YOUR EMPLOYEE BENEFIT PLAN

AMERICAN AIRLINES, INC. AND OTHER PARTICIPATING SUBSIDIARIES OF AMR CORPORATION

Optional Short Term Disability Benefits

Certificate Date: March 1, 2021

Exhibit Number 4A

INTRODUCTION

We are pleased to present you with a Certificate of Insurance for group disability insurance. This Certificate states your benefits and summarizes some special services available to you at no additional cost. All of us appreciate the financial protection that group benefit plans provide in the event of illness or injury. Group disability insurance is an especially important benefit since it replaces a reasonable portion of your income lost due to a disability.

Your Employer recognizes the value of your services and the impact your absence can have on the organization. Therefore your benefit plan has been designed with a goal of rehabilitation and return to work in mind. The plan offers financial incentives for returning to work, while still receiving a benefit.

The benefits outlined in this Certificate are the foundation for comprehensive managed disability services. These special services focus on your ***abilities***, versus a disability, and are available to you at no additional cost. They are tailored to meet your individual needs and are designed to help you to return to work as soon as possible. Managed disability services may also coordinate with other benefit programs in which you participate.

Your comprehensive disability program includes:

Financial Incentives for returning to work.

Return to Work Program that focuses on vocational rehabilitation, which means identifying the necessary training, therapy and job modifications that can help you return to work.

Easy Claim Application Process that may be started simply by calling an "800" claims hotline or sending us a claim form. Initial submission of the claim should be made no later than 5 days following your original date of disability or as soon as reasonably possible thereafter.

This Certificate is in an easy-to-read format and we urge you to read it carefully. We also recommend you keep it with your other important records for future reference. If you have any questions about the Certificate or the benefits it provides, please contact your Employer.

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE
for the Employees of

American Airlines, Inc.
(called the Employer)

This is your Certificate of Insurance for Short Term Disability Insurance as long as you are insured under This Plan. The Group Policy and this Certificate may be changed or canceled according to the terms, conditions and provisions of the Group Policy. This Certificate describes the benefits under the Plan in effect as of March 1, 2021. Any prior Certificate relating to the coverage set forth herein is void.

The Group Policy is delivered in and administered according to the laws of the governing jurisdiction.

Whenever a reference to "you" or "your" is made in this Certificate of Insurance, it means the covered Employee. Reference to "we", "us" or "our" means MetLife. Reference to "This Plan" means that part of the Employer's plan of employee benefits that is insured by MetLife.

Michel Khalaf
President

Group Policy No.: 29900-G

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

For Maryland residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

For West Virginia Residents: You have the right to return this certificate within ten days of its receipt and to have your premium refunded if, after examination of the certificate, you are not satisfied for any reason.

For New Hampshire Residents: 30 Day Right to Examine Certificate.
Please read this Certificate. You may return the Certificate to Us within 30 days from the date You receive it. If you return it within the 30 day period, the Certificate will be considered never to have been issued and We will refund any premium paid for insurance under this Certificate.

Form G.24303-Cert.

Metropolitan Life Insurance Company
New York, New York

CERTIFICATE RIDER

Group Policy No.: 29900-1-G

Employer: American Airlines, Inc.

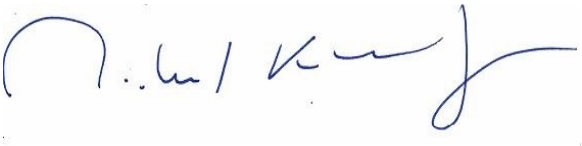
Effective Date: March 1, 2021

The certificate is changed as shown below:

The definition of Domestic Partner is added as follows:

> **"Domestic Partner"** means each of two people, one of whom is an Employee of the Employer, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

This rider is to be attached to and made a part of the Certificate



Michel Khalaf
President

GCR09-07
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NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Arkansas residents please be advised of the following:

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT THE POLICYHOLDER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL THE TOLL FREE TELEPHONE NUMBER SHOWN ON THE CERTIFICATE FACE PAGE.

POLICYHOLDERS HAVE THE RIGHT TO FILE A COMPLAINT WITH THE ARKANSAS INSURANCE DEPARTMENT (AID). YOU MAY CALL AID TO REQUEST A COMPLAINT FORM AT (800) 852-5494 OR (501) 371-2640 OR WRITE THE DEPARTMENT AT:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1 COMMERCE WAY, SUITE 102
LITTLE ROCK, ARKANSAS 72202

California residents please be advised of the following:

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT YOUR GROUP EMPLOYER OR METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904

1-800-438-6388

IF, AFTER CONTACTING YOUR GROUP EMPLOYER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE AT:

DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013

WEBSITE: http://www.insurance.ca.gov/

1-800-927-4357 (within California)
1-213-897-8921 (outside California)

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Idaho residents please be advised of the following:

IMPORTANT NOTICES

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

IDAHO DEPARTMENT OF INSURANCE

CONSUMER AFFAIRS

700 WEST STATE STREET, 3RD FLOOR

PO BOX 83720

BOISE, IDAHO 83720-0043

1-800-721-3272 OR WWW.DOI.IDAHO.GOV

NOTICE FOR RESIDENTS OF MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You or any person authorized to act on Your behalf may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR RESIDENTS OF MASSACHUSETTS RESIDENTS

CONTINUATION OF DISABILITY INCOME INSURANCE

If your disability income insurance ends due to a Plant Closing or Covered Partial Closing, your coverage will continue for a 90 day period after the date it ends.

If your disability income insurance ends because:

- you cease to be in an eligible class; or
- your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of your disability income insurance under the TERMINATION OF COVERAGE subsection will end before the end of continuation periods shown above if you become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

NOTICE FOR RESIDENTS OF MISSISSIPPI

CLAIMS

Notice of Disability

Notify us of your Disability as soon as you are able.

To notify us you may call us directly. You may obtain this phone number from Your Employer. You will be instructed on how to give proof of Disability. You will be required to answer all questions concerning your Disability.

If you do not receive statements or instructions within 15 days after you have notified us, you may submit your statement in a letter.

Proof of Disability

Provide proof of Disability within 3 months after the end of your Waiting Period.

No benefits are payable for claims submitted more than, except in the absence of legal capacity, one year after the date of Disability. However, you can request that benefits be paid for late claims if you can show that:

1. it was reasonably possible to give written proof of Disability during the one year period; and

2. proof of Disability satisfactory to us was given to us as soon as was reasonably possible.

Documentation

At your expense, you must provide documented proof of your disability. Proof includes, but is not limited to:

1. the date your Disability started;

2. the cause of your Disability; and

3. the prognosis of your Disability.

You will be required to provide signed authorization for us to obtain and release medical and financial information, and any other items we may reasonably require in support of your Disability.

These will include but are not limited to:

1. proof of continuing Disability;

2. proof you have applied, or are not eligible, for Other Income Benefits. If you do not provide proof you have applied for Other Income Benefits, we may reduce your Weekly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit;

3. Proof that you applied for Social Security disability benefits until denied at the Administrative Law Judge level; and

4. Proof you have applied for Workers' Compensation benefits or benefits under a similar law. If you do not provide proof that you have applied for these benefits, we may reduce your Weekly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit.

If you do not provide satisfactory documentation within 60 days after the date we ask for it, your claim may be denied.

NOTICE FOR RESIDENTS OF MISSISSIPPI (Continued)

Method of Payment

When we determine you are Disabled:

1. Subject to due written proof of loss, all accrued benefits for loss for which this certificate provides periodic payment will be paid Weekly, with respect to Short Term Disability Benefits.

   Any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

   Any benefit due and not paid within 30 days of our receipt of proof will accrue interest at a rate of three percent (3%) per month on the amount due, until the claim is finally settled or adjudicated.

2. Subject to the Legal Actions provision below, if we do not pay benefits when due and payable you may bring an action to recover such benefits, any interested which has accrued with respect to such benefits, and any other damages which may be allowed by law. If it is determined in such action that we acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, you or your health care provider shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

3. Benefits will be paid to you. However, benefits unpaid at your death will be paid to:

   a. your spouse, if living; otherwise

   b. your children, if living, divided equally;

   c. your estate. If benefits are payable to your estate, we may pay up to $1,500 to someone related to you by blood or by marriage whom we deem entitled to this amount. We will be discharged to the extent of any payment made in good faith.

4. Weekly benefits due for a period of less than a week will be paid at a daily rate of 1/7th of the Weekly Benefit payable.

Right To Recover Overpayments

We have the right to recover from you any amount that we determine to be an Overpayment. You have the obligation to refund to us any such amount. Our rights and your obligations in this regard are also set forth in the reimbursement agreement you are required to sign when you become eligible for benefits under This Plan. This agreement: (i) confirms that you will repay all Overpayments; and (ii) authorizes us to obtain any information relating to Other Income Benefits.

An Overpayment occurs when we determine that the total amount paid by us on your claim is more than the total of the benefits due under This Plan. This includes any Overpayments resulting from:

1. retroactive awards received from sources shown in the List of Other Income Benefits;

2. fraud; or

3. any error we make in processing your claim.

The Overpayment equals the amount we paid in excess of the amount we should have paid under This Plan. In the case of a recovery from a source other than This Plan, our Overpayment recovery will not be more than the amount of the recovery.

You have the right to appeal any Overpayment recovery.

An Overpayment also occurs when payment is made by us that should have been made under another group plan. In that case, we may recover the payment from one or more of the following:

1. any other insurance company;

2. any other organization; or

3. any person to or for whom payment was made.

We may, at our option, recover the Overpayment by:

1. reducing or offsetting against any future benefits payable to you or your survivors;

2. stopping future benefit payments (including Minimum Benefits) which would otherwise be due under This Plan. Payments may continue when the Overpayment has been recovered; or

3. demanding an immediate refund of the Overpayment from you.

Legal Actions

No legal action of any kind may be filed against us:

1. within the 60 days after proof of Disability has been given; or

2. more than three years after proof of Disability must be filed. This will not apply if the law in the area where you live allows a longer period of time to file proof of Disability.

Medical Examinations

We will have the right to have you examined at reasonable intervals by medical specialists of our choice. The examination will be at our expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of your benefits.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for 2 years. It can be declared invalid due to nonpayment of premium.

No statement of health used by any person to get coverage can be used to declare coverage invalid if the person has been covered under This Plan for 2 years. In order to use a statement of health to deny coverage before the end of 2 years, it must have been signed by the person. A copy of the signed statement must be given to the person or the person's beneficiary.

Assignment

You may not assign your benefits. This means that you may not give or transfer your benefits to anyone else.

Workers' Compensation

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance or any government mandated temporary disability income benefits law.

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 in disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metlife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-275-4638

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 - fax
www.scc.virginia.gov - web address
BureauOfInsurance@scc.virginia.gov- email

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

TABLE OF CONTENTS

PLAN HIGHLIGHTS

This Plan Highlights section is a summary of your Short Term Disability Benefits and provisions. See the rest of your Certificate for more information.

It is important to read the rest of your Certificate. It describes your benefits as well as any exclusions and limitations that apply to these benefits. Please read it carefully. You should talk with your Employer if you have any questions.

You will notice that some of the terms used in your Certificate begin with capital letters. These terms have special meanings. They are explained in this Certificate.

EMPLOYEE ELIGIBILITY

Eligible Employee: All Agents, Flight Attendants, and Transport Workers Union (TWU) FSE/FCTI/SIMP Employees who are employed and paid for services by the Employer

Optional Short Term Disability Eligibility Waiting Period: None

Eligibility Date: March 1, 2021 or the date you become an eligible employee, whichever is later.

SHORT TERM DISABILITY BENEFITS

Weekly Benefit: 50% of your Predisability Earnings, derived from Adjusted Monthly Salary, reduced by Other Income Benefits. Other Income Benefits are described in Section B. of Short Term Disability Benefits.

Waiting Period:

For Accidental Injury: 7 Days of continuous Disability or the exhaustion of company sponsored accrued sick pay, whichever is later.

For Sickness and Pregnancy: 7 Days of continuous Disability or the exhaustion of company sponsored accrued sick pay, whichever is later.

Maximum Benefit Duration:

TWU Employees…..……..…..26 weeks
All other Employees……..…..26 weeks or until Long Term Disability benefits begin, whichever is earlier

Maximum Covered Salary……..…...$200,000 annually

Work Incentive:

Work while Disabled: No offset for employment earnings unless the total income you are receiving (including Rehabilitation Incentive and Family Care Expenses) exceeds 100% of your Predisability Earnings.

Rehabilitation Incentive: While participating in an approved Rehabilitation Program your Weekly Benefit before reduction for Other Income Benefits is increased by 10%.

Family Care Expenses: While participating in an approved Rehabilitation Program, after the 4th week of Disability, up to $100 per week incurred for Eligible Family Care Expenses for each Eligible Family Member.

LIMITATIONS

Limitation for Occupational Disabilities: Benefits are not payable for any Disability: (i) which happens in the course of any work performed by you for wage or profit; or (ii) for which you are eligible to receive benefits under any Workers' Compensation or any similar law.

Limitation for Pre-existing Conditions: Coverage for Pre-existing Conditions begins 12 months after your Effective Date of coverage.

CONTRIBUTIONS

Your Short Term Disability Benefits are paid for by you.

BENEFITS CHECKLIST

In order to receive benefits under This Plan, you must provide to us at your expense, and subject to our satisfaction, all of the following documents. These are explained in this Certificate. Initial submission of these documents should be made no later than the 12th week following your original date of disability.

- ✓ Proof of Disability.
- ✓ Evidence of continuing Disability.
- ✓ Proof that you are under the Appropriate Care and Treatment of a Doctor throughout your Disability.
- ✓ Information about Other Income Benefits.
- ✓ Any other material information related to your Disability which may be requested by us.

Form G.24303-A

EMPLOYEE ELIGIBILITY

Active Employee

You are an Active Employee if you:

1. are an Eligible Employee working for the Employer doing all the material duties of your occupation at (i) your usual place of business; or (ii) some other location that your Employer's business requires you to be;

2. are a citizen or legal resident of the United States or Canada; and

3. are not a temporary or seasonal employee.

You will be deemed an Active Employee if:

1. you meet the above conditions; and

2. you are absent from work solely due to vacation days, holidays, scheduled days off, or approved leaves of absence not due to Disability.

Effective Date of Coverage

If you make written application for coverage no later than 3 months after your Eligibility Date and agree to have the required contributions deducted from your pay, you will be covered on the later of:

1. your Eligibility Date;

2. the date you meet the Active Employee requirements; or

3. the date of your written application.

If you were covered under the California State Disability Insurance plan and you move to a non-statutory disability state, you will have 31 days from the date you move to elect coverage. You will be covered on the later of:

1. your Eligibility Date;

2. the date you meet the Active Employee requirements; or

3. the date of your written application.

If you were covered under the Massachusetts Paid Family and Medical Leave (PFML) plan and you move to a non-statutory disability state, you will have 60 days from the date you move to elect coverage. You will be covered on the later of:

1. your Eligibility Date;

2. the date you meet the Active Employee requirements; or

3. the date of your written application.

If you do not elect coverage within 60 days and choose to elect coverage at a later date, you will be required to provide Evidence of Good Health to us. Your coverage will become effective when we approve your Evidence of Good Health.

If you enroll in this plan, you will not be required to participate in the plan for two calendar years and you can change your coverage at the next annual enrollment. If you fail to enroll for coverage at the initial offering, you will be required to wait until the next annual enrollment period and your enrollment will be treated as a Waiver of Coverage.

Waiver of Coverage

If you were eligible for coverage under the prior plan but did not elect to be covered under the prior plan, you will be required to provide Evidence of Good Health satisfactory to us. Your coverage will become effective when we approve your Evidence of Good Health.

"Evidence of Good Health" is a statement providing your medical history. We will use this statement to determine your insurability under This Plan. This statement must be provided to us at your expense.

Changes in Amount of Weekly Benefit

The amount of your Weekly Benefit may change as a result of a change in your earnings or class. The new Weekly Benefit amount:

1. will take effect on the date of the change; and

2. will apply only to Disabilities commencing thereafter.

However, if you are not an Active Employee on the above date, the new Weekly Benefit amount will take effect on the date you are again an Active Employee.

Form G.24303-B

SHORT TERM DISABILITY BENEFITS

A. Weekly Benefit

You will be paid a Weekly Benefit, in accordance with Plan Highlights, if we determine that:

1. you are Disabled; and

2. you became Disabled while covered under This Plan.

Benefits will begin to accrue on the date following the day you complete your Waiting Period. Payment of the Weekly Benefit will start on the date one week after completion of the Waiting Period. Subsequent payments will be made each week thereafter. Payment is based on the number of days you are Disabled during each one week period.

After we determine that you are Disabled, your Weekly Benefits will not be affected by:

1. termination of This Plan;

2. termination of your coverage; or

3. any plan change that is effective after the date you became Disabled.

When Benefits End

Weekly Benefits will end on the earliest of the following dates:

1. the end of the Maximum Benefit Duration;

2. the date you are no longer Disabled;

3. the date you fail to provide us with any of the information listed in Plan Highlights under Benefits Checklist;

4. the day you die;

5. the date you fail to attend a medical examination requested by us as described in Medical Examination.

Waiting Period

Your Waiting Period begins on the day you become Disabled. It is a period of time during which no benefits are payable. Your Waiting Period is shown in Plan Highlights. You must be under the continuous care of a Doctor during your Waiting Period.

Definition of Disability

“Disabled” or “Disability” means that, due to sickness, pregnancy or accidental injury, you:

- are receiving Appropriate Care and Treatment and complying with the requirements of such treatment; and

- unable to perform the duties of any gainful occupation for any employer for which you are reasonably qualified taking into account your training, education and experience.

Your loss of earnings must be a direct result of your sickness, pregnancy or accidental injury. Economic factors such as, but not limited to, recession, job obsolescence, pay cuts and job-sharing will not be considered in determining whether you meet the loss of earnings test.

For an Employee whose occupation requires a license, "loss of license" for any reason does not, in itself, constitute Disability.

"Appropriate Care and Treatment" means medical care and treatment that meet all of the following:

1. it is received from a Doctor whose medical training and clinical experience are suitable for treating your Disability;

2. it is necessary to meet your basic health needs and is of demonstrable medical value;

3. it is consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;

4. it is consistent with the diagnosis of your condition; and

5. its purpose is maximizing your medical improvement.

"Doctor" means a person who: (i) is legally licensed to practice medicine; and (ii) is not related to you. A licensed medical practitioner will be considered a Doctor:

1. if applicable state law requires that such practitioners be recognized for the purposes of certification of disability; and

2. the care and treatment provided by the practitioner is within the scope of his or her license.

"Own Occupation" means the activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you held with your Employer. It may be a similar activity that could be performed with your Employer or any other employer.

"Local Economy" means the geographic area surrounding your place of residence which offers reasonable employment opportunities. It is an area within which it would not be unreasonable for you to travel to secure employment. If you move from the place you resided on the date you became Disabled, we may look at both that former place of residence and your current place of residence to determine local economy.

Work Incentive

While you are Disabled, you are encouraged to work or participate in a Rehabilitation Program during your Waiting Period or while Weekly Benefits are being paid to you. Reimbursement for Eligible Family Care Expenses may also be available when you work or participate in an approved Rehabilitation Program while Disabled.

When you work while Disabled, you will receive the sum of the following amounts:

1. your Weekly Benefit (including your Rehabilitation Incentive when applicable);

2. the amount of your earnings for working while Disabled; and

3. the amount of Family Care Expenses for which you are eligible.

Your Weekly Benefit will be reduced if the total amount you receive from the above sources and Other Income Benefits exceeds 100% of your Predisability Earnings. Your Weekly Benefit will be reduced by that portion of the total you receive which exceeds 100% of your Predisability Earnings.

If your Weekly Benefit is reduced as a result of your receiving earnings from any work or service while Disabled, the Minimum Weekly Benefit will not apply.

"Rehabilitation Program" means:

1. a return to active employment by you on either a part-time or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified taking into account your training, education, experience and past earnings; or

2. participating in vocational training or physical therapy. This must be deemed by one of our rehabilitation coordinators to be appropriate.

Rehabilitation Incentive

While Disabled, your Weekly Benefit, before reduction for Other Income Benefits, is increased by 10% when you participate in a Rehabilitation Program approved by us.

Family Care Expenses

After the 4th week of Disability, when you work or participate in a Rehabilitation Program approved by us, you will be reimbursed for Eligible Family Care Expenses incurred with respect to each Eligible Family Member.

"Eligible Family Member" means a person who is:

1. living with you as part of your household; and

2. chiefly dependent on you for support.

"Eligible Family Care Expenses" mean the weekly expenses incurred by you in order for you to participate in a Rehabilitation Program, up to $100 for each Eligible Family Member. These are expenses incurred:

1. to provide childcare with respect to an Eligible Family Member under age 13. Childcare must be provided by a licensed childcare facility or other qualified childcare provider. The childcare provider may not be a member of your immediate family or living in your residence.

2. to provide care to an Eligible Family Member who as a result of mental or physical impairment, is incapable of caring for himself or herself. Family Care Expenses for services provided by a member of your immediate family or anyone living in your residence will not be reimbursed.

Eligible Family Care Expenses do not include expenses for which you are eligible for reimbursement under any other group plan or from any other source.

You must provide satisfactory proof to us that you incurred such charges. You must give us proof that the Eligible Family Member is incapable of caring for himself or herself and is chiefly dependent on you for support. The proof must be satisfactory to us.

Predisability Earnings

"**Predisability Earnings**" means your Adjusted Monthly Salary divided by 4,333.

"**Adjusted Monthly Salary**" means your monthly salary based on your annual base salary or annualized hourly pay, plus any skill or license premiums and market rate differentials, as determined by the Employer's established personnel practices.

B. Reduction of Benefits - Other Income Benefits

Your Weekly Benefit is reduced by Other Income Benefits shown below. The Weekly Benefit payable to you:

1. will not be less than the amount shown in Plan Highlights under Minimum Weekly Benefit (except in the case of an Overpayment or while receiving work earnings);

2. will not be further reduced due to cost-of-living increases payable under Other Income Benefits after the correct reductions has been determined;

3. will not be reduced by any reasonable attorney fees included in any award or settlement; and

4. will not be reduced by any sources other than those shown below.

If you receive Other Income Benefits in a lump sum instead of in weekly payments, you must provide to us satisfactory proof of the breakdown of: (i) the amount attributable to lost income; and (ii) the time period for which the lump sum is applicable. If you do not provide this information to us, we may reduce your Weekly Benefit by an amount equal to the Weekly Benefit otherwise payable. We will reduce the Weekly Benefit each

month until the lump sum has been exhausted. However, if we are given proof of the time period and amount attributable to lost income, we will make a retroactive adjustment.

List of Sources of Other Income Benefits

1. **Work Earnings, Rehabilitation Incentive, and Family Care Expenses** will not be used to reduce your Weekly Benefit except as described in Work Incentive.

2. **No-fault Auto Laws**

   Only the basic reparations portion for loss of income of a law providing for payments without determining fault in connection with automobile accidents will be counted. Supplemental disability benefits you buy under a no-fault auto law will not be counted.

3. **Third Party Recovery**

   The amount of recovery you receive for loss of income as a result of claims against a third party by judgement, settlement or otherwise.

4. **Other Programs or Plans including:**

   a. a compulsory benefit program of any government which provides payment for loss of time from your job because of your disability will be counted;

   b. any other group disability income plan, fund, or other arrangement, no matter what called, if the Employer contributes toward it or makes payroll deductions for it, will be counted;

   c. any sick pay or other salary continuation, other than vacation pay, paid to you by the Employer will be counted; and

   d. benefits received under the Employer's self-insured plan for that portion of a pregnancy Disability starting with the birth of a child, through 10 consecutive weeks of Disability following the birth of the child.

Exceptions to Other Income Benefits

Other Income Benefits will not include:

1. group credit or mortgage disability insurance benefits; or

2. early retirement benefits not taken into constructive receipt; or

3. individual Insurance policies.

C. Temporary Recovery

Once benefits become payable under This Plan, you may Temporarily Recover from your Disability. If you become Disabled again due to the same or related condition, you may not have to begin a new Waiting Period.

Once you have satisfied your Waiting Period, a period of Temporary Recovery is your return to work for less than 60 days for each period of Temporary Recovery.

During the Temporary Recovery you will not qualify for any change in coverage caused by a change in any of the following:

1. the rate of earnings used to determine your Predisability Earnings; or

2. the terms, provisions, or conditions shown in your Certificate of Insurance.

If your recovery lasts longer than the Temporary Recovery period allowed, when you become Disabled again you will have to begin a new Waiting Period.

D. Concurrent Disability

If a new Disability occurs while Weekly Benefits are payable, it will be treated as part of the same period of Disability. Weekly Benefits will continue while you remain Disabled. They will be subject to both of the following:

1. the Maximum Benefit Duration; and

2. Limitations and Exclusions that apply to the new cause of Disability.

E. Limitations

Limitation for Occupational Benefits

No benefits are payable for any Disability: (i) which happens in the course of any work performed by you for wage or profit; or (ii) for which you are eligible to receive benefits under any Workers' Compensation or any similar law.

Limitation for Pre-existing Conditions

You may be Disabled due to a Pre-existing Condition. No benefits are payable under This Plan in connection with that Disability unless your Waiting Period starts after you have been an Active Employee under This Plan for 12 consecutive months.

A Pre-existing Condition is an injury, sickness, or pregnancy for which you in the 3 months before your Effective Date:

1. received medical treatment, consultation, care, or services;

2. took prescription medications or had medications prescribed; or

3. had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care, or treatment.

F. Exclusions

This Plan does not cover any Disability which results from or is caused, or contributed to by:

1. war, insurrection, or rebellion;

2. active participation in a riot;

3. intentionally self-inflicted injuries or attempted suicide;

4. committing a felony.

TERMINATION OF COVERAGE

This provision applies to you if you are not Disabled.

You will cease to be covered on the earliest of the following dates:

1. the date This Plan terminates;

2. the date you cease to be an Eligible Employee;

3. the date you stop making any required contributions;

4. the date you go on strike or are locked out; or

5. the date you are laid-off.

Approved Leave of Absence

Your Employer may continue your coverage for an approved leave of absence by paying the required premium payments. Coverage may continue until the earliest of:

1. the date the Employer stops paying the required premium;

2. the date the leave ends; or

3. the last day of the month in which your leave of absence begins.

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or other similar laws for continuation of insurance. Please contact the Employer-for information regarding such legally mandated leave of absence laws.

Reinstatement of Coverage

If your coverage ends, you may become covered again as an Eligible Employee. Coverage is subject to the following:

1. If your coverage ends because you cease to be an Eligible Employee, and if you become an Eligible Employee again within 3 months, the Eligibility Waiting Period will be waived. You will not have to provide Evidence of Good Health.

2. If your coverage ends because you cease making the required contribution while on an approved Family Medical Leave Act (FMLA) leave of absence, or other legally mandated leave of absence, and you become an Eligible Employee again within 31 days of the earlier of:

   a. the end of the period of leave you and your Employer agreed upon; or

   b. the end of the eligible leave period required under the FMLA or other similar legally mandated leave of absence law,

   the Eligibility Waiting Period will be waived and you will not have to provide Evidence of Good Health.

3. In all other cases, if your coverage ends because you fail to make the required contribution, you must provide Evidence of Good Health to become covered again.

4. If you become covered again as described in 1. and 2. above, the Pre-existing Condition Limitation will be applied as if there had been no gap in coverage.

Form G.24303-D

EXTENSION OF BENEFITS

This provision applies if your coverage ceases while you are Disabled.

During your Waiting Period your coverage will continue while you are continuously Disabled until the end of your Waiting Period. Benefits will begin after the end of your Waiting Period. Your coverage will continue in either of the following situations:

1. This Plan terminates; or

2. you cease to be an Eligible Employee but required payments are made to us.

Benefits are payable if your Disability began while coverage was in force and continues without interruption after termination.

Extension of benefits beyond the period coverage was in force is limited to the Maximum Benefit Duration. Extension of benefits is subject to all of the following:

1. your Waiting Period; and

2. payment of any required contributions; and

3. all other applicable provisions of This Plan.

Form G.24303-C

CLAIMS

Notice of Disability

Notify us of your Disability as soon as you are able.

To notify us you may call us directly. You may obtain this phone number from your Employer. You will be instructed on how to give proof of Disability. You will be required to answer all questions concerning your Disability.

If you do not receive statements or instructions within 15 days after you have notified us, you may submit your statement in a letter.

Proof of Disability

Provide proof of Disability within 45 days after the end of your Waiting Period.

No benefits are payable for claims submitted more than 6 months after the date of Disability. However, you can request that benefits be paid for late claims if you can show that:

1. it was not reasonably possible to give written proof of Disability during the 6 month period; and

2. proof of Disability satisfactory to us was given to us as soon as was reasonably possible.

Documentation

At your expense, you must provide documented proof of your Disability. Proof includes, but is not limited to:

1. the date your Disability started;

2. the cause of your Disability; and

3. the prognosis of your Disability.

You will be required to provide signed authorization for us to obtain and release medical and financial information, and any other items we may reasonably require in support of your Disability.

These will include but are not limited to:

1. proof of continuing Disability;

2. proof you have applied, or are not eligible, for Other Income Benefits. If you do not provide proof you have applied for Other Income Benefits, we may reduce your Weekly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit;

3. proof that you applied for Social Security disability benefits until denied at the Administrative Law Judge level; and

4. proof you have applied for Workers' Compensation benefits or benefits under a similar law. If you do not provide proof that you have applied for these benefits, we may reduce your Weekly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit.

If you do not provide satisfactory documentation within 60 days after the date we ask for it, your claim may be denied.

Method of Payment

When we determine you are Disabled:

1. Weekly Benefits are paid one week after you qualify for them and on a weekly basis thereafter.

2. Benefits will be paid to you. However, benefits unpaid at your death will be paid to:

a. your spouse, if living; otherwise

b. your children, if living, divided equally;

c. your estate. If benefits are payable to your estate, we may pay up to $1,500 to someone related to you by blood or by marriage whom we deem entitled to this amount. We will be discharged to the extent of any payment made in good faith.

3. Weekly Benefits due for a period of less than a week will be paid at a daily rate of 1/7th of the Weekly Benefit payable.

Right To Recover Overpayments

We have the right to recover from you any amount that we determine to be an Overpayment. You have the obligation to refund to us any such amount. Our rights and your obligations in this regard are also set forth in the reimbursement agreement you are required to sign when you become eligible for benefits under This Plan. This agreement: (i) confirms that you will repay all Overpayments; and (ii) authorizes us to obtain any information relating to Other Income Benefits.

An Overpayment occurs when we determine that the total amount paid by us on your claim is more than the total of the benefits due under This Plan. This includes any Overpayments resulting from:

1. retroactive awards received from sources shown in the List of Other Income Benefits;

2. fraud; or

3. any error we make in processing your claim.

The Overpayment equals the amount we paid in excess of the amount we should have paid under This Plan. In the case of a recovery from a source other than This Plan, our Overpayment recovery will not be more than the amount of the recovery.

You have the right to appeal any Overpayment recovery.

An Overpayment also occurs when payment is made by us that should have been made under another group plan. In that case, we may recover the payment from one or more of the following:

1. any other insurance company;

2. any other organization; or

3. any person to or for whom payment was made.

We may, at our option, recover the Overpayment by:

1. reducing or offsetting against any future benefits payable to you or your survivors;

2. stopping future benefit payments (including Minimum Benefits) which would otherwise be due under This Plan. Payments may continue when the Overpayment has been recovered; or

3. demanding an immediate refund of the Overpayment from you.

Legal Actions

No legal action of any kind may be filed against us:

1. within the 60 days after proof of Disability has been given; or

2. more than three years after proof of Disability must be filed. This will not apply if the law in the area where you live allows a longer period of time to file proof of Disability.

Medical Examinations

We will have the right to have you examined at reasonable intervals by medical specialists of our choice. The examination will be at our expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of your benefits.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for 2 years. It can be declared invalid due to non-payment of premium.

No statement of health used by any person to get coverage can be used to declare coverage invalid if the person has been covered under This Plan for 2 years. In order to use a statement of health to deny coverage before the end of 2 years, it must have been signed by the person. A copy of the signed statement must be given to the person or the person's beneficiary.

Assignment

You may not assign your benefits. This means that you may not give or transfer your benefits to anyone else.

Workers' Compensation

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance or any government mandated temporary disability income benefits law.

Form G.24303-E

THE PRECEDING PAGE IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.

SPECIAL SERVICES

RETURN TO WORK PROGRAM

Goal of Rehabilitation

The goal of MetLife is to focus on Employees' abilities, instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what Employees can do versus what they can't, we can assist you in returning to work sooner than expected.

Incentives For Returning To Work

Your disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many Employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable but you do not participate in the Return to Work Program, your Disability benefits may cease.

Vocational Rehabilitation Services

As a covered Employee you are automatically eligible to participate in our Return to Work Program. The Program focus is vocational rehabilitation, which means identifying the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities.

There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. **Vocational Analyses**

   Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your employer.

2. **Labor Market Surveys**

   Studies to find jobs available in your local economy that would utilize your abilities and skills.

3. **Retraining Programs**

   Programs to facilitate return to your previous job, or to train you for a new job.

4. **On-Site Job Analyses**

   Analyses to determine what modifications may be made to maximize your employment opportunities.

5. **Job Modifications**

   Changes in your job or modifications to help you perform the previous job or a similar vocation.

6. **Training in Job Seeking Skills**

   Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

Rehabilitation Staff

The Case Management Specialist handling your claim will begin the rehabilitation process. You may be referred to our professional Rehabilitation staff that includes Registered Nurses and vocational rehabilitation coordinators. Registered Nurses might address how your medical condition impacts your ability to return to work. Vocational rehabilitation coordinators will focus on identifying how your abilities can be best applied to either your previous job or a new job.

These rehabilitation specialists will contact you personally. They will coordinate their activities with your medical carrier and/or attending physician for a broad understanding of your diagnosis, prognosis, and expected return to work date.

Rehabilitation Vendor Specialists

In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. Attending physician's evaluation and recommendations;

2. Your individual vocational needs; and

3. Vendor's credentials, specialty, reputation, and experience.

When working with vendors, you and your Doctor still maintain control and direction of the case.

Premium Deduction Service

As a service to you while you are disabled, MetLife will assist you by reducing the administrative burden of deducting premium payments for insurance coverage(s), other than your disability income insurance with MetLife (Other Coverage), that are part of your employer's insurance program for you.

We will do this by deducting from either your weekly or monthly benefit, as applicable, payable to you under the disability income insurance plan that your employer has with MetLife, the required premium amounts for Other Coverage for which you were enrolled under your employer's insurance plan immediately prior to the start of your disability. Your employer will notify MetLife of the amount of your required premium payments that MetLife is to deduct for such Other Coverage. MetLife will then pay this amount to your employer to be applied toward the premium payments required for such Other Coverage when due, subject to the following terms and conditions:

The amount of premium we deduct from your disability income benefit and then pay to your employer, may be:

- Increased, if there are increases in the amount of premium due for Other Coverage(s) that you are enrolled in, and, your employer notifies us of such increases;
- Reduced or terminated upon a request from you or your employer; or,
- Terminated by MetLife upon the earliest of:
    - 30 days advanced notice to you;
    - your return to work;
    - notification to us of the termination of your employment; or,
    - your disability income benefits end date.

In no event will any payment be made to your employer under the above described service, if the amount of either the weekly or monthly benefit, as applicable, payable to you under the MetLife disability income insurance plan is less than the amount of the applicable premium payroll deductions.

Your Employer will be solely responsible for remitting the amount of premium payments for Other Coverage(s) received from MetLife to the appropriate party or parties.

If while you are Disabled, You do not want MetLife to deduct the premium for Other Coverage as described above, you must notify MetLife of your intention. When we receive your notice, we will stop making premium deductions for Other Coverage(s).

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

1.Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

2.Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

3.Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company, and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

4.How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901, or by contacting MIB at www.mib.com.

5.Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

6.Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our "Using Your Information" section above

7.HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act ("HIPAA") protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MeLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

8.Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

9.Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954

privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

MetLife

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.: **29900-G**

Policyholder: **American Airlines, Inc.**

Effective Date: **January 1, 2022**

The certificate is changed as follows:

Applicable to All Agents, Flight Attendants, and Transport Workers Union (TWU) FSE/FCT/SIMP Employees who are employed and paid for services by the Employer.

1. In **EMPLOYEE ELIGIBILITY**, replace **Eligible Employee** with the following:

   "**Eligible Employee**: All Agents, Flight Attendants, and Transport Workers Union (TWU) FSE/FCT/SIMP Employees who are employed and paid for services by the Employer, excluding Employees working in California."

2. In **SHORT TERM DISABILITY BENEFITS**, add **Minimum Weekly Benefit**:

   "**Minimum Weekly Benefit**: The greater of: (i) 10% of the Weekly Benefit not reduced by Other Income Benefits; or (ii) $25. The Minimum Weekly Benefit is subject to the Overpayments and Rehabilitation Incentive subsections of this certificate."