed in outpatient facility $25 co-pay, no deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees if performed in doctor's office as part of office visit. If performed in outpatient facility, the Plan pays 100% of discounted in-network fees for lab charges and 100% of discounted in-network fees after annual deductible for x-rays and related services, except mammograms performed in outpatient facility $25 co-pay, no deductible	The Plan pays 80% of R&C charges, after annual deductible
Immunizations	$25 co-pay	Not covered	$25 co-pay	Not covered	$25 co-pay	Not covered
Inpatient Hospital Care						
Room allowance (semi-private room covered; private room covered only when medically necessary)	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 90% of discounted in-network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible

Schedule of PPO Plan Benefits						
Feature	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Surgery	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 90% of discounted in-network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Maternity Care						
Obstetric Services (including office visits)	$25 co-pay (initial visit only); thereafter, the Plan pays 80% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 60% of R&C charges, after annual deductible	$25 co-pay (initial visit only); thereafter, the Plan pays 90% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 70% of R&C charges, after annual deductible	$25 co-pay (initial visit only); thereafter, the Plan pays 100% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 80% of R&C charges, after annual deductible
Hospital Charges (including newborn nursery care)	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 90% of discounted in-network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Prescription Drugs (benefits provided Pharmacy Claims Administrator)						
Retail Co-pay (up to 34-day supply)	$15 generic $30 preferred brand $50 non-preferred brand	Not covered	$15 generic $30 preferred brand $50 non-preferred brand	Not covered	$15 generic $30 preferred brand $50 non-preferred brand	Not covered
Mail Order Co-pay (> 34-day supply and up to 90-day supply)[1]	$30 generic*[2] $60 preferred brand $100 non-preferred brand	Not covered	$30 generic[2] $60 preferred brand $100 non-preferred brand	Not covered	$30 generic[2] $60 preferred brand $100 non-preferred brand	Not covered

[1] Applicable to PBM Smart 90 for certain medications.

[2] Effective January 1, 2009, some generic drugs are available through mail order for a $10 co-pay for up to a 90-day supply.

Schedule of PPO Plan Benefits						
Feature	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health and Chemical Dependency						
Inpatient Care	The Plan pays 80% of discounted in-network fees, after annual deductible *No visit maximum*	The Plan pays 60% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 90% of discounted in-network fees, after separate deductible *No visit maximum*	The Plan pays 70% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 100% of discounted in-network fees, after annual deductible *No visit maximum*	The Plan pays 80% of R&C charges, after annual deductible *No visit maximum*
Alternative Mental Health Care Center (residential treatment	The Plan pays 80% of discounted in-network fees, after annual deductible *No visit maximum*	The Plan pays 60% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 90% of discounted in-network fees, after separate deductible *No visit maximum*	The Plan pays 70% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 100% of discounted in-network fees, after annual deductible *No visit maximum*	The Plan pays 80% of R&C charges, after annual deductible *No visit maximum*
Alternative Mental Health Care Center (intensive Outpatient and partial hospitalization)	The Plan pays 80% of discounted in-network fees, after annual deductible *No visit maximum*	The Plan pays 60% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 90% of discounted in-network fees, after separate deductible *No visit maximum*	The Plan pays 70% of R&C charges, after annual deductible *No visit maximum*	The Plan pays 100% of discounted in-network fees, after annual deductible *No visit maximum*	The Plan pays 80% of R&C charges, after annual deductible *No visit maximum*
Outpatient Care	$25 co-pay *No visit maximum*	The Plan pays 60% of R&C charges, after annual deductible *No visit maximum*	$25 co-pay *No visit maximum*	The Plan pays 70% of R&C charges, after annual deductible *No visit maximum*	$25 co-pay *No visit maximum*	The Plan pays 80% of R&C charges, after annual deductible *No visit maximum*
Telehealth office visit	$20 co-pay *No visit maximum*	Not covered	$20 co-pay *No visit maximum*	Not covered	$20 co-pay *No visit maximum*	Not covered
Other Coverage						
Emergency Room	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)	$100 co-pay (waived if admitted)

Schedule of PPO Plan Benefits						
Feature	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment (some Durable Medical Equipment may have certain limitations, such as one custom pair of shoe inserts per benefit period)	$500 per year paid at 100%, then the Plan pays 80% of discounted in-network fees, after annual deductible Prior Plan Approval must be obtained after first $500 paid has been met	The Plan pays 60% of R&C charges, after annual deductible	$500 per year paid at 100%, then the Plan pays 90% of discounted in-network fees, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met	The Plan pays 70% of R&C charges, after annual deductible	$500 per year paid at 100%, then the Plan pays 100% of discounted in-network fees, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met	The Plan pays 80% of R&C charges, after annual deductible
Physical Therapy and Occupational Therapy 40-visit maximum per year (in- and out-of-network care is combined for maximums). Visits above 40 per year subject to ongoing medical necessity review.	$40 co-pay	The Plan pays 60% of R&C charges, after annual deductible	$40 co-pay	The Plan pays 70% of R&C charges, after annual deductible	$40 co-pay	The Plan pays 80% of R&C charges, after annual deductible
Speech Therapy (20-visit maximum per year combined for in- and out-of- network care). Visits above 20 per year subject to ongoing medical necessity review.	$40 co-pay	The Plan pays 60% of R&C charges, after annual deductible	$40 co-pay	The Plan pays 70% of R&C charges, after annual deductible	$40 co-pay	The Plan pays 80% of R&C charges, after annual deductible

Schedule of PPO Plan Benefits						
Feature	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Chiropractic Care (20-visit maximum per year; visits beyond the per year maximum are covered if medically necessary). Visits above 20 per year subject to ongoing medical necessity review.	$40 co-pay	Not covered	$40 co-pay	Not covered	$40 co-pay	Not covered
Home Health Care (100-visit maximum per year). Visits above 100 per year subject to ongoing medical necessity review.	The Plan pays 100% of discounted in-network fees	Not covered	The Plan pays 100% of discounted in-network fees	Not covered	The Plan pays 100% of discounted in-network fees	Not covered
Hospice Care	The Plan pays 100% of discounted in-network fees, after annual deductible.	Not covered	The Plan pays 100% of discounted in-network fees, after annual deductible.	Not covered	The Plan pays 100% of discounted in-network fees, after annual deductible.	Not covered
Skilled Nursing Care Facility (60-day maximum per year combined for in- and out-of- network care)	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 90% of discounted in-network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Ambulance Services[3]	The Plan pays 80% of discounted in-network fees, after annual deductible.	The Plan pays 80% of R&C charges, after annual deductible.	The Plan pays 90% of discounted in-network fees, after annual deductible.	The Plan pays 90% of R&C charges, after annual deductible.	The Plan pays 100% of discounted in-network fees, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.

[3]Air transport and ambulance service between facilities must be medically necessary as determined by the Claims Administrator.

Schedule of PPO Plan Benefits						
Feature	**PPO 80/60**		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
All other covered and medically necessary services including, but not limited to: Medical Supplies (blood, oxygen, prosthetics) and Dialysis Services.	The Plan pays 80% of discounted in-network fees, after annual deductible.	The Plan pays 60% of R&C charges, after annual deductible.	The Plan pays 90% of discounted in-network fees, after annual deductible.	The Plan pays 70% of R&C charges, after annual deductible.	The Plan pays 100% of discounted in-network fees, after annual deductible.	The Plan pays 80% of R&C charges, after annual deductible.

Important Notes About PPO Plan Benefits

1. Deductible amounts and out-of-pocket maximum amounts for in-network and out-of-network services are mutually exclusive. That means that amounts you pay toward the deductible and out-of-pocket maximum for in-network care do not count toward satisfying the out-of-network deductible and out-of-pocket maximum for out-of-network care. Likewise, amounts you pay toward the out-of-network deductible and out-of-pocket maximum do not count toward satisfying the deductible and out-of-pocket maximum for in-network care.
2. The annual deductible and out-of-pocket maximum amounts applicable to expenses for medical services DO apply to covered expenses for mental health and chemical dependency services. There is a combined annual deductible and a combined out-of-pocket maximum you must meet before the plan pays 100% for medical and/or mental health and chemical dependency care.
3. If you move from a PPO Plan to an Out-of-Area ("OOA") Plan in the same calendar year, the in-network medical and mental health/chemical dependency deductibles and out-of-pocket maximums that you met under the PPO Plan will transfer to the OOA plan deductibles and out-of-pocket maximums for that year.

Pre-certifying Care For Certain Medical Services

Pre-certifying care means notifying your Claims Administrator to make sure a treatment plan is approved in advance. All inpatient surgical procedures and hospital stays (including emergency admissions, skilled nursing care facilities and in-patient hospice care facilities) must be pre-certified. **It is important to understand your responsibility for pre-certifying care since failure to do so will result in a $250 penalty**, which does not count toward satisfying your annual deductible or your annual out-of-pocket maximum.

When You See In-Network Providers

When you see an in-network provider, the provider should coordinate the notification process on your behalf. However, it's a good idea to verify with your provider that your care has been pre-certified in advance of any surgery or hospital stay. In the event that the $250 notification penalty is applied to your "In-Network claim" in error, please contact your Claims Administrator to have the penalty waived.

When You See Out-of-Network Providers

When you see providers that are not part of the PPO network, notification is *your* responsibility. Before any in-patient surgical procedure or hospital stay (including emergency admissions, and skilled nursing care facilities), you, your doctor, or someone else familiar with your situation must contact your Claims Administrator to pre-certify your care in advance. A $250 penalty for failure to pre-certify will apply, which does not count toward satisfying the annual deductible or annual out-of-pocket maximum. You can review more information about how R&C is determined in the Glossary, under "Reasonable and Customary Charges".

Pre-certifying Care – Mental Health and Chemical Dependency

All inpatient mental health and/or chemical dependency care you receive must be pre-certified through your Claims Administrator. That means you, your doctor, or someone else close to you, must call your Claims Administrator *before* you receive services. **It is important to understand your responsibility for pre-certifying care since failure to do so will result in a $250 penalty**, which does not count toward satisfying your separate annual deductible or annual out-of-pocket maximum.

When You See In-Network Providers

If you receive care from an in-network provider, the provider will coordinate the Pre-Certification process for you. However, it's a good idea to verify with your provider that your care has been pre-certified in advance of any treatment. In the event that the $250 Pre-Certification penalty is applied to your "In-Network claim" in error, please contact your Claims Administrator to have the penalty waived.

When You See Out-of-Network Providers

If you receive care from a provider who is not part of the network, Pre-Certification is *your* responsibility. Before any treatment or admission, you, your provider, or someone else familiar with your situation must contact your Claims Administrator to pre-certify your care. **If you do not pre-certify your care in advance, a penalty of $250 will apply.** This penalty does not count toward your separate annual deductible or annual out-of-pocket maximum.

If You Are Enrolled in the Out-of-Area Program

If you are enrolled in the Out-of-Area Program, Pre-Certification is *your* responsibility. Before any treatment or admission, you, your provider, or someone else familiar with your situation must contact your Claims Administrator to pre-certify your care. **If you do not pre-certify your care in advance, a penalty of $250 will apply.** This penalty does not count toward your separate annual deductible or annual out-of-pocket maximum.

If You Need Emergency Care

For emergency admissions to a hospital or mental health or chemical dependency treatment facility, you do not need to call your Claims Administrator first before being admitted. In this case, benefits will be paid at normal plan levels as long as you (or someone on your behalf) call your Claims Administrator within 48 hours after the emergency admission. If you do not call within 48 hours, no benefits will be paid.

If you seek emergency mental health and/or chemical dependency treatment in a non-emergency situation, even with notification of the admission in the required timeframe, your benefits will be reduced to 50%, and you will be responsible for the balance.

What constitutes: a mental health or chemical dependency emergency?

The Plan defines an emergency as a situation where the patient exhibits such severe symptoms that a prudent layperson possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the individual's heath (or for a pregnant woman, the unborn child's health) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Danger to others

Filing a Claim

When You See In-Network Providers

If you receive care from an in-network provider, you do not need to file a claim to receive benefits — your provider files the claim for you.

When You See Out-of-Network Providers

If you receive care from an out-of-network provider, you must file a claim with your Claims Administrator to receive benefits. To file a claim, you must complete a claim form, attach your original itemized bills, and mail them to the address shown on the form. All claims must be filed within 18 months following the end of the Plan Year during which the care was received. If your claim is submitted after that period of time, it will not be eligible for payment.

You can obtain a claim form via my.aa.com or by contacting your Claims Administrator. You may be asked to pay for your care at the time of your visit and submit a claim for reimbursement.

The Out-of-Area Program ("OOA")

If you live outside any PPO Plan network service area, medical coverage is available through the Out-of-Area Program. The Out-of-Area Program is a non-network program. With a non-network program, you may receive care from any provider you want. After you pay an annual deductible, the Plan will begin to share the cost of care with you. Generally, the Plan pays a certain percentage of the reasonable and customary (R&C) charges for services and you pay the rest. R&C charges are based on the typical amounts charged by most providers in your geographic area for specific medical services. If the cost of your care is more than the R&C limit set by the Plan, you pay the amount that exceeds the limit in addition to any applicable deductible and coinsurance amounts.

When you reach the annual out-of-pocket maximum, the Plan will pay 100% of your eligible expenses for the rest of the Plan Year (excluding charges above the R&C limit or charges not otherwise covered by the Plan).

The Out-of-Area Program offers three coverage options from which to choose that vary based on the amounts of your annual deductible, annual out-of-pocket maximum, and coinsurance levels.

On the following pages, you will find an overview of the Out-of-Area Program and the benefits it includes.

Schedule of Out-of-Area Program Benefits

An Overview of Out-of-Area Program Benefits

The following chart is an overview of the key features of the Out-of-Area Program ("OOA"), including the benefits for OOA 80, OOA 90, and OOA 100. The chart is an overview only and does not list every covered service. For more information on how the Plan covers services under the Out-of-Area Program, contact your Claims Administrator.

Schedule of Out-of-Area Program Benefits			
Feature	**OOA 80**	**OOA 90**	**OOA 100**
Annual Deductible (1 person/2 or more people)	$450/$900	$225/$450	$225/$450
Coinsurance	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Annual Out-of-Packet Maximum (1 person/2 or more people)	$3,000/$6,000	$1,500/$3,000	$225/$450
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Medical Office Services			
Doctor's Office Visits	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Telehealth	$20 co-pay	$20 co-pay	$20 co-pay
Preventive Care *includes routine physicals and well child care* (no limit on visits until age 5, then one routine physical per year)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
OB/GYN Exams	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

Schedule of Out-of-Area Program Benefits			
Feature	**OOA 80**	**OOA 90**	**OOA 100**
X-Rays and Lab Tests	The Plan pays 100% of R&C charges, after meeting annual deductible, if performed in doctor's office as part of office visit. If performed in outpatient facility, the Plan pays 100% of R&C charges for lab charges and 80% of R&C charges for x-rays and related services	The Plan pays 100% of R&C charges, after meeting annual deductible, if performed in doctor's office as part of office visit. If performed in outpatient facility, the Plan pays 100% of R&C charges for lab charges and 90% of R&C charges for x-rays and related services	The Plan pays 100% of R&C charges, after annual deductible.
Immunizations (No age limitation)	The Plan pays 80% of charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Inpatient Hospital Care			
Room Allowance (semi-private room covered; private room covered only when medically necessary)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Surgery	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Maternity Care			
Obstetric Services (including office visits)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Hospital Charges (including newborn nursery care)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Prescription Drugs (benefits provided through Pharmacy Claims Administrator)			
Retail Co-pay (up to 34-day supply)	$15 generic $30 preferred brand $50 non-preferred brand	$15 generic $30 preferred brand $50 non-preferred brand	$15 generic $30 preferred brand $50 non-preferred brand

Schedule of Out-of-Area Program Benefits			
Feature	**OOA 80**	**OOA 90**	**OOA 100**
Mail Order Co-pay[4] (> 34-day and up to 90-day supply)	$30 generic[5] $60 preferred brand $100 non-preferred brand	$30 generic[5] $60 preferred brand $100 non-preferred brand	$30 generic[5] $60 preferred brand $100 non-preferred brand
Mental Health and Chemical Dependency			
Inpatient Care	The Plan pays 80% of R&C charges, after annual deductible *No day maximum*	The Plan pays 90% of R&C charges, after annual deductible *No day maximum*	The Plan pays 100% of R&C charges, after annual deductible *No day maximum*
Alternative Mental Health Care Center (residential treatment	The Plan pays 80% of R&C charges, after annual deductible *No day maximum*	The Plan pays 90% of R&C charges, after annual deductible *No day maximum*	The Plan pays 100% of R&C charges, after annual deductible *No day maximum*
Alternative Mental Health Care Center (intensive Outpatient and partial hospitalization)	The Plan pays 80% of R&C charges, after annual deductible *No day maximum*	The Plan pays 90% of R&C charges, after annual deductible *No day maximum*	The Plan pays 100% of R&C charges, after annual deductible *No day maximum*
Telehealth	$20 co-pay	$20 co-pay	$20 co-pay
Outpatient Care	The Plan pays 50% of R&C charges, after separate annual deductible *No visit maximum*	The Plan pays 50% of R&C charges, after separate annual deductible *No visit maximum*	The Plan pays 50% of R&C charges, after separate annual deductible *No visit maximum*
Telehealth	$20 co-pay	$20 co-pay	$20 co-pay
Other Coverage			
Emergency Room	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

[4] Applicable to PBM Smart 90 for certain medications.

[5] Effective January 1, 2009, some generic drugs are available through mail order for a $10 co-pay for up to a 90-day supply

Schedule of Out-of-Area Program Benefits			
Feature	**OOA 80**	**OOA 90**	**OOA 100**
Durable Medical Equipment (some Durable Medical Equipment may have certain limitations, such as one custom pair of shoe inserts per benefit period)	$500 per year at 100% of R&C, then the Plan pays 80% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met	$500 per year at 100% of R&C, then the Plan pays 90% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met	$500 per year at 100% of R&C, then the Plan pays 100% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first $500 paid has been met
Physical and Occupational Therapy (40-visit maximum per year). Visits above 40 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Speech Therapy (20-visit maximum per year). Visits above 20 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Chiropractic Care (20-visit maximum per year). Visits above 20 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Home Health Care (100-visit maximum per year). Visits above 100 per year subject to ongoing medical necessity review.	The Plan pays 100% of R&C charges	The Plan pays 100% of R&C charges	The Plan pays 100% of R&C charges
Hospice Care	The Plan pays 100% of R&C charges, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.

Schedule of Out-of-Area Program Benefits			
Feature	**OOA 80**	**OOA 90**	**OOA 100**
Skilled Nursing Care Facility (60-day max. per year)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Ambulance Services[6]	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
All other covered and medically necessary services including, but not limited to: Medical Supplies (blood, oxygen, prosthetics) and Dialysis Services	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

[6] Air transport and ambulance service between facilities must be medically necessary as determined by the Claims Administrator.

Important Notes About Out-of-Area Program Benefits

1. The annual deductible and out-of-pocket maximum amounts applicable to expenses for medical services DO apply to covered expenses for mental health and chemical dependency services. There is a combined annual deductible and a combined out-of-pocket maximum you must meet before the plan pays 100% for medical and/or mental health and chemical dependency care.
2. If you move from an OOA Plan to a PPO Plan in the same calendar year, the medical and mental health/chemical dependency deductibles and out-of-pocket maximums that you met under the OOA Plan will transfer to the PPO plan in-network deductibles and out-of-pocket maximums for that year.

Pre-certifying Care For Certain Medical Services (Out-of-Area Program)

Pre-certifying care means notifying your Claims Administrator to make sure a treatment plan is approved in advance. All in-patient surgical procedures and hospital stays (including emergency admissions, skilled nursing care facilities and in-patient hospice facilities) need to be pre-certified. It's important to understand your responsibility for pre-certifying care since failure to do so will result in financial penalties you must pay.

Notification is *your* responsibility. Before any surgical procedure or hospital stay, you, your doctor, or someone else familiar with your situation must contact your Claims Administrator to pre-certify your care. **If you do not pre-certify your care in advance, a penalty of $250 will apply.** This penalty does not count toward the annual deductible or annual out-of-pocket maximum.

Filing a Claim (Out-of-Area Program)

To receive benefits for care, you must file a claim. To file a claim, you must complete a claim form, attach your original itemized bills, and mail them to the address shown on the form. All claims must be filed within 18 months following the end of the Plan Year during which your care was received. If your claim is submitted after that period of time it will not be eligible for payment. This 12 month requirement does not apply if you are legally incapacitated

You can obtain a claim form via my.aa.com or by contacting your Claims Administrator. You may be asked to pay for your care at the time of your visit and submit a claim for reimbursement from the Plan.

Medical Services Covered Under the Plan

In general, the PPO Plan and Out-of-Area Programs cover a wide range of covered health services and supplies your doctor prescribes or authorizes to treat an illness or injury. *(See the "Schedule of PPO Plan Benefits" and "Schedule of Out-of-Area Program Benefits" sections of this SPD for a summary of covered services).*

If you have further questions about the medical services covered under the Plan, call your Claims Administrator.

Bariatrics:

Medically necessary services or expenses associated with the treatment of obesity, weight reduction or dietary control, limited to one surgical procedure per lifetime. It is your responsibility to contact your Claims Administrator to discuss your eligibility and surgical options covered under this Plan. Failure to do so may result in denial of your claim. Benefits will not be provided for reversals or reconstructive procedures.

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.

Cochlear implants:

Cochlear implants are covered In-Network and Out-of-Network.

Colonoscopy:

- In-Network: The first Colonoscopy and all related ancillary services per calendar year will be covered in full regardless of diagnosis billed. Ancillary services to the first colonoscopy seven (7) days after will also be covered in full, with no copay. All subsequent procedures will be covered in full after a copay.
- Out-of-Network: Out-of-Network, deductible and coinsurance apply.
- This section applies to both facility and professional charges.

Diagnostic mammograms:

- In-Network: Subject to a co-pay, regardless of whether it is performed in an office setting or in a facility. If it is performed in an office setting, a co-pay is charged for the office visit during which the mammogram is performed, but no additional co-pay is charged for the mammogram.

- Out-of-Network: The deductible applies, then out-of-network Reasonable & Customary co-insurance applies.
- A maximum of two mammograms per year are covered (combined In-Network and Out-of-Network) for any reason. After the two mammograms, an unlimited number are covered if medically necessary.

Gender Reassignment/Sex Changes:

- The Gender Reassignment Benefit (GRB) provides coverage for gender reassignment for the treatment of gender dysphoria. The GRB only offers benefits on an In-Network basis. There are no GRB benefits offered Out-of-Network.
- Effective January 1, 2016, the surgical benefit is available to employees and their eligible Dependents age 18 and over enrolled in a Medical Benefit Option.
- This GRB is available to the employee and their eligible Dependents (age 18 and over for the surgical benefit) 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.
  - One genital revision surgery (either male to female or female to male, as applicable) and one bilateral mastectomy or one 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 (either male to female or female to male, as applicable) 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 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.
- **Pre-Certification for the GRB.** You must have approval from the Claims Administrator **both** at the time you begin your treatment and at the time you are admitted for surgery. Your failure to obtain Pre-Certification **both** at the time you

begin treatment and at the time you are admitted for surgery will result in denial of your claims.

- **Cosmetic Surgeries:** Procedures primarily aimed to enhance appearance and/or physical modification, to resemble secondary sex characteristics of the chosen/reassigned gender such as hair removal, liposuction/body contouring, thyroid cartilage shaving, plastic surgery of eyelids/eyes/lips/chin, facial bone reduction, face lifts, voice modification surgery, nose modification, skin resurfacing, and any other cosmetic surgeries are not covered.

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/Page/Name/uspstf-a-and-b-recommendations/

Prostheses:

Prostheses (such as a leg, foot, arm, hand or breast) necessary because of illness, injury or surgery. Replacement prostheses are allowed once every 36 months. Exceptions for replacements include if the device was stolen, destroyed in a fire and/or natural disaster, is rendered non-repairable or non-functional, or prescription or condition has changed, or due to the natural growth of a child.

Proton beam therapy:

Effective January 1, 2018, proton beam therapy (at In-Network Providers and In-Network facilities only) for Definitive Therapy is covered for the treatment of prostate cancer.

- This benefit is subject to an overall maximum of $50,000 per episode. If there is a recurrence of prostate cancer following a period of time when the cancer could not be detected, this is considered a different episode and coverage will be available again, up to the maximum of $50,000 per episode.
- The overall maximum of $50,000 applies only to the proton beam therapy delivery and does not apply to treatment planning, imaging, physician consultations, professional services or other associated ancillary charges.
- The following limitations apply:
  - The service or procedure must be performed by an In-Network Provider and be administered in an In-Network facility (unless a network gap exception has been approved by the Network/Claim Administrator).

- The benefit requires Pre-Certification. However, prior claims incurred on or after January 1, 2018 may be paid once Pre-Certification has been approved by the Network/Claim Administrator.

- Services received at an Out-of-Network Provider or Out-of-Network facility are excluded. See the "Medical Expenses Not Covered" section, "Proton Beam Therapy" for details.

Repetitive Transcranial Magnetic Stimulation (RTMS):

Claims for RTMS will be referred for further review. RTMS is unproven and not medically necessary for treating all medical conditions.

Routine colon cancer screenings, fecal occult blood test, barium enema and sigmoidoscopies:

These procedures are covered in full In-Network, with no copay. Out-of-network, they are subject to deductible and coinsurance.

Routine bone density (with or without an office visit):

Routine bone density is covered in full with no copay when conducted by an In-Network provider.

Routine hearing screening (performed with wellness exam):

Routine hearing screening is covered in full, with no copay, when performed as part of a wellness exam.

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 application. 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. Doctor on Demand cannot provide treatment for chronic conditions like diabetes, or medical emergencies like chest pain or severe burns. For details about the telehealth benefit for mental health and chemical dependency conditions, see "Mental health and chemical dependency care."

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:
    - Transplant

- Cancer
- Congenital heart disease
- Bariatric surgery; or

(2) you receive care at an In-Network surgery Provider for gender reassignment surgery.

- These treatments and procedures 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 a treatment or procedure because it is not offered in your immediate home area, travel to an In-Network Provider (for gender reassignment surgery) or a Center of Excellence (COE) and lodging expenses will be reimbursed up to a maximum of $10,000, regardless of your 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 a treatment or procedure 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 Claims Administrator. Contact your Claim Administrator for instructions on receiving reimbursement for your expenses.

Treatment and Observation rooms:
Treatment and observation rooms are not subject to an emergency room co-pay if an emergency room visit is not billed and is subject to the applicable deductible and coinsurance. If an emergency room visit is billed, then an emergency room co-pay will apply.

Medical Services NOT Covered Under the Plan

The PPO Medical Benefit Options and Out-of-Area Medical Benefit Options exclude coverage for certain services. Please contact your Claims Administrator if you have questions about what services are excluded.

The following services are excluded from coverage:

- Services and supplies that are not medically necessary covered health services, as determined by your Claims Administrator;
- Custodial care: care essentially designed to assist individuals to meet their activities of daily living, such as but not limited to services which constitute personal care (including; help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not entail or require continuous attention of trained medical personnel);
- Cosmetic procedures and supplies, except when reconstructive/cosmetic surgery is necessary as a result of Sickness, Injury or Congenital Anomaly, or to comply with the requirements of The Women's Health and Cancer Rights Act of 1998. *(See the "*Additional Rules That Apply to Your Medical Coverage*" section of this SPD.)* Examples of procedures that are excluded from coverage include: rhinoplasty (nose), mentoplasty (chin), rhytidoplasty (face lift), glabellar rhytidoplasty, (space between eyebrows) surgical planning (dermabrasion), blepharoplasty (eyelid), mammoplasty (reduction, suspension or augmentation), superficial chemosurgery (chemical peel) and liposuction;
- Treatment or tests performed on an inpatient basis that could have been performed safely and effectively on an outpatient basis;
- Experimental/Investigational or unproven procedures, unless the Plan has agreed to cover them as stated in the Glossary;
- Medically necessary services or expenses associated with the treatment of obesity, weight reduction or dietary control beyond one surgical procedure per lifetime. It is your responsibility to contact your Claims Administrator to discuss your eligibility and surgical options covered under this Plan. Failure to do so may result in denial of your claim. Benefits will not be provided for reversals or reconstructive procedures;
- Services or supplies not needed for diagnosis or treatment of a specific illness or injury;
- Services or expenses provided by a physician or other health care provider related to the covered person by blood or marriage;
- Services or supplies you received before you had coverage under the Plan, or after your coverage under the Plan ends;
- Services or supplies payable by Medicare, or any other government or private program;

- Private duty services provided by sitters or companions. Private duty services by Registered Nurses or Licensed Practical Nurses will also be excluded unless the services are part of an approved home health care or hospice program;
- Reversals of tubal ligations or vasectomies;
- Infertility treatment, services and associated expenses for artificial insemination including In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs including collection and preparation;

  Note: Diagnostic testing to determine the cause of infertility and prescription medication to treat infertility is covered under the Plan.
- Prescription drugs purchased at a doctor's office, skilled nursing facility, hospital or any other place that is not a pharmacy licensed to dispense drugs in the state where it is operated;
- Prescription medications prescribed or consumed in dosage, quantity, or for condition(s) not approved by the US Food and Drug Administration, and prescription medications used in a manner, quantity, dosage, or route of administration not approved by the US Food and Drug Administration for such medication.
- Any service or treatment for complications resulting from any non-covered procedures;
- Any service or supply rendered to a covered person for the diagnosis or treatment to change gender or to improve or restore sexual function;
- Marriage, family or child counseling for the treatment of premarital, marital, family or child relationship dysfunction;
- Food supplements including infant formula available over the counter. Coverage of food supplements is restricted to sole source nutrients which are not available over the counter or without a prescription;
- Prescription drugs used for cosmetic purposes or hair growth;
- Travel whether or not recommended by a physician, except in connection with medically necessary travel for an organ transplant, cancer treatment, congenital heart disease treatment, bariatric surgery, or gender reassignment surgery, subject to and only if approved in accordance with the Travel and Lodging Reimbursement Guidelines;
- Durable Medical Equipment over $500 when required preauthorization is not obtained;
- Services and supplies related to human organ and tissue transplants when the required pre-approval is not obtained;
- Any service or supply the covered person is not legally obligated to pay;
- Services for the removal of impacted teeth;
- Eyeglasses, contact lenses (except after cataract surgery), hearing aids and examination for the prescription or fitting thereof and any hospital or physician charges related to refractive care;

- Any medical social services, visual, recreational, behavioral, educational or play therapy or bio-feedback, except when part of a pre-authorized home health plan or hospice care program;
- Premarital and pre-employment exams;
- Dental services, except for dental treatment and oral surgery related to the mouth that is required as the result of an accident and started prior to a year after the accident, unless under the age of 18 when the accident occurred. Dental services required as the result of an accident may be covered under the medical program subject to certain medical necessity limitations and could include treatment for standard reconstruction (plates and crowns). Services are also limited to the replacement of sound and natural teeth. Only when deemed a medically necessary covered health service and the only alternative to restore the tooth/teeth/arch to its functional condition, implants may be a covered expense (to a $15,000 lifetime maximum);
- Services and supplies received for the treatment of any work related accident or illness;
- Services or expenses for treatment of injury sustained in the commission of a crime or for treatment while confined in a prison, jail, or other penal institution;
- Services or expenses for personal hygiene, comfort or convenience items such as air-conditioners, humidifiers, whirlpool baths, and physical fitness or exercise apparel and health club memberships. Exercise equipment is also excluded. Some examples of exercise equipment are shoes, weights, exercise bicycles or tracts, weights or variable resistance machinery, and equipment producing isolated muscle evaluations and strengthening. Treatment programs, the use of equipment to strengthen muscles, and related services performed during the same therapy session are also excluded;
- Any surgical procedure relating to the eye other than one which is a result of trauma or disease. This includes, but is not limited to, Lasix, radial Keratotomy; any other procedure to correct refractive disorders not a consequence of trauma, or disease; or repair of prior ophthalmic surgery unless original surgery was a covered expense under this Plan;
- Acupuncture;
- Hair transplants and treatment of baldness;
- Routine prostate screening exams at an Out-of-Network Provider;
- Proton beam therapy at an Out-of-Network Provider or administered in an Out-of-Network facility if you do not receive Pre-Certification approval from the Network/Claim Administrator. Coverage is also excluded when metastases are present.
- Chelation Therapy, except for treatment of heavy metal poisoning;
- Alternative treatments including but not limited to: acupressure, aromatherapy, hypnotism, massage therapy, rolfing (holistic tissue massage), and other forms of alternative treatments as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institute of Health; and

- Routine hearing examinations.

Mental Health and Chemical Dependency Benefit Limitations and Exclusions

The following services, treatments, and supplies listed below are not Covered Services.

- Services, treatment or supplies provided without prior authorization as described in this SPD, except those provided as Emergency Treatment;
- Services, treatment or supplies rendered to a participant which are not Covered Health Services;
- Services, treatment and supplies primarily for rest, custodial, domiciliary or convalescent care;
- Diagnosis and treatment for personal growth and/or development, personality reorganization or in conjunction with professional certification;
- Services, treatment or supplies determined to be experimental, investigational or unproven services;
- Private hospital rooms and/or private duty nursing, unless determined to be Covered Health Services and authorized by your behavioral health Claims Administrator;
- Marriage counseling, except for if it is needed for the treatment of a diagnosed Mental Health/Substance Abuse Condition;
- Treatment of congenital and/or organic disorders, including, but not limited to, organic brain disorder and Alzheimer's disorder;
- Treatment of mental retardation, other than the initial diagnosis;
- Diagnosis and treatment of developmental disorders, including, but not limited to, developmental reading disorder, developmental arithmetic disorder, or developmental articulation disorder;
- Any non-medical counseling or ancillary services, including but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety and services, training, educational therapy, boarding schools, wilderness programs, or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation;
- Education, training, and bed and board while confined in an institution that is mainly a school or training institution, a place of rest, a place for the aged or a rest home;
- Services, treatment or supplies provided as a result of any Workers' Compensation or similar law, or obtained through, or required by, any governmental agency or program or caused by the conduct or omission of a third-party for which the participant has a claim for damages or relief, unless the participant provides the behavioral health Claims Administrator with a lien against such claim for damages or relief in a form and manner satisfactory to the Plan;

- Any court-ordered diagnosis and/or treatment, including any diagnosis and/or treatment ordered as a condition of parole, probation or custody and/or visitation evaluation, except as such diagnosis and/or treatment is a Covered Health Service;
- Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings (including but not limited to parole or probation proceedings);
- Other psychological testing, except when conducted for the purpose of diagnosis of a Mental Health/Chemical Dependency condition;
- Services, treatment or supplies for disabilities resulting from service in the military ;
- Treatment of detoxification in newborns;
- Treatment of obesity or weight reduction, or for the cessation of smoking, including supplies;
- Stress management therapy;
- Aversion therapy;
- Treatment of pain, except for a Covered Health Services treatment of pain with psychological or psychosomatic origins;
- Sex therapy, treatment for sexual deviance or diagnosis or treatment in conjunction with sexual reassignment procedures;
- Damage or other harm to an In-Network Provider caused by a participant (the participant shall be solely responsible for all such damage or harm);
- Treatment for a Chronic Mental Condition, except for (i) stabilization of an acute episode of such disorder, or (ii) management of medication;
- Charges for failure to keep medical appointments

Additional Rules That Apply to Your Medical Coverage

Coordination With Medicare for Employees on Leave of Absence and Disabled Individuals

If you or your covered Dependent(s) are enrolled in Medicare while you are actively employed, participation in this Plan will continue as long as you are an active employee and remain enrolled. This Plan will be the primary carrier and Medicare will be the secondary carrier.

If you are on a leave of absence or you are receiving disability benefits, please note the following important rules regarding coverage under Medicare:

Leave of Absence: If you take a leave of absence and retain coverage under the Plan, the Plan will continue to pay primary for as long as you retain your right to return to active employment, i.e., your employment is not terminated by the company. If your employment is terminated by the company, Medicare will become primary.

Disability: If you take a medical leave of absence, retain coverage under the Plan, and start receiving disability benefits from the Company, the Plan will continue to pay primary for the first 6 months of your disability coverage (i.e., while disability benefits are subject to FICA tax). After this 6 month period, Medicare will become primary for you and/or any covered Dependents. If you are Medicare-eligible and Medicare would be the primary payer, the Plan will pay benefits as though you had enrolled in Medicare Part A (hospital) and Part B (physicians and other services) regardless of whether you have actually done so. If Medicare would be the primary payer, the Plan will not pay expenses that would otherwise be covered by Medicare. Timely enrollment in Medicare Parts A and B will ensure proper coordination of benefits. You may obtain further information on Medicare eligibility by contacting Medicare directly at 1-800-MEDICARE or www.Medicare.gov.

The Plan includes coverage for prescription drug benefits. However, as a Medicare eligible individual you are also entitled to enroll in a prescription drug plan under Medicare Part D. Please note that you will not receive benefits from both this Plan and a Medicare Part D prescription drug plan. Therefore, if you enroll in a Medicare Part D plan you may be paying for coverage you will not receive. If Medicare verifies that you have prescription drug coverage through this Plan, Medicare may coordinate with your Part D prescription drug plan enrollment. You are therefore urged to consider the options carefully prior to making a Medicare Part D election.

Example

The following example shows how benefits coordinate with Medicare where Medicare pays primary (e.g., where you are entitled to Medicare based on disability and you have received disability benefits from the Company for more than 6 months). Let's assume

you enroll in Out-of-Area Program, OOA 90, you have already met your annual deductible, and you incur a claim for which the Medicare Allowable Amount is $2,000. Medicare Part B covers these expenses at 80%, while the OOA 90 covers them at 90%. Medicare Part B will first pay 80% of the Medicare Allowable Amount, or $1,600. Then, the Out-of-Area Program will pay 10% of the Medicare Allowable Amount. This is the difference between 90% (what the Out-of-Area Program would pay if it were your primary coverage) and 80% (what Medicare pays), $200 in this example. Both plans coordinate to pay 90% of the total charge, or $1,800—the same benefit you would have received from the Out-of-Area Program if it had been your primary coverage. If you had only enrolled in Medicare Part A, the Plan would still pay as if you were enrolled in both Medicare Part A and Medicare Part B, and you would be responsible for the balance, or $1,800 (the Medicare portion and your payment portion) as in the example below.

Medicare*		**Out-of-Area Plan, PPO 90/70**	
Physician Charges	$2,500	Physician Charges	$2,500
Medicare Allowable Amount	2,000	Medicare Allowable Amount	2,000
Medicare Pays 80% of Medicare Approved Charges	1,600	Plan Benefit at 90% of Medicare Approved Charges	1,800
Remaining balance	400	Less Medicare Payment	-1,600
		Out-of-Area Program Payment	200
		Your Payment	200

*If your physician accepts Medicare assignment, you cannot be charged, by the provider, for amounts over what Medicare approves.

Your Prescription Drug Benefit

The Plan includes prescription drug coverage through a broad network of retail pharmacies and a convenient mail order program. The prescription drug program provides coverage for both generic and brand name prescription drugs and includes several administrative programs designed to encourage safe, appropriate, and effective use of medications. Current programs include Managed Drug Limitations, Prior Authorization and Step Therapy. Medications and limitations are selected for these programs based on clinically approved prescribing guidelines. They are routinely reviewed by your Claims Administrator to ensure clinical appropriateness and are subject to change.

This section provides important information about the prescription drug coverage available through the Plan including:

- The pharmacy Claims Administrator's responsibilities;
- A summary of prescription drug benefits at in-network pharmacies and through the mail order program; and
- Other Important Information about Your Prescription Drug Benefits.

Claims Administrator Responsibilities

The Pharmacy Benefit Manager, or "PBM," is responsible for all prescription drug coverage under the Plan. PBM's specialize in prescription drug benefit management and administration. They maintain national networks of retail pharmacies, a mail order program and provide member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the PBM.

An Overview of Your Prescription Drug Program Benefits

Through Participating Retail Pharmacies

You can fill a prescription at any pharmacy that is part of your PBM network. You can also take advantage of the mail order program for maintenance prescriptions or other prescriptions you use on a regular basis. When you fill a prescription through a participating retail pharmacy, there are no claim forms to file. At the pharmacy, you pay one of three co-pay amounts depending on whether the drug you receive is generic, a preferred brand name, or a non-preferred brand name.

A **generic drug** is a chemically equivalent version of a brand-name drug, and is available when patent protection expires on the brand-name drug. Generally, generic drugs are less expensive than brand-name drugs.

A **preferred brand-name drug** is one that is on your PBM's primary/preferred drug list. Drugs on this list are judged by your PBM to maximize clinical results and economic value. Your PBM may update its primary/preferred drug list from time to time, so it's a good idea to review it every so often to see if certain drugs have been added or dropped.

A **non-preferred brand-name drug** is one that is not on your PBM primary/preferred drug list.

Here is a look at the co-pays for generic, preferred brand-name, and non-preferred brand-name prescription drugs when you visit a participating retail pharmacy.

Up to a 34-day supply	At a participating in-network pharmacy	At a non-network pharmacy
Generic drug	$15	No coverage
Preferred brand-name drug	$30	No coverage
Non-preferred brand-name drug	$50	No coverage

When you fill your prescription at an in-network pharmacy, you receive up to a 34-day supply after you make your co-pay.

Through Non-Participating Retail Pharmacies

There is no coverage for prescriptions filled at pharmacies that are not part of your PBM network.

Through the Mail Order Program

The Plan has a mandatory mail order program for maintenance medications. A maintenance medication is a drug that you take on a regular basis, generally for a long period of time. You are required to fill your maintenance drugs through mail order after the third retail fill. When you fill your maintenance prescription drug through the mail order program, you can receive up to a 90-day supply after you make your mail order co-pay.

Here is a look at the co-pays for generic, preferred brand-name, and non-preferred brand-name prescription drugs when you use the mail order program.

Up to a 90-day supply[7]	When you use the mail order program
Generic drug	$30
Preferred brand-name drug	$60
Non-preferred brand-name drug	$100

Effective January 1, 2009, some generic drugs at mail order will have a $10 co-pay subject to change at any time.

Using the Mail Order Program

To fill a prescription through the mail order program, complete a mail order drug form (which you can find online at your PBM's website) and return it, along with your prescription, to the address shown on the form. For all refills after your initial mail order, you can order your refills online at your PBM's website or by calling the PBM Customer Service.

About "vacation supplies" and prescriptions filled outside the United States

If you're planning to be on vacation, you may be able to receive more than the usual maximum day supply of your prescription. Call your PBM for more information on a vacation supply for your prescription.

If you are outside of the United States and need to fill a prescription, note that prescription drug coverage may be different than the benefits described in this SPD. Call your PBM for more information about prescription drug coverage outside the United States.

[7] Applies to Smart 90 where applicable

Other Important Information about Your Prescription Drug Benefits

Quantity Limits for Certain Drugs

To help control the cost of certain high-cost drugs without eliminating their coverage altogether, the Plan includes quantity limits for certain covered medications. For these drugs only, if you exceed the Plan's quantity limits, you pay the full cost. The limits *only* apply to the amount of medication that the Plan covers. You may be able to obtain greater quantities at your own expense. The final decision regarding the amount of medication you receive remains between you and your doctor. If you have any questions related to these limitations, you or your doctor can contact your PBM.

Generic Substitution/Dispense As Written

When a generic is available, but the pharmacy dispenses the brand name for any reason other than your physician indicating "dispense as written," you will pay the difference between the brand name medicine and the generic plus the generic co-payment.

Prior Authorization

In order for some prescription drugs to be covered as part of your benefit, your PBM will conduct an evaluation to determine if the drug's prescribed use meets defined clinical criteria. Through this process, your doctor and your PBM pharmacist will work together to ensure that the drug you are prescribed is the most appropriate for your condition. If prior authorization is required, your doctor will need to contact your PBM. This call will determine whether the drug will be covered under the prescription benefit. If coverage is denied, your doctor may prescribe another drug or you can choose to have the original prescription filled and pay the total cost. To inquire if a drug is subject to prior authorization, contact your PBM.

Step Therapy

Step Therapy helps ensure your safety and that you receive clinically appropriate medication based on your prescription history. The Step Therapy Treatment guidelines are in accordance with current medical literature, manufacturer recommendations and U.S. Food and Drug Administration guidelines. The Plan may require a review for certain drugs under this program before providing coverage to determine if other cost-effective therapies are available and have been tried. To inquire if a drug is subject to Step Therapy, contact your PBM.

HMO Medical Benefit Option

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 coverage through the PPO 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.

Your Employee Assistance Program

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 per issue or concern. 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.

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 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 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 and Chemical Dependency" in the Schedules.

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

Your Dental Options

The Plan includes benefits for a wide variety of services for preventive dental care, minor dental care, major dental care and orthodontia. Both in-network and out-of-network benefits are available.

This section provides important information about the dental benefits available through the Plan including:

- The dental Claims Administrator's responsibility;
- A summary of your dental benefits;
- Information on predetermination of benefits for certain services;
- How to file a claim;
- Dental services covered under the Plan; and
- Dental services not covered under the Plan.

Claims Administrator Responsibilities

Your dental Claims Administrator is responsible for all dental coverage options under the Plan. Your dental Claims Administrator maintains dental coverage networks, processes dental claims, and provides member services to Plan participants. In the "*Plan Administration*" section, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the dental Claims Administrator.

Dental PPO Program

If you live in your dental Claims Administrator's network service area, you are eligible to participate in the dental PPO program. Under the dental PPO program, you can receive care from a dental provider who is part of the dental PPO network or from a dental provider outside the network. No matter where you receive care, the Plan will pay a certain level of benefits for covered services.

If Your Provider Is An In-Network Provider

When you see dental providers that are part of your dental claim administrator's dental PPO network, you will pay less, overall for your dental services, because the fees for your service are lower than what an out-of-network provider may charge. That is because in-network providers have agreed to provide services at negotiated or discounted rates.

If Your Provider is an Out-of-Network Provider

When you see dental providers that are not part of your dental Claims Administrator's dental PPO network, the Plan will pay benefits based on the reasonable and customary

(R&C) charge for a particular service. If the out-of-network provider charges more than the R&C amount, you will be responsible for paying the amount that exceeds the R&C charge, in addition to the applicable coinsurance and deductible. You may be asked to pay for your care at the time of your visit and submit a claim form for reimbursement.

An Overview of Dental PPO Program Benefits

The following chart summarizes services that are covered by the dental PPO Program. The chart is an overview only and does not list every covered service. (For a more detailed list of covered dental services, see the "*Dental Services Covered Under the Plan"* section of this SPD, or contact your dental Claims Administrator.)Dental PPO Program Benefits

Dental PPO Program Benefits		
Feature	**In-Network**	**Out-of-Network**
Annual deductible (1 person/2 or more people)	None	$50/$100
Preventive care *Exam* (twice per calendar year) *Prophylaxis* (twice per calendar year) *Fluoride treatment* (once per year, up to age 19) *Sealants* (once every 36 months up to age 15) *X-rays* (bitewing—as part of routine exam, once per year; full-mouth—once every 60 months)	The Plan pays 100% of discounted in-network fees	The Plan pays 80% of reasonable and customary (R&C) charges, with no deductible
Minor care *Oral surgery* *Extractions* *Fillings* *Endodontics* *Periodontics*	The Plan pays 80% of discounted in-network fees	The Plan pays 50% of R&C charges, after annual deductible
Major care *Bridgework* *Dentures* *Crowns* *Inlays and onlays* *Repairs and replacement of bridges, crowns, inlays, onlays, dentures* *Implant services and repairs*	The Plan pays 50% of discounted in-network fees	The Plan pays 50% of R&C charges, after annual deductible
Orthodontia *Services for children and adults*	The Plan pays 50% of discounted in-network fees *$2,000 lifetime maximum*	The Plan pays 50% of R&C charges *$2,000 lifetime maximum*
Annual Benefit Maximum (excluding orthodontia)	$1,500 per person	$1,000 per person

What to Do in an Emergency

The Plan does not cover services provided in a hospital room, surgi-center or urgent care facility. You are covered for procedures provided in a dental office by a licensed dentist, provided the services are covered under the Plan.

Predetermination of Benefits

If you need specialist care, orthodontic care, or any other dental care and the expected cost of care will be $150 or more, you should ask your dentist to prepare a treatment plan and send it for a predetermination of benefits to your dental Claims Administrator.

Your dental Claims Administrator will review the treatment plan and within 10 days will send you and your dentist an explanation of benefits that details the benefits payable under the Plan. The predetermination of benefits is valid for six months.

After reviewing your dentist's treatment plan, your dental Claims Administrator may suggest a different, less costly treatment if it meets accepted dental standards. Your benefits will be based on the less expensive treatment. You and your dentist can follow any treatment plan you want, but you will pay any charges above the cost of any less expensive treatment suggested and approved by your dental claim administrator.

Filing a Claim

When You See In-Network Providers – Dental Program

If you see an in-network provider, the provider may file a claim for you. You should confirm this with your provider's office.

When You See Out-of-Network Providers – Dental Program

If you see an out-of-network provider, you must file a claim using a claim form to receive benefits.

You can obtain a claim form via my.aa.com or by contacting your dental Claims Administrator. Complete and send your claim form with the original bills and receipts to the address on the claim form. Claims should be submitted within 90 days after the expense is incurred to ensure prompt payment. However, all claims must be filed within 18 months following the end of the Plan Year during which the care was received. If your claim is submitted after that period of time, it will not be eligible for payment.

If you use an out-of-network provider or receive in-network care not covered 100%; you must pay the provider any amount the Plan doesn't pay. This amount will be shown on an Explanation of Benefits (EOB), which you will receive, from your dental Claims Administrator.

Payment for Orthodontia Services

You must receive approval from your dental Claims Administrator to receive orthodontic care. Once you receive approval, benefits are considered on a monthly basis and will be paid at the end of each quarter. If the monthly amount the orthodontist charges is more than the fixed monthly amount, you will be responsible for any amounts over the benefits paid. If the orthodontist's charges are less than the fixed monthly amount, benefits are paid on the actual amount charged.

In order for benefits to be paid, the orthodontist must install the first appliance while you (or your covered Dependent) are covered under the Plan. Also, you (or your covered Dependent) must be covered on the first day of the month to receive a payment for that month.

If orthodontic treatment is stopped for any reason before it is completed, you'll receive only benefits for the period during which you were receiving active treatment. The Plan will not pay for orthodontic treatment that began before you (or your covered Dependent) were covered under the Plan.

If you lose coverage under the Plan while in the middle of a course of orthodontic treatment, the Plan will only pay benefits in connection with the services you receive prior to losing coverage.

Dental Services Covered Under the Plan

The dental PPO Dental Program cover the following dental services and supplies, which meet the Plan's definition of covered dental services:

Preventive and Diagnostic Care:

- Two exams per person per Plan Year;
- Two cleanings per person per Plan Year;
- Adult bitewing x-rays, once per Plan Year;
- X-rays to diagnosis a specific condition needing treatment;
- Full mouth x-rays, once every 60 months;
- Fluoride treatments up to age 19, once each calendar year;
- Sealants for permanent molars for children under age 15, once every 36 months; and
- Space maintainers for children up to age 19.

Restorative Care:

- Silver (amalgam), silicate, plastic, porcelain, and composite fillings (all teeth); and

- Crowns and gold fillings to repair a tooth broken down by decay if the tooth cannot be repaired with a less expensive type of filling and only if the old crown or filling is at least five years old and unserviceable.

Endodontic Care

- Root canals; and
- Apicoectomy.

Periodontal Care

- Treatment of gum and mouth tissues;
- Surgical gum treatment, including gingivectomy, gingivoplasty, and osseous surgery; and
- Periodontal scaling and root planing.

Prosthodontic Care

- Full and partial dentures and adjustments;
- Bridgework and bridge re-cementing;
- Repairs to broken crowns, inlays, bridgework, and dentures;
- Rebasing or relining dentures at least six months old (once per 36 consecutive months);
- Adding teeth to bridgework or partial dentures, if the natural tooth was lost or extracted while you were covered under the Plan;
- Replacing dentures or bridges that are at least five years old and no longer effective;
- Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in an 84 month period;
- Repair of implants, but not more than once in a 12 month period;
- Implant supported Cast Restorations, but no more than once for the same tooth position in an 84month period;
- Implant supported fixed Dentures, but no more than once for the same tooth position in an 84 month period; and
- Implant supported removable Dentures, but no more than once for the same tooth position in an 84 month period.

Oral Surgery

- Extractions; and
- General anesthesia for oral surgery, fractures, dislocations, and gum treatment.

Therapeutic Care

- Extractions and cutting procedures in the mouth; and
- Antibiotic drugs injected by dentist or doctor.

Orthodontic Care

- Diagnostic procedures; and
- Braces and other appliances to re-align the teeth.
- Please contact your dental Claims Administrator if you have questions about covered services

Dental Services NOT Covered Under the Plan

The following dental services are excluded from coverage under the Plan:

- Treatment that does not meet accepted standards of dental practice;
- Replacement of teeth that were lost or extracted before your dental coverage began under the Plan, including congenitally missing teeth;
- Treatment associated with a pre-existing dental condition for which treatment was received during the 12-month period prior to your becoming covered under the Plan;
- Treatment by someone other than a dentist, except cleaning and fluoride treatment by a hygienist who is supervised by your dentist;
- Cosmetic dental services, such as whitening of teeth;
- Services or supplies that are covered under your medical coverage;
- Treatment of temporomandibular joint dysfunction (TMJ) that may be covered under medical Plan services;
- Work done to increase distance between nose and chin or to change the way top and bottom teeth meet or mesh (other than as a part of authorized Orthodontia services);
- Charges exceeding calendar year and/or lifetime maximums;
- Treatment of dental injuries received as a result of military service;
- Replacement or repair of orthodontic appliances;
- Prescription drugs;
- Duplicate and temporary devices and appliances;
- Replacement of dentures or dental appliances, which are lost or stolen;
- Services that are reimbursable or provided at no cost through a U.S. public program, government agency or covered by Workers' Compensation or similar laws;
- Charges for failure to keep dental appointments;
- Charges for replacement of a bridge or denture unless they are at least five years old and unserviceable;
- Charges for any special work that you request on a standard denture; and
- Charges for special techniques or precision attachments.

Your Vision Plan

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

This section provides important information about the dental benefits available through the Plan including:

- Eligibility;
- Coverage Levels;
- Using In-Network Providers; and
- Plan Exclusions

The insurance certificate is available on the Vision page of my.aa.com. With respect to the vision insurance benefit, the terms of the insurance certificate control when describing specific benefits that are covered or insurance-related terms.

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 Claim Administrator for the vision insurance benefit. Visit the EyeMed website or contact EyeMed at 1-844-714-5678 for more information on the Vision Insurance Benefit. 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.

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:

Feature	Your In-Network Cost	Your Out-of-Network Reimbursement[1]
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		
Frames	$0 Co-Pay, $140 Allowance, 20% off balance over $140	Up to $45
Standard Plastic Lenses		
Single Vision	$25 Co-Pay	Up to $40
Bifocal	$25 Co-Pay	Up to $60
Trifocal	$25 Co-Pay	Up to $80
Lenticular	$25 Co-Pay	Up to $80
Standard Progressive	$25 Co-Pay	Up to $60
Premium Progressive Tier 1 Tier 2 Tier 3 Tier 4	 $45 Co-Pay $55 Co-Pay $70 Co-Pay $25 Co-Pay, 80% of charge less $120 Allowance	 Up to $60 Up to $60 Up to $60 Up to $60
Standard Lens Options		
UV coating	$0	Up to $8
Tint (solid and gradient)	$0	Up to $8

[1] 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.

Feature	Your In-Network Cost	Your Out-of-Network Reimbursement[1]
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 Tier 2 Tier 3	 $52 Co-Pay $63 Co-Pay 80% of charge	 Up to $3 Up to $3 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[2]		
Conventional	$0 Co-Pay; $150 allowance, 15% off balance over $150	Up to $150
Disposable	$0 Co-Pay; $150 allowance, plus balance over $150	Up to $150
Medically necessary	$0 Co-Pay, 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	

[2] 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 $**00.00**
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 $**40.00**
The total cost to the member is:	**$123.00**

Claims Procedures

Please see the "Claims Procedures" section 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.

Your Voluntary Long-Term Care Plan

This plan is closed to new entrants effective September 30, 2013.

The voluntary long-term care plan provides long-term care if you or your eligible Dependents suffer a chronic illness. If you choose to enroll in the plan, then you are responsible for the entire cost of the plan. Details of coverage and costs are available via AAAddedbenefits.com.

The Long-Term Care Plan

The plan pays cash benefits to help you and your family defrays the substantial costs of long-term care. It provides a long-term care facility monthly benefit of $2,000 to $10,000 per month in $1,000 increments for 3 or 6 years. You may choose a home care benefit that will pay up to 50% of your long-term care facility monthly benefit. The amounts of your benefit and premium depend on the level you select. For more details on benefit and premium levels under the plan, please contact your long-term care Claims Administrator.

Claims Administrator Responsibilities

Your long-term care Claims Administrator is responsible for all long-term care coverage options under the Plan. The carrier processes long-term care claims and provides member services to Plan participants. In the "*Plan Administration*" section of this SPD, under "*Organizations Providing Administrative Services Under the Plan*," you will find contact information for the administrator.

How to File a Claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the insurance certificate provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Voluntary Long-Term Care Plan.

Retiree Health Coverage

Eligibility for You

You are eligible for retiree health coverage (referred to as the "Access Plan") if you are a former employee of Legacy US Airways or America West Airlines, Inc. who meets the following requirements:

- You are less than age 65, and have attained the minimum retirement age of 55 as determined by Legacy US Airways' corporate policy or the minimum age as required under a collective bargaining agreement (between Legacy US Airways and a labor union) that regulates the terms and conditions of your employment; and
- You are retiring from either an active or leave/furlough payroll status that was based in the US; and
- You have at least ten (10) years of service with Legacy US Airways, unless otherwise specified in your collective bargaining agreement.

In addition, you must meet one of the following criteria:

- You are a former Flight Simulator Engineer or a Flight Crew Training Instructor who were covered by the collective bargaining agreements entered into between US Airways and the TWU and who retired prior to January 1, 2018;
- You are a former Dispatcher who was covered by the collective bargaining agreements entered into between US Airways and the TWU and who retired prior to January 1, 2017;
- You are a former Agents/Representatives/Planners (ARP) employee of the Company who was represented by the Communications Workers of America and the International Brotherhood of Teamsters ("CWA-IBT") and retired prior to January 1, 2017;
- You are a former flight attendant who retired prior to January 1, 2016;
- You are a former pilot who retired prior to January 1, 2015;
- You are a former Officer, Management/Specialist, Support Staff (OMSS) employed by the Company who retired prior to January 1, 2015; or
- You are a former employee in the maintenance and related groups who was represented by collective bargaining agreements between Legacy US Airways, Inc. and the IAM.

The medical plan and options available under the Access Plan are the same PPO and OOA plans and options that were available to you as an active employee. This coverage can continue until you reach age 65, providing all premiums are paid. Dental coverage is not included in the Access Plan.

Eligibility for Your Dependents upon Retirement

You may enroll your Spouse and any other eligible Dependents at the same time that you enroll for retiree health coverage under the Plan. Please refer to the following provisions of this SPD for further information relating to eligibility of Dependents: *"Eligibility for your Dependents."*

Retiree Health Coverage for Those who Retired Prior to March 1, 2005

Pre-merger Legacy US Airways employees who retired on or before March 1, 2005 may have received health coverage including dental benefits in accordance with the Section 1114 ruling (in accordance with the Bankruptcy Court) dated January 6, 2005. Coverage for these individuals is pursuant to the medical and/or dental "PPO Plan," and "Prescription Drug Program" sections of this SPD. For those retirees/survivors with coverage beyond age 65, the medical coverage may transition to the Out-of-Area Program. Eligibility criteria for those employees who retired prior to March 1, 2005, can be found under *Pre-Merger Retiree Coverage* on https://newjetnet.aa.com/

When Coverage Begins

Your coverage begins on the first of the month coincident to or following your retirement date.

Coverage Levels

When you enroll in the Plan, you may choose from one of the following medical and/or dental coverage levels:

- Retiree only;
- Spouse only;
- Retiree and Spouse;
- Retiree and child or children with no Spouse; or
- Retiree and family, which includes you, your Spouse and your eligible Dependent children.

If You Do Not Enroll for Coverage

If you do not elect retiree health coverage when you first become eligible, you will lose your eligibility and will not be allowed to participate in the Plan at any time in the future.

Paying for Coverage

You are responsible for the full cost of your Access Plan coverage. American Airlines determines your cost for the Access Plan prior to the beginning of each Plan Year, based on an evaluation of expected medical administration and claim expenses for the upcoming year for all retirees. Payments will be made to a third party administrator.

You may be eligible to offset a portion of your cost by electing to apply your sick bank accrual (if you have one) at the time of your retirement.

Making Changes After Retirement

In general, after you make your retiree health elections, you will not be able to increase your level of coverage in the future. However, you may change your level of coverage after retirement if a Life Event occurs, as outlined in the chart below. Changes must be made within 31 days following the event. You can decrease or terminate your level of coverage at any time after your retirement.

Note: If, for any reason, you drop your retiree health coverage, you will not be permitted to re-enroll at any time in the future.

In the Event of:	What You May Do:
An address change that results in a change into or out of your coverage under the PPO network	▪ May change coverage option and coverage level. Change must be made within 31 days.
For pre-65 retirees participating in a PPO Plan only	
You (if you Retired Prior to March 1, 2005 and retain access to post-65 benefits) or your Spouse attaining age 65 *Coverage Effective Date is the first of the month following attainment of age 65*	▪ May change coverage option. ▪ May not increase coverage level. ▪ May decrease or drop coverage at any time.
Marriage	▪ May change coverage option. ▪ May change coverage level to add your Spouse and new Dependents. ▪ May decrease or drop coverage at any time. *Documentation is required*.

In the Event of:	What You May Do:
Divorce	▪ Must drop Spouse coverage within 31 days. ▪ *Former Spouse is eligible for COBRA up to 60 days after divorce date*. ▪ May change your coverage option. ▪ May change coverage level to drop Spouse and add/drop Dependents. ▪ May decrease or drop coverage at any time. *Documentation is required*.
Birth or Adoption of a Child, Legal Guardianship or other Gain of Dependency Status	▪ May change coverage option. ▪ May change coverage level. *Documentation may be required*. ▪ May decrease or drop coverage at any time.
Retiree Death	▪ May change your coverage option. ▪ May decrease or drop coverage at any time. *Surviving Dependents may be eligible for coverage*.
Dependent Death	▪ May change coverage option. ▪ May change coverage level. ▪ May decrease or drop coverage at any time. *Note: If your Spouse dies while covering eligible Dependents under another plan, you may add Dependents to your coverage*.
Spouse Gains Employment/Coverage	▪ May drop self and Dependents from coverage within 31 days. ▪ May decrease or drop coverage at any time. *Documentation is required*.
Spouse Loses Employment/Coverage	▪ May elect, waive or change coverage level or coverage option within 31 days. ▪ May add Spouse and Dependents. *Documentation is required*.
Loss of Dependent's Eligibility	▪ May decrease or waive coverage ▪ May change coverage option if notified within 31 days of the event date. *Documentation of loss of eligibility is required*. ▪ May decrease or drop coverage at any time.
Dependent Regains Eligibility	▪ May change coverage option. ▪ May increase coverage level. *Documentation of Dependent eligibility is required; only Dependents causing the event may be added*. ▪ May decrease or drop coverage at any time.
Address Change/Relocation—that results in a transfer into or out of the /TO service area	▪ May change coverage option. ▪ May not change coverage level. ▪ May decrease or drop coverage at any time.

How to Make Changes to Your Elections

To change your elections under the Plan, call the American Airlines Benefit Service Center at 1-888-860-6178.

You must notify American Airlines Benefit Service Center of a Life Event within 31 days of the event if you want to change your benefit elections.

When Coverage Ends

- In general, your Plan coverage will end for you when:
- You stop making required contributions;
- You die;
- You are no longer eligible to participate in the Plan; or
- The Plan is terminated.

Coverage for your Spouse or eligible Dependents will end when:

- Your Spouse is no longer eligible to participate in the Plan;
- Your eligible Dependent children are no longer eligible to participate in the Plan;
- The responsible party stops making required contributions;
- Your Spouse dies; or
- The Plan is terminated.

Your eligible Dependents may be able to continue Plan coverage under certain circumstances in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA). *(See "Continuation of Coverage for Retirees" under the "COBRA Continuation of Coverage" section of this SPD for further details.)*

Surviving Spouses and Other Eligible Surviving Dependents

In the event you die while covered under these retiree health coverage provisions, your surviving Spouse, and your surviving Dependent children may be eligible to continue participation provided they were enrolled prior to your death. This continuation coverage is provided pursuant to company policy or your respective collective bargaining agreement as applicable and is separate from COBRA continuation coverage. Information will be provided to your surviving Spouse and eligible Dependent children upon notification of your death.

Coordination With Medicare for Retirees

If you or your covered Dependent(s) are enrolled in Medicare while you are retired, participation in this Plan will continue as long as you remain enrolled. However, this Plan will be the secondary carrier and Medicare will be primary carrier.

When you become eligible for Medicare due to age and Medicare is the primary payer, you must enroll in Medicare Part A (hospital) and Part B (physicians and other services), since the Plan assumes you are enrolled in both Medicare Part A and B. If Medicare is the primary payer and the Plan is the secondary payer for your medical benefits, you or your provider should first submit your claim to Medicare each time you have an eligible medical expense. The Plan will coordinate benefits according to the Medicare Allowable Amount.

The Plan includes coverage for prescription drug benefits. However, as a Medicare eligible individual you are also entitled to enroll in a prescription drug plan under Medicare Part D. Please note that you will not receive benefits from both this Plan and a Medicare Part D prescription drug plan. Therefore, if you enroll in a Medicare Part D plan you may be paying for coverage you will not receive. If Medicare verifies that you have prescription drug coverage through this Plan, Medicare may coordinate with your Part D prescription drug plan enrollment. You are therefore urged to consider the options carefully prior to making a Medicare Part D election. Timely enrollment in Medicare Parts A and B will ensure proper coordination of benefits. If you are Medicare-eligible and Medicare would be the primary payer, the Plan will pay benefits as though you had enrolled in Medicare regardless of whether you have actually done so. If Medicare would be the primary payer, the Plan will not pay expenses that would otherwise be covered by Medicare. You may obtain further information on Medicare eligibility by contacting Medicare directly at 1-800-MEDICARE or http://www.medicare.gov/.

Example

The following example shows how benefits coordinate with Medicare. Let's assume you enroll in Out-of-Area Program, OOA 90, you have already met your annual deductible, and you incur a claim for which the Medicare Allowable Amount is $2,000. Medicare Part B covers these expenses at 80%, while the OOA 90 covers them at 90%. Medicare Part B will first pay 80% of the Medicare Allowable Amount, or $1,600. Then, the Out-of-Area Program will pay 10% of the Medicare Allowable Amount. This is the difference between 90% (what the Out-of-Area Program would pay if it were your primary coverage) and 80% (what Medicare pays), $200 in this example. Both plans coordinate to pay 90% of the total charge, or $1,800—the same benefit you would have received from the Out-of-Area Program if it had been your primary coverage. If you had only enrolled in Medicare Part A, the Plan would still pay as if you were enrolled in both

Medicare Part A and Medicare Part B, and you would be responsible for the balance, or $1,800 (the Medicare portion and your payment portion) as in the example below.

Medicare*		**Out-of-Area Plan, PPO 90/70**	
Physician Charges	$2,500	Physician Charges	$2,500
Medicare Allowable Amount	2,000	Medicare Allowable Amount	2,000
Medicare Pays 80% of Medicare Approved Charges	1,600	Plan Benefit at 90% of Medicare Approved Charges	1,800
Remaining balance	400	Less Medicare Payment	-1,600
		Out-of-Area Program Payment	200
		Your Payment	200

Important Reminder:

Covered services and benefit levels under Medicare are subject to change by the Federal government. Remember that enrollment in Medicare is not automatic. You must apply for it with your local Social Security office. You can contact your local Social Security office by calling 1-800-772-1213 or on the Internet at www.ssa.gov.

*If your physician accepts Medicare assignment, you cannot be charged, by the provider, for amounts over what Medicare approves.

Additional Rules that Apply to the Plan

Unless otherwise stated in this SPD, the following rules apply to both active employees and retirees covered under the Plan and enrolled in one or more of the following benefits: medical (including prescription drug), employee assistance program, dental, and vision. These provisions do not apply to other programs under the Plan unless specifically stated or addressed in materials provided by the applicable Claims Administrator.

Qualified Medical Child Support Order (QMCSO)

The medical, dental, vision and EAP coverage options under the Plan will comply with all the terms of a Qualified Medical Child Support Order (QMCSO). A QMCSO is 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. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the Plan's receipt of the order and a copy of the Plan's procedures for determining if the order is valid. Coverage under the Plan pursuant to a medical child support order will not become effective until the administrator of the Plan determines that the order is a QMCSO. Once a determination is made, the Plan Administrator will notify the affected participant and each child (or the child's representative) as to whether the order is a QMCSO. If you have any questions or would like to receive a free copy of the written procedures for determining whether a QMCSO is valid, please contact the American Airlines Benefit Service Center at 1-888-860-6178.

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 percent 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 percent 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 percent 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 percent 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.

Coordination of Benefits If You Are Covered by More than One Plan

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 Benefit Option 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 Benefit Option were your only coverage.

For example, if your dependent is covered by another benefit/plan and the Plan is his or her secondary coverage, the Plan pays only up to the maximum benefit amount payable under the Plan, 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 percent 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 Benefit Options 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:
  - 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 unmarried child age 26 and over who is disabled and dependent on you, 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 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 this 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.

Protecting Your Health Information: The HIPAA Privacy Rules

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information (the "Privacy Rule"). The private health information protected under the Privacy Rule includes any individually identifiable health information maintained or transmitted by the Plan in any form or medium. Individually identifiable health information is health information that identifies you or creates a reasonable basis to believe it could be used to identify you, including information relating to your health condition or receipt of health care. This Plan, and American Airlines as the Plan sponsor, will not use or disclose information that is protected under the Privacy Rule except as necessary for treatment, payment, health care operations, and Plan administration, or as permitted by law. In particular, the Plan will not, without authorization, use or disclose private health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Company. Under the Privacy Rule, all of the benefit administrators providing medical services under the Plan must also protect your private health information.

Under the Privacy Rule, you have certain rights with respect to your private health information, including certain rights to inspect and copy the information, receive an accounting of certain disclosures of the information, and under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices. A copy of the notice is available to you, upon request, from the American Airlines Benefit Service Center by calling 1-888-860-6178.

The Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits group health plans from using "genetic information" about employees (and their Dependents or other family members) for setting or adjusting premium rates, for underwriting purposes, and for determining eligibility for enrollment in the group health plan. For example, under GINA a plan cannot require or request that an employee or family member undergo a genetic test prior to or as a condition of enrollment under the plan. Also, restrictions are placed on the collection and use of family medical history information prior to enrollment. Specifically, the rules prohibit the use of rewards or incentives for completion of family medical histories prior to enrollment. GINA does not restrict genetic testing as ordered by a medical provider or the use of family medical history or genetic testing data to enhance plan benefits after enrollment has occurred and a

medical provider has been consulted. GINA becomes effective for the Plan on January 1, 2010.

Worker's Compensation

The benefits under the Plan are not designed to duplicate any benefit for which you are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to you or a Dependent shall be reimbursed by, or on behalf of, you or a Dependent to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation or equivalent employer liability or indemnification law.

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.

Qualifying Events for Continuation Under Federal Law (COBRA)

You may be able to continue your medical coverage under this Plan under certain conditions. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) you, your Spouse and Dependent children may elect to temporarily continue medical coverage under this Plan in certain instances where coverage otherwise would be reduced or terminated. Individuals entitled to COBRA continuation (qualified beneficiaries) are you, your Spouse and your Dependent children who are covered at the time of a qualifying event. In addition, a child who is born to you or adopted by or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary. Also, any child covered pursuant to a QMCSO is a qualified beneficiary. The table below provides a summary of the COBRA provisions outlined in this Section of the SPD.

Qualifying Events that Result in Loss of Coverage	Maximum Continuation Period		
	Employee	Spouse	Child
Employee's work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee or Dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of the COBRA continuation period that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 Months	36 Months
Employee and Spouse legally divorce	N/A	36 Months	36 Months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 Months[1]	36 Months
Child no longer qualifies as a Dependent	N/A	N/A	36 months

[1] 36-month period is counted from the date of eligibility for Medicare benefits.

Qualifying Events

As summarized in the preceding table, the following are examples of “qualifying events:”

- Termination;
- Reduction in hours;
- Disability;
- Death of employee;
- Divorce; and
- Loss of dependency status.

If any of the above events occur, you may be entitled to continue your benefits under the Plan with COBRA.

If your employment terminates for any reason other than gross misconduct, or if your hours worked are reduced so that your Plan coverage terminates, you, your covered Spouse and Dependent children may continue health coverage under the Plan for up to 18 months.

If you (the employee) should die, become divorced or become entitled to Medicare, your covered Dependents whose health coverage under the Plan would be reduced or terminated may continue health coverage under the Plan for up to 36 months. Also, your covered children may continue health coverage for up to 36 months after they no longer qualify as covered Dependents under the terms of the Plan.

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- If you, your Spouse, or your Dependent(s) experience a second qualifying event within the original 18-month period that was due to termination of employment or reduction in hours, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event). (start here)
- If you (the employee) become entitled to Medicare (even if it was not a qualifying event for your covered Dependents because their coverage was not lost or reduced) and then a second qualifying event due to either your termination of employment or reduction in hours of work happens within 18 months, your Dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.
- If you or your Dependent is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA continuation coverage, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months) if the original qualifying event was termination or reduction in hours. To qualify for this disability extension, the Plan Administrator must be

notified of the person's disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator within 30 days after this determination.

Important Note

If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a Spouse or Dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation coverage upon your divorce or loss of your child's Dependent status under the Plan, you or one of your Dependents must notify the Plan Administrator of your divorce or loss of Dependent status within 31 days of the later of the date of the event or the date the individual would lose coverage under the Plan. Your covered Dependents will then be provided with instructions for continuing their health coverage. Individuals already on COBRA continuation must notify the Plan Administrator within the same time frame if a divorce or loss of a child's Dependent status occurs that would extend the period of COBRA coverage for your Spouse or Dependent child(ren).

For other qualifying events (if your employment ends, your hours are reduced or you become entitled to Medicare), you and your covered Dependents will be provided with instructions for continuing your health coverage under the Plan. In the event of your death, the Company will contact your covered Dependents to inform them how to continue health coverage under the Plan.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered Dependents must elect to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered Dependents(s) lose coverage as a result of the qualifying event; or
- The date the Plan notifies you and/or your covered Dependents of your right to elect to continue coverage as a result of the qualifying event.

Premium Due Date

If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA

premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation coverage, but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your COBRA continuation coverage will be terminated retroactively to the last day for which timely payment was made.

Cost of COBRA Continuation of Coverage

Continuing Coverage

The cost of COBRA continuation of coverage, including any extended period for disability is 102 percent of the full cost of Plan coverage.

Coverage During the Continuation Period

If coverage under the Plan is changed for active employees during the COBRA continuation period, the change also applies to individuals on COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections under COBRA continuation coverage during the annual enrollment periods, if a change in status occurs, or at other times under the Plan to the same extent that similarly situated employees not receiving COBRA continuation coverage may do.

When COBRA Continuation Coverage Ends

COBRA continuation coverage for any person will end when any of the following first occurs:

- The applicable COBRA continuation period ends;
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due;
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare (This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA coverage if bankruptcy is the qualifying event);
- The qualified beneficiary becomes covered under another group health plan with no exclusion or limitation for any pre-existing condition;
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months;
- In the case of newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, COBRA continuation

coverage ends for them on the date your COBRA continuation period ends unless a second qualifying event has occurred; or

- Group health coverage for all employees is terminated.

When your COBRA continuation coverage terminates, you may be able to convert to individual coverage under the Plan's conversion rights feature. Contact your COBRA administrator for more information about your conversion rights.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, eligible employees are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted due to military service, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

You may continue your medical and dental coverage for a period of time by paying premiums as stated per Company policy or your collectively bargained agreement.

If you choose not to continue your medical and dental coverage while on military leave, you are entitled to reinstated 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 work day 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 reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days; or
- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Continuation of Coverage While on a Family and Medical Leave

Under the Family and Medical Leave Act (FMLA), eligible employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical and dental coverage benefits during this time. If you take this unpaid leave and wish to continue your medical and dental coverage under the

Plan, you will be billed directly on a monthly basis, at the same rates applicable before the unpaid leave began.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care;
- To care for a Spouse, child, or parent who has a serious health condition; or
- For your own serious health condition.
- The number of weeks of unpaid leave available to you for family and medical reasons may vary based on the applicable state law requirements.

Eligible employees may take up to 26 weeks of leave in a single 12-month period to care for a covered military member recovering from a serious injury or illness incurred in the line of duty on active duty. Eligible employees are entitled to a combined total of up to 26 weeks of all types of Family and Medical Leave during a single 12-month period.

Continuation of Coverage for Retirees

Coverage for the Retiree (and his Spouse or Dependents) under the Access Plan at the date of retirement is considered alternative COBRA coverage and no further COBRA benefits are generally available to the Retiree. However, the Spouse or Dependent of a Retiree who is covered under the Access Plan at the date of the Retiree's retirement may incur a subsequent Qualifying Event when there is a divorce or death of the retiree, or when an eligible Dependent ceases to be eligible for benefits under the Plan, for example, when he or she attains age 26, **but only if the Qualifying Event occurs while the retiree remains eligible for coverage under the Access Plan (i.e., prior to the retiree turning age 65).** A retiree, Spouse or eligible Dependent, as applicable, must notify the Plan Administrator in the event of divorce, death or when an eligible Dependent ceases to eligible for coverage under this Plan. Failure to notify the Plan Administrator within 60 days will result in the loss of COBRA continuation coverage. The prior provisions regarding notice, election and paying for COBRA continuation coverage will apply once timely notice has been received by the Plan Administrator.

Claims Procedures

Unless otherwise stated in this SPD, the following rules apply to both active employees and retirees. Generally, your provider will file your claim with the appropriate Claims Administrator. Under certain circumstances you must file your claim (e.g., for out-of-network claims or claims under Out-of-Area coverage). Once filed, all claims are subject to the following rules.

Time Frame for Initial Claim Determination

For **urgent care claims** *(see the "Urgent Care Claims" section of this SPD for a definition)* and **pre-service claims** (claims that require approval of the benefit before receiving medical care), the appropriate Claims Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- 72 hours after receipt of an **urgent care claim** (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
- 15 days after receipt of a **pre-service claim**.

For **post-service claims** (claims that are submitted for payment after receiving medical care), the appropriate Claims 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 under the Plan.

For **urgent care claims**, if you fail to provide the appropriate Claims Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the appropriate Claims 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 appropriate Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For **pre- and post-service claims**, a 15-day extension may be allowed to make a determination, provided that the appropriate Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the appropriate Claims Administrator must notify you before the end of the first 15- or 30-day period of the reasons(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 failure to submit necessary information, the applicable claim administrator's time frame for making a benefit determination is tolled or suspended from the date the appropriate Claims 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 Plan's knowledge of such 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; or
- A communication that names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is required.

Urgent Care Claims

Urgent care claims are a special type of pre-service claim which, 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 with an average knowledge of health and medicine will 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.

Note that the Company makes the initial claims determination for prescription drug claims only. The Claims Administrators make the initial claims determination for the other benefits.

If the Claims Administrator denies the claim, the initial notice of denial of an urgent care claim may be provided orally, provided that written notification is provided to you within three days after the oral notification.

Concurrent Care Claims

There are two types of concurrent care claims: 1) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and 2) where an extension is requested beyond the initially-approved period of time or number of treatments. 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 after receipt of your claim, provided your request is made at least 24 hours prior to the end of the approved course of 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 claim, 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 be considered an adverse benefit determination, unless the reduction or termination of such course of treatment is the result of a Plan amendment or Plan termination.*

If You Receive an Adverse Benefit Determination

The appropriate Claims Administrator will provide you with a written 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 ER1SA after an appeal of an adverse benefit determination;
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;

- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- If the adverse benefit determination concerns a claim involving **urgent care**, a description of the expedited review process applicable to the claim.

Procedures for Appealing an Adverse Benefit Determination

If you receive an adverse benefit determination, you may ask for a review by contacting the appropriate Claims Administrator/Claims Fiduciary. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. A failure to file a request for review within 180 days will constitute a waiver of your right to request a review of the claim denial. *(For more details, see the "How to Contact Your Claims Administrator/Claims Fiduciary" section of this SPD)*

Note that the Company conducts the second level of appeal for prescription drug appeals only. The Claims Administrators determine the second level of appeal for the other benefits.

You have the right to:

- Authorize a representative to act on your behalf, as long as such designation is in writing and submitted to the Claims Administrator. Submit written comments, documents, records and other information relating to the claim for benefits;
- Upon a request, and 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 benefits determination; and
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination;
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination;

- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate;
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental);
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision; and
- 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; and
  - 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.
- Ordinarily, a decision regarding your appeal will be reached within:
  - 72 hours after receipt of your request for review of an **urgent care claim**;
  - 15 days after receipt of your request for review of a **pre-service claim**; or
  - 30 days after receipt of your request for review of a **post-service claim**.
- The notice of an adverse benefit determination on appeal, from the appropriate Claims Administrator/Claims Fiduciary, will contain all of the following information:
- The specific reason(s) for the adverse benefit determination;
- References to the specific Plan provisions on which the benefit determination is based;
- 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 your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;
- 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 medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

- You may not bring a lawsuit to recover benefits under this Plan until you have exhausted all levels of appeals (2 levels) offered through the administrative process described in this Plan. No legal action to recover benefits under the Plan may be filed beyond three years after the date a final decision is made on your claim for benefits. The three-year statute of limitations on suits for all benefits shall apply in any forum where the Beneficiary may initiate such suit.

External Review

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the External Review Program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons/medical judgment (medical judgment includes a decision based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a decision that a treatment is experimental or investigational).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Claims Administrator fails to respond to your appeal in accordance with applicable regulations.

If the above conditions are satisfied, you may request an independent review of the adverse benefit determination. Neither you nor the Claims Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. You or an authorized designated representative must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination. A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement.

The independent review will be performed by an independent review organization (IRO). The IRO has been contracted by the Claims Administrator and has no material affiliation or interest with the Claims Administrator or American Airlines, Inc. The Claims Administrator will choose the IRO based on a rotating list of appropriately accredited IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of the Claims Administrator's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by the Claims Administrator in making a decision on the case; and
- All other information or evidence that you or your Physician has already submitted to the Claims Administrator.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Claims Administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes required by law. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claims Administrator with the reviewer's decision, and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan is required to provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

The following Claims Administrators do not have an External Review Program:

- MetLife Dental
- EyeMed

Your decision to seek External Review will not affect your rights to any other benefits under this Plan and nothing contained in this section will affect an employee's grievance rights under the collective bargaining agreement. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

How to Contact Your Claims Administrators/Claims Fiduciaries

Here is a contact list for each of the Claims Administrators/Claims Fiduciaries who provide services under the Plan.

Claims Administrator/ Claims Fiduciary	Phone Number	Web Site Address
United Healthcare Services, Inc. (UHC) (medical benefits)	1-800-955-8095	americanairlines.welcometouhc.com
Blue Cross Blue Shield of Texas (medical benefits and mental health and chemical dependency benefits, for employees who have BCBSTX as their claims administrator, effective January 1, 2016)	1-877-235-9258	www.bcbstx.com/americanairlines
Express Scripts (ESI) (prescription drug benefits)	1-800-988-4125	www.express-scripts.com
Kaiser Permanente	1-800-464-4000	http://www.my.kp.org/americanairlines
EyeMed (vision benefits)	1-844-714-5678	www.eyemedvisioncare.com/american
MetLife (dental benefits)	1-866-838-1072	https://mybenefits.metlife.com/

Plan Administration

This information about the administration of the Plan is provided in compliance with the Employee Retirement Income Security Act of 1974 (ERISA). While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Plan.

Plan Sponsor

The name, address and telephone number of the Plan sponsor are:

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

The American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees is a group health plan providing medical, dental and vision (including prescription drug, mental health and chemical dependency benefits) and employee assistance services benefits.

Plan Administrator

The name, address and telephone number of the Plan Administrator are:

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 Alight Solutions, including answering questions on behalf of American Airlines, Inc. Alight Solutions 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.

Agent for Service of Legal Process

The name, address and telephone number of the agent for service of legal process:

Vice President, Benefits
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

Legal process also can be served on the Plan Administrator.

Identification Numbers

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to American Airlines, Inc. is 13-1502798. The plan number for the Plan is 501.

Plan Year

The Plan Year for purposes of the Plan's fiscal records is January 1 through December 31.

Organizations Providing Administrative Services under the Plan

Listed below are the names, addresses, phone numbers, and web site addresses of the organizations that provide administrative services under the Plan. These services include administering claims, administering appeals, and providing participant assistance.

Type of Benefits	Claims Administrator and Claims Fiduciary
Medical	**United HealthCare** American Airlines, Inc. Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551 Phone: 1-800-955-8095 Website: www.americanairlines.welcometouhc.com **Blue Cross and Blue Shield of Texas** P.O. Box 660044 Dallas, TX 75266-0044 Phone: 1-877-235-9258 Website: www.bcbstx.com/americanairlines
Prescription Drugs	**Mail Order Pharmacy Service:** Express Scripts P.O. Box 3938 Spokane, WA 99220-3938 Phone: 1-800-988-4125 Website: www.express-scripts.com/americanairlines **Prescriptions – Prior Authorization:** Express Scripts 8111 Royal Ridge Parkway, Suite 101 Irving, TX 75063 Phone: 1-800-988-4125 Website: www.express-scripts.com/americanairlines

Type of Benefits	Claims Administrator and Claims Fiduciary
	Filing Retail Prescription Claims: Express Scripts P.O. Box 2160 Lee's Summit, MO 64063-2160 Phone: 1-800-988-4125 Website: www.express-scripts.com/americanairlines
Employee Assistance Program	**American Airlines, Inc. On-Site Employee Assistance Program** EAP at American Airlines Phone: 1-800-555-8810 **Optum Employee Assistance Program (EAP)** Optum Health Phone: 1-800-363-7190 Website: www.liveandworkwell.com Access Code: American
Wellness	**WebMD** Phone: 1-888-383-8740 www.webmdhealth.com/AmericanAirlines
Health Maintenance Organizations (HMOs)	**Kaiser Northern California** Phone: 1-800-464-4000 http://www.my.kp.org/americanairlines Group Number: 8653 **Kaiser Southern California** Phone: 1-800-464-4000 http://www.my.kp.org/americanairlines Group Number: 102105
Vision Care	**EyeMed Vision Care** 4000 Luxottica Place Mason, OH 45040 Phone: 1-844-714-5678 www.eyemedvisioncare.com/american
Dental	**MetLife** American Airlines, Inc. Dental Claim Unit P.O. Box 981282 El Paso, TX 79998-1282 Phone: 1-866-838-1072 Website: https://mybenefits.metlife.com/

Type of Benefits	Claims Administrator and Claims Fiduciary
Voluntary Long-Term Care	**Unum Life Insurance Company of America** 2211 Congress Street Portland, ME 04122 Phone: 1-866-679-3054 Website: www.unum.com
Added Benefits Programs	**Added Benefits** Phone: 1-855-550-0706 Website: www.AAaddedbenefits.com Covered services include: • Hyatt Legal Plan • Group Homeowner's and Automobile Insurance • LifeLock Identity Theft Protection • Veterinary Pet Insurance (VPI) • Group Accident Insurance • Critical Illness Insurance • Group Homeowners' and/or Automobile Insurance • Dental Discount • Hospital Indemnity

Plan Funding

The Plan is a self-insured plan for benefits provided through the medical and dental coverage portions of the plan. Benefits are paid from employee contributions, as applicable, and from the general assets of American Airlines, Inc. American Airlines, Inc. has contracted with third party administrators to administer the Plan. Certain programs under the Plan are funded by insured arrangements. These programs are currently employee-pay-all arrangements that employees can elect to pay through payroll deduction (e.g., include but are not limited to the Vision Plan, HMOs). The costs of the Employee Assistance Program are paid entirely from the general assets of American Airlines, Inc.

Plan Document

This SPD is intended to help you understand the main features of the Plan. It should not be considered a substitute for the Plan document, which governs the operation of the Plan. That document sets forth all of the details and provisions concerning the Plan and is subject to amendment; the official Plan document may consist of one or more documents designated as Plan documents by the Company. If any questions arise that are not covered in this SPD or if this SPD appears to conflict with the official Plan document, the text of the official Plan document will govern.

You can request a copy of the Plan documents by contacting:

Alight Solutions
P.O. Box 1345
Carol Stream, IL 60132-1345
Phone: 1-888-860-6178

For certain employee groups, coverage under the Plan is maintained pursuant to a collective bargaining agreement. You can obtain a copy of your collective bargaining agreement by contacting your local management or union representative. A copy is also available for examination at the office of the Plan Administrator during normal business hours.

Future of the Plan

The Company reserves the right, in its sole discretion, to change, modify amend or terminate the Plan, in whole or in part, to the extent it deems advisable, at any time for any reason. Such changes, modifications, amendments or termination will be undertaken by action of the Company's Board of Directors or an authorized officer or as otherwise required by the Plan document. Furthermore, the Company reserves the right, in its sole discretion, to change any third party providing services to the Plan, including the Claims Administrator, and reserves the right to insure the benefits through insurance carrier(s) of its choice. Upon termination, any amounts payable under the terms of the Plan as in effect immediately before the termination will be paid in

accordance with Plan terms. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.

The benefits under this Plan do not vest. The Company reserves the right, in its sole discretion, to determine the nature and amount of benefits, if any, that will be provided to individuals (and their Dependents) under the Plan, as well as the right to reduce, terminate or modify the terms or the amount of such benefits.

Limitation on Assignment

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to your creditors or anyone else. However, you may assign your right to benefits to the health provider who rendered the services under the Plan.

Required Benefit Notices

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-C-ertification, contact your Plan 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.

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 August 10, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.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.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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

LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http:/www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid	
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	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/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

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:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 nine months after the end of the plan year or two months after the SAR is due (if an extension has been granted by the IRS).

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan 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 the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a 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 medical child support order, you may file suit in a Federal court.

If it should happen that the 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 N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Your Employment

Your eligibility or your right to benefits as an active employee under the Plan should not be interpreted as a guarantee of employment. The Company's employment decisions are made without regard to the benefits to which you are entitled under the Plan upon employment.

This SPD provides detailed information about the Plan and how it works. This SPD does not constitute an expressed or implied contract or guarantee of employment.

Glossary

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:
    i. The Department of Veterans Affairs.
    ii. The Department of Defense.
    iii. 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.

Claims Administrators — The third-party organizations with which American Airlines maintains contracts to maintain provider networks, provide case and disease management programs, provide payment and customer services for American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees participants.

Claims Fiduciaries — The parties designated by American Airlines to make initial claims determinations, including review of claims appeals for benefits under the Plan. The decision of the applicable claims fiduciary upon review of claims appeals is final and binding. American Airlines does not have the authority to change the decision of the claims fiduciary.

Coinsurance — The portion (usually expressed as a percentage) of the total covered benefit costs that the Plan pays (or that you pay).

Company – American Airlines, Inc.

Congenital Anomaly — A physical development defect that is present at birth and is identified within the first twelve months of birth.

Coordination of Benefits ("COB") — When considering a claim for reimbursement of an eligible expense that is payable by the American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees and at least one other plan, the process of determining how much of the expense should be paid by American Airlines. Coordination of benefits ensures American Airlines will pay no more for such an expense than it would have had you been eligible for benefits under only the American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees.

Cosmetic Procedure — Procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be changed or improved, but there would be no improvement in function like breathing.

Co-pay/Co-payment — The fixed amount you pay up front for certain services covered under the Plan. After you pay the applicable co-pay, some services are subject to coinsurance.

Cost Effective — The least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services — Those health services and supplies that are: provided for the purposes of preventing, diagnosing or treating Sickness, Injury, Mental Health/Chemical Dependency Condition or their symptoms, provided to a Covered Person who meets the Plan's eligibility requirements, and not identified as an exclusion in this SPD.

Custodial Care — Services that do not require special skills or training and that provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating); do not seek to cure, or which are provided during period when the medical condition of the patient who requires the service is not changing or do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible — An annual amount you must pay for certain services before the Plan pays benefits for eligible expenses.

Definitive Therapy — Treatment of prostate cancer with a curative intent and not for palliative care. Treatment of a local recurrence of the primary tumor may be considered Definitive Therapy if there has been a long disease-free interval, generally 2 years or more, and treatment is with curative intent and not for palliative care.

Dependent — Dependents eligible for coverage under the Plan include your Spouse. Dependents eligible for coverage under the Plan also include all children who have not yet reached the age limit stated in the "*About Your Participation- Active Employees*" and "*Retiree Health Coverage*" Sections of the SPD. Children include biological children, legally adopted children, children placed for adoption, and stepchildren. Also included are your children (or children of your Spouse) for whom you or your Spouse has legal responsibility resulting from a valid court decree. (It is not necessary for your Spouse to be covered under the Plan in order for a child for whom your Spouse has legal custody or legal guardianship to be eligible).

Your unmarried children age 26 and over who are not self-supporting because of a permanent physical or mental disability and who are dependent upon you, as defined by the Internal Revenue Code for income tax purposes, remain covered under the Plan no matter what age, provided that the children remain disabled and that such children were physically or mentally disabled *and* covered by the Plan on the day before attaining age 26. Proof of incapacity may be required annually by the Plan, and you may be required to give the Claims Administrator evidence of your child's incapacity within 31 days of the child attaining age 26.

Durable Medical Equipment — Non-disposable, non-implantable equipment that is primarily used within the home and serves a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.

Experimental/Investigational Services — Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, procedures, drug therapies, medications or devices that at the time the health care providers and Claims Administrators make a treatment/coverage/claims determination, are: not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed

use; not identified in the American Hospital Formulary Service or the United States Pharmacopoeia of Dispensing Information as appropriate for the proposed use; not subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the Humanitarian Use Device exemption are not considered to the Experimental or Investigational); or not the subject of an ongoing Clinical Trial and meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight. If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the health care providers and Claims Administrator may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, it must be determined that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

Injury — Bodily damage other than Sickness, including related conditions and recurrent symptoms

In-Network — Refers to benefits and services you receive from doctors, dentists, hospitals, pharmacies, and other service providers that contract with the Claims Administrators. Generally, your benefits under the Plan are higher (and your out-of-pocket expenses lower) when you use in-network services.

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.

Mail Order — An option available for receiving prescription drugs through the mail or other process as defined by the Plan. Mail Order prescriptions include up to a 90-day supply and may be mandated for maintenance medications after a certain number of approved retail drug store “monthly” fills.

Medical Benefit Options – 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:

- PPO (three options)
- OUT-OF-AREA (three options)
- HMO

Medicare — The hospital and medical insurance program sponsored by the U.S. Government.

Medical Necessity -- 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 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 provided 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 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/Chemical Dependency Condition — A nervous, mental, or chemical dependency condition that is (i) a clinically significant behavioral or psychological syndrome or pattern; (ii) associated with present distress or substantial or material

impairment of the patient's ability to function in one or more major life activities {for example, employment); (iii) not merely an expectable response to a particular event (for example, the death of a loved one); (iv) listed as an Axis I disorder (other than a V Code of the DSM-IV, or its replacement).

Network — A group of hospitals, doctors, pharmacies, dentists, and other health care professionals that provide services at discounted rates. (See the definition of "in-network" for more details)

Out-of-Area — Refers to medical, mental health and chemical dependency, and dental care received through the Out-of-Area portion of the American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees. Out-of-area is different from out-of-network. You are eligible to participate in the Out-of-Area medical program only if you live outside a PPO Plan network service area.

Out-of-Network — Refers to benefits and services received from doctors, dentists, hospitals, and other service providers that are not part of the medical and dental Claims Administrator's networks. The Plan includes Out-of-Network benefits for medical, mental health and chemical dependency and dental benefits. Prescription drugs are available in-network only. 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 Maximum — An annual individual or family limit on the amount you spend out of your own pocket for expenses that the Plan does not cover in full, including deductibles but excluding co-payments.

Pharmacy Benefit Manager (PBM) — The prescription drug benefits provider and Claims Administrator for Legacy US Airways prescription drug benefits.

Preferred Provider Organization (PPO)— Short for "Preferred Provider Organization," an organization that contracts with a network of doctors, dentists, hospitals and other health care providers who deliver services for set fees, usually at a discount. PPO is often used as the name of a plan type as well. PPO plans offer both in-network and out-of-network benefits. You may use any licensed provider you like, but your benefits are highest (and your out-of-pocket costs lower) when you use in-network providers.

Plan Administrator — In its role as Plan Administrator, American Airlines maintains sole responsibility of the American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees 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.

Pre-Certification — The notification, review and approval process your health care provider will conduct with the applicable Claims Administrator before you begin receiving certain services covered under the Plan. Your doctor, you, or anyone close to you can start the process by notifying your Claims Administrator before the services are rendered. Financial penalties apply for failure to pre-certify care.

Primary Doctor/Primary Care Physician (PCP) — A physician who is a General Practitioner, Family Practice Physician, Pediatrician or Internist. An Obstetrician or Gynecologist is a Primary Doctor for maternity or annual preventive care female physical services but is a Specialist Physician for all other services.

Provider — A medically licensed practitioner or facility providing services under the Plan.

Reasonable and Customary Charges (R&C Charges) — The average prevailing cost in a particular geographic area for medical and dental plan services, subject to change over time. Effective March 1, 2015, the reasonable and customary (R&C) amount is the maximum amount that the Plan will consider as an eligible expense for medical or dental services and supplies. For purposes of the Plan, "reasonable and customary" shall be equivalent with the terms "usual and customary", "usual and prevailing", and "usual, reasonable and customary". The primary factors considered when determining if a charge is within the reasonable and customary fee limits are:

- The range and complexity of the services provided
- The typical charges in the geographic area where the service or supply is rendered/provided and other geographic areas with similar medical cost experience

The Plan Administrator utilizes a database of charge information about healthcare procedures and services, and this database is reviewed, managed, and monitored by FairHealth. Information about FairHealth and its work on this database is available at www.fairhealthus.org.

Information from this FairHealth database is utilized by American Airlines medical administrators in determining the eligible expense for medical or dental services and supplies provided by non- participating and out-of-network providers (FairHealth data for out-of-network expenses are used at the 90th percentile to determine eligible expenses).

Reasonable and customary fee limits can also be impacted by the number of services or procedures you receive during one medical treatment. Under the Plan, when reviewing a claim for reasonable and customary fee determination, the 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.

Reconstructive Procedure — A procedure performed to address a physical impairment where the expected outcome is restored or improved function.

Right of Reimbursement — The right to reimbursement means that if a third party causes a Sickness or Injury for which you receive a settlement, judgment, or other recovery; you must use those proceeds to fully return to the Plan 100 percent of any Benefits you received for that Sickness or Injury.

Sickness — Physical illness, disease or pregnancy. The term Sickness as used in this SPD does not include Mental Health/Chemical Dependency Condition or substance abuse, regardless of the cause or origin of the Mental Health/Chemical Dependency Condition.

Specialist — A specialist is any medical provider or entity, other than a Primary Physician**.**

Spouse — For the purpose of this Plan, a Spouse is defined as an individual who is lawfully married to the employee and not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.