American Airlines, Inc.
Health & Welfare Plan for Active Employees Summary Plan Description Effective January 1, 2022

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Introduction

American Airlines, Inc. (the "Company") provides you with a comprehensive benefits package designed to help you meet the health, life, accident, disability, and dependent care needs of you and your eligible family members. To help you make the most of those benefits, this Summary Plan Description ("SPD") describes the provisions of the American Airlines, Inc. Health & Welfare Plan for Active Employees (the "Plan") effective January 1, 2022.

This SPD provides a comprehensive overview of the benefits available under the Plan as well as limitations, exclusions, Deductible and Co-Insurance requirements. A list of benefit types provided under the Plan can be found in the chapter "Benefits under the Plan and Contact Information."

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

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

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

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

Eligibility and Enrollment

Employee eligibility
Dependent eligibility
Employees married to other employees
When coverage begins
Benefits continuation if you go on a leave of absence
Making changes during the year
When coverage ends

Employee Eligibility

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

Eligible Employees

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

Ineligible Employees

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

- **A leased employee, as defined in section 414(n) of the Internal Revenue Code.** This includes any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service ("IRS"), or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker. This term includes any of the following former classifications:
    - **Temporary employee.** If a temporary worker becomes a Regular Employee, and meets all of the other requirements to participate in the Plan without a break in service, the time worked as a full-time temporary worker will be credited solely toward the eligibility requirement for the Plan. Under no circumstances will time worked as a temporary worker entitle the individual to retroactive coverage under the Plan.
    - **Provisional employee.**
- Associate employee.
- An independent contractor.
- Any person:
- Who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion);
- Who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate; or
- Who tells the Company he/she is an independent contractor, or is employed by another company while providing services to the Company, even if the worker is, or may be reclassified at a later date as, an employee of the Company by the courts, the IRS or the DOL.

The following individuals are not eligible to participate in the Short-Term Disability benefits under the Plan:

- Employees of American Airlines, Inc. who are covered by the collective bargaining agreements entered into between the TWU/IAM Association covering Mechanics & Related, Material Logistics Specialists, Maintenance Training Specialists, Maintenance Control Technicians, and Fleet Service.

Employee Eligibility for Medical Benefit Options

You are eligible for the CORE Medical Benefit Option, STANDARD Medical Benefit Option, HIGH COST COVERAGE Medical Benefit Option, the Plus Plan for Active Employees, the DFW Connected Care Plan in certain zip codes or an HMO if you list an address where the Network/Claim Administrator or HMO offers a Network.

You are allowed to list two addresses in the Update my Information page of Jetnet, via the Team Member Services tab:

- a home address (i.e., the address you use for tax purposes/your permanent residence)
- an alternate/benefits address (i.e., a P.O. Box or street address other than your home address).

You are eligible for the CORE Medical Benefit Option, STANDARD Medical Benefit Option, HIGH COST COVERAGE Medical Benefit Option, the Plus Plan for Active Employees, the DFW ConnectedCare Plan in certain zip codes or an HMO by zip code as follows:

- You have an alternate/benefits address on record and the ZIP code of your alternate/benefits address on record matches a ZIP code in which the Network/Claim Administrator or HMO offers a Network; or
- You have no alternate/benefits address on record and the ZIP code of your home address on record matches a ZIP code in which the Network/Claim Administrator or HMO offers a Network.

If your alternate/benefits address is not in an area with a Network/Claim Administrator or HMO, then you are only eligible for the OUT-OF-AREA Medical Benefit Option.

If you do not have an alternate/benefits address listed in the Update my Information page of Jetnet, via the Team Member Services tab, your benefit eligibility is based on your home address on record. If you have no alternate/benefits address on record and the ZIP code of your home address on record does not match a ZIP code in which the Network/Claim Administrator or HMO offers a Network, then you are only eligible for the OUT-OF-AREA Medical Benefit Option.

Eligibility in the Plan for Active Employees After Age 65

As long as you are working as an active employee for American Airlines, Inc., you are eligible for health and welfare benefit plan coverage irrespective of your age—even if you're age 65 or older. When you reach age 65 (or your Spouse reaches age 65), you (or your Spouse) must process a Life Event if you want Medicare to be your only coverage. Please see the "Life Event" section for information about how to process a Life Event. If you elect Medicare as your only coverage, your Company-sponsored active medical coverage will terminate, including coverage for your Eligible Dependents. If your Spouse elects Medicare as his or her only coverage, only your Spouse's Company-sponsored active medical coverage will terminate. Please see the Retiree Benefit Guide for information about retiree medical benefit coverage under the American Airlines, Inc. Group Life and Health Plan for Retirees and the American Airlines, Inc. Supplemental Medical Plan.

Dependent Eligibility

Dependent Eligibility by Benefit

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

Company-Recognized Domestic Partners and their Children are considered Eligible Dependents for the CORE Option, Dental, Vision, Spouse and Child Life Insurance, and Spouse and Child Accident Insurance under the Plan.

Medical, Dental, and Vision Coverage

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

- Spouse, Common Law Spouse or Company-Recognized Domestic Partner.
    - Company-Recognized Domestic Partners and their Children may be eligible for coverage under your HMO. The decision to offer HMO coverage to Company-Recognized Domestic Partners is made by individual HMO plans, not by American Airlines. Contact your HMO directly for eligibility criteria.
    - Company-Recognized Domestic Partners and their Children are not eligible to participate in Flexible Spending Accounts, unless they are your tax dependents.
    - Company-Recognized Domestic Partners and their Eligible Dependents are eligible for the CORE Option only (not the STANDARD, HIGH COST COVERAGE, OUT-OF-AREA

Options or the Plus Plan for Active Employees), Dental and Vision, or an HMO, as noted above.

- Child until the end of the month he/she turns 26 (as defined below in the Determining a Child's Eligibility section).
- Disabled Dependent Child age 26 or over, as defined below under "Coverage for a Disabled Dependent Child – Medical, Dental, and Vision Coverage."
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Note for HMO Medical Benefit Option: If your Child does not live with you, contact the HMO to find out if your Child can be covered. If you are providing the Child's coverage under a Qualified Medical Child Support Order (QMCSO) and the HMO cannot cover your Child, you may be required to select a different Medical Benefit Option for your entire family.

Coverage for a Disabled Dependent Child — Medical, Dental, and Vision Coverage

A "Disabled Dependent Child" age 26 or older is eligible for continuation of coverage if <u>all</u> of the following criteria are met:

- The Child is mentally or physically incapable of self-support and was deemed mentally or physically incapable of self-support prior to turning age 26.
- You complete and return the "Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability" to the American Airlines Benefits Service Center prior to the date coverage would otherwise end, or if the child is not in coverage within 31 days of your qualifying Life Event (such as marriage or loss of coverage).
- The American Airlines Benefits Service Center will review your request for administrative eligibility, then forward your request to your Network/Claim Administrator for medical review of the application for approval.
- The Child continues to meet the criteria for dependent coverage under this Plan.
- You provide additional medical proof of disability as may be required from time- to-time when requested. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your Network/Claim Administrator determines the Child is no longer disabled. If you elect to drop coverage for your Child, you may later reinstate it if requested within 60 days of your qualifying life event (such as loss of coverage).

- Either the Child maintains legal residence with you and is wholly dependent on you for maintenance and support, or you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.
- You, as the employee, are required to take to these steps to request disability status for your dependent Child.*

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

An Eligible Dependent is a Child as defined below (other than the employee covered by the Benefit Option) who lives in the United States, Puerto Rico or the U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. Child means the following:

- Under the age of 26 or,
- Age 26 or older, if all of the following criteria are met:
    - The Child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law.
    - You provide proof of such handicap to the insurance carrier (listed in the chapter Benefits under the Plan and Contact Information) within 31 days after the date the child attains the age limit and at reasonable intervals after such date.
    - The Child continues to meet the criteria for dependent coverage under this Plan, other than being under age 26.

The term “Child” does not include any person who:

- Is in the military of any country or subdivision of any country; or
- Is covered under an employer group plan as an employee.

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

- Your grandchild who is under age 25, unmarried and who was able to be claimed by you as a dependent for federal income tax purposes at the time you applied for Life Insurance.

If you enroll or are enrolled in Child Term Life Insurance or Child AD&D Insurance, you are required to designate your eligible dependent by adding his or her name and date of birth on the American Airlines Benefits Service Center website.

Designating an eligible dependent for child life and/or child AD&D coverage ensures your dependents are enrolled in coverage for which they are eligible. Please note if you do not designate an eligible dependent for coverage, we will remove this coverage.

You will not be required to provide verification for the dependent. Eligible dependents are not required to enroll in other benefits (i.e. medical, dental, etc) in order for you to elect Child Term Life Insurance and Child AD&D.

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

An Eligible Spouse, Common Law Spouse, or Company-Recognized Domestic Partner (for Spouse AD&D) is an individual (other than the employee covered by the Benefit Option) who lives in the United States, Puerto Rico or the U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S.

Dependent Eligibility Requirements - Generally (All Benefits)

Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Spouse, Company-Recognized Domestic Partner (for the CORE Option, Dental, Vision, Spouse and Child Life Insurance, and Spouse and Child Accident Insurance) or Common Law Spouse as defined by the Plan
- Stepchild
- Special Dependent, if you meet all of the following requirements:
    - You or your Spouse must have legal custody or legal guardianship of the child. (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).
    - The child must maintain legal residence with you and be wholly dependent on you for maintenance and support.
    - You must submit copies of the official court documents awarding you custodianship or guardianship of the child to the American Airlines Benefits Service Center
    - American Airlines Benefits Service Center will send you a letter notifying you of its determination. If your request is approved, the notification letter will include an approval date. If you submit your request within 60 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by American Airlines Benefits Service Center. If you submit the request after the 60-day time frame, the child will not be added to your coverage, unless you experience another Life Event or during the next Annual Enrollment.

- QMCSO Dependent: A child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Parents or Grandchildren

Neither your parents nor grandchildren (except as noted in the Child Life Insurance section) are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchild's legal guardian). Note that you may be eligible for reimbursement of their eligible expenses under the Health Care Flexible Spending Account (see the Health Care Flexible Spending Account section) and Dependent Care Flexible Spending Account (see the Dependent Care Flexible Spending Account section) if you claim your parent or grandchild as a dependent on your federal income tax return.

Dependents of Deceased Employees

If you have elected medical coverage for your Spouse, Company-Recognized Domestic Partner (for the CORE Option) and Children and you die as an active employee, your dependents' medical coverage will continue for 90 days at no contribution cost.

Your covered dependents are also eligible to continue Medical, Dental, and Vision Benefit Option coverage for up to 36 months under COBRA Continuation Coverage at the full COBRA rate, if they had these benefits at the time of your death. If your covered dependents elect COBRA Continuation Coverage, the 90 days of coverage provided at no contribution cost immediately after your death are part of the 36 months of COBRA coverage. See the "COBRA" section for further information.

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

Determining a Spouse (SP), Company-Recognized Domestic Partner (DP) or Common Law Spouse Eligibility (CLSP)

The Plan will cover as your Eligible Dependent only one of the following at any given time: Spouse, Company-Recognized Domestic Partner or Common Law Spouse.

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

- Spouse (SP): Your Spouse means an individual who is lawfully married to the employee 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.

- **Common Law Spouse**: Common Law Spouses are eligible for enrollment in Plan benefits only if the common law marriage is recognized and deemed (certified) legal by the individual state where the employee resides, and only if the employee and spouse have fulfilled the state's requirements for common law marriage. To enroll your Common Law Spouse for benefits, you must complete and return a Common Law Marriage Recognition Request and provide proof of common law marriage, as specified on the form.

Company-Recognized Domestic Partner (DP): A Domestic Partnership is defined as two people in a spouse-like relationship who meet all of the following criteria:

- Are the same- or opposite- gender
- Reside together in the same permanent residence, living in a spouse-like relationship, for the last 6 months
- Are both at least 18 years of age and are not related by blood in a degree that would bar marriage
- Are not legally married or the Domestic Partner of any other person
- You will be required to submit a minimum of 3 documents proving the requirements above, for example, a joint mortgage or lease, evidence of joint financial responsibility and/or primary beneficiary designation.
- As an alternative to submitting multiple documents if you and your Domestic Partner reside in a state or locality that allows for registration of domestic partnerships, you can provide the following documentation:
    - Declaration of Domestic Partnership; and
    - Registration form from the state or locality.

Domestic Partners and their Eligible Dependent Child(ren) are eligible to be covered under the following Benefit Options under the Plan:

- CORE Option
- Dental
- Vision
- Spouse and Child Life Insurance
- Spouse and Child Accident Insurance

If you need additional information regarding benefits available to Company- Recognized Domestic Partners, please contact the American Airlines Benefits Service Center

Note on HMOs: Company-Recognized Domestic Partners may be eligible to participate in Health Maintenance Organizations (HMOs). The decision to offer HMO coverage to Company-Recognized Domestic Partners is made by individual HMO plans, not by American Airlines. Contact your HMO directly for eligibility criteria.

Note on Tax Dependents: Unless your Company-Recognized Domestic Partner and his/her Children are your tax dependents, the Company will be required to report the value of any medical, dental, or vision coverage provided to them as additional wages on your Form W-2, which will also be visible as imputed income on your paychecks. Contributions for medical, dental, and vision coverage for your Domestic Partner and his/her Child(ren) will be collected on an after-tax basis. In addition, under current laws, a Company-Recognized Domestic Partner's health care expenses may not be reimbursed from your Health Care Flexible Spending Account, your Limited Purpose Health Care Flexible Spending Account, or your Health Savings Account, unless the Company-Recognized Domestic Partner is your tax dependent.

Proof of Dependent Eligibility

If you:

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

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

Requests for proof of your dependents' eligibility will be provided via email and/or paper correspondence mailed to your address on file. Failure to respond to these requests within 31 days of the original notice will result in your request to add coverage for your dependents being denied. **Important:** It is your responsibility to respond to the emails, phone calls, and/or paper correspondence you will receive within the 31-day timeframe. Coverage will not be in place until you have timely requested their enrollment and provided satisfactory proof of eligibility. If such proof is timely provided, enrollment and coverage will be retroactive to the date of the event (i.e. Marriage, Birth, or Hire Date) and you will be responsible for any applicable costs.

American Airlines, Inc. reserves the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions may result in termination of Benefit Option or Plan coverage and efforts to recover any overpaid benefits will be made.

Married Employees and Dependent Children Whose Parents are Employees

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

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

- First, the Married Employee who will be covered as the dependent Spouse must elect "No Coverage";
- Next, the Married Employee who will be designated as the employee will elect to cover both Married Employees for Medical, Dental and/or Vision Benefit Option, and must add his or her Spouse as a dependent (and any other Eligible Dependents) by contacting the American Airlines Benefits Service Center.

The following Benefit Options must still be maintained independently:

- Employee Accidental Death & Dismemberment (AD&D) Insurance
- Employee Term Life Insurance
- Health Reimbursement Accounts

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

Active employees married to retiree dependents: Retiree dependents married to active employees are only eligible for coverage as dependents of active employees if they are not enrolled in retiree medical benefits sponsored by the Company. The benefits available and benefit limits, if any, are defined by the active employee's coverage.

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

If the Married Employee on leave elects to be covered as the Dependent of his or her actively working Married Employee, then the actively working Married Employee's health

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

The actively working Married Employee may elect to:

- Add the Spouse on leave as a dependent
- Cover only Eligible Dependent Children
- Cover both the Spouse and Children
- Enroll himself or herself, and the Spouse and Children as dependents.

If the Spouse on leave is covered as a dependent during the leave of absence, the following conditions apply:

- Optional coverages (Life, Short-term disability, etc.) the Spouse elected as an active employee end, unless payment for these coverages is continued while on leave.
- Proof of Good Health may be required to re-enroll or increase optional coverages upon the Spouse's return to work.
- Provided the Spouse on leave makes Timely Payments for benefits, Company- provided coverage (where the Company pays its share of the cost and the Spouse on leave pays his/her share) will continue for the first twelve months2 of leave of absence for family, sick, injury-on-duty or maternity leaves.

Eligible Dependent Children:

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

Contributions: If Married Employees choose to be covered under one employee, the contributions for the employee covering both will reflect either "Employee plus Spouse/Company-Recognized Domestic Partner" or "Employee plus Family," if the employee also elects to cover dependent Children. This applies to contributions for the Medical, Dental and Vision Benefit Options. Contributions for benefits that still must be maintained independently, such as Life Insurance (see the Life Insurance section), will be applied appropriately and payroll-deducted from each Married Employee's paycheck.

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

Accident Death and Dismemberment (AD&D) coverage: Married Employees cannot be covered both as an employee and as a dependent. For Married Employees without Children, both you and your Spouse/Company-Recognized Domestic Partner must enroll separately as employees.

Flexible Spending Accounts: Contributions to the Health Care Flexible Spending Account and/or the Limited Purpose Spending Account (see the Health Care Flexible Spending Account section) and Dependent Care Flexible Spending Account (see the Dependent Care Flexible Spending Account section) may be made by one or both Spouses. Either of you may submit claims to the account. However, if only one Spouse is making contributions to the account, claims must be submitted under that person's Social Security number. If you both make contributions to the Dependent Care Flexible Spending Account, you may only contribute the maximum amount federal law permits for a couple filing a joint tax return (e.g. $5,000, or the Spouse's earned income). For the Health Care Flexible Spending Account or Limited Purpose Spending Account, you may each make contributions up to $2,750 per employee.

You may not file claims for expenses incurred by a Company-Recognized Domestic Partner who is an employee of the Company (or his or her dependents) under your Flexible Spending Accounts according to federal law, unless he or she is your tax dependent. Company-Recognized Domestic Partners who are both employees of the Company may each have their own Flexible Spending Accounts.

Health Savings Account: You may not use tax-free HSA funds for medical expenses incurred by a Company-Recognized Domestic Partner who is an employee of the Company (or his or her dependents) under your Health Savings Account according to federal law, unless he or she is your tax dependent.

When Coverage Begins

New Employees

New Employee Enrollment

As a new employee, you will receive information shortly after you begin working regarding enrollment in the Plan. You have **60 days** from your Hire Date to enroll in the Plan and you may elect coverage for yourself and your Eligible Dependents (see the Dependent Eligibility section).

Note regarding Voluntary Term Life Insurance: Upon being hired, you also have a one-time opportunity to enroll in the Employee Voluntary Term Life Insurance benefit without having to provide Proof of Good Health. For new employees, coverage levels in excess of three (3) times your salary or $500,000 (whichever is less) require Proof of Good Health). Proof of Good Health is also required at certain other times, as described in the Life Insurance Benefits chapter. If you would like coverage on the life of your Spouse, he/she will need to complete the Proof of Good Health form online within seven (7) days after your enrollment deadline. If you do not complete the form online within seven (7) days after your enrollment deadline, a Proof of Good Health form will be mailed to you. You will then need to mail a completed, dated and signed Proof of Good Health

form to MetLife, postmarked within 30 days after your enrollment deadline. If your Proof of Good Health is not postmarked within 30 days after the close of your new employee enrollment window, your application for this coverage will not be considered, and you must wait until the next Annual Enrollment (or your next Life Event) to apply for this benefit. Please note that enrollment may be denied based upon the presence of certain health conditions as determined by MetLife and the Plan.

Waiving Coverage

All eligible employees are automatically enrolled into medical coverage effective your date of hire. You may choose to waive medical coverage if you wish. If you wish to waive medical coverage, you MUST take action to waive the coverage at the time you are first eligible by using the online enrollment tool — the American Airlines Benefits Service Center.

Your dependents will not receive medical coverage if you waive such coverage. If you waive coverage for any Plan Year, you can enroll in coverage later in the year only if you experience a Life Event, such as marriage, divorce or the birth or adoption of a Child or during Annual Enrollment.

Default Coverage for New Employees

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

DEFAULT TABLE FOR NEW EMPLOYEES		
Benefit Option	**Default**	**Comments**
Medical	CORE Medical Option (Employee only)	If the CORE Medical Benefit Option is not available, you will automatically default into another Medical Benefit Option selected by the Plan Administrator.
Dental	No coverage	
Vision	No coverage	
Optional STD	No coverage	This benefit only applies to Flight Simulator Engineers (FSEs),Flight Crew Training Instructors (FCTSs), and Simulator Pilot Instructors (SimPs) represented by the TWU and employees by the Communication Workers of America, AFL-CIO, CLC, IBT, PAFCA and Flight Attendants.
Pilot STD	$50 per week	The benefit applies only to employees represented by the APA
STD	STD Coverage – Taxable Benefit or Non-Taxable Benefit	This benefit applies only to Officer, Management, and Support Staff workgroups

Basic Term Life Insurance	2 times pay	Up to a maximum of $70,000
Basic AD&D Insurance	2 times pay	Up to a maximum of $70,000 This benefit applies only to Officer, Management, and Support Staff workgroups
Basic AD&D Insurance	$10,000	This benefit applies only to Flight Employees
Voluntary Term Life Insurance	No coverage	N/A
Voluntary AD&D Insurance	No coverage	This benefit applies only to Ground Employees
Voluntary Personal Accident Insurance	No coverage	This benefit applies only to Flight Employees
Spouse Life Insurance	No coverage	N/A
Child Life Insurance	No coverage	N/A
Spending Accounts (Dependent Care FSA, HSA, Health Care FSA, and Limited Purpose FSA)	No coverage	Your Spending Accounts will default to $0.00 unless you take action to establish the accounts and enter a dollar amount for the accounts (Note that participants in the default Medical Benefit Option, the CORE Medical Option, are not eligible for a Health Care FSA.)

When Coverage Begins as a Newly Hired Employee

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

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

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

Current Employees

Annual Enrollment

Each year, eligible employees have the opportunity to select benefits for the upcoming Plan Year — January 1 through December 31. During Annual Enrollment you can:

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

Default Medical Coverage for Current Employees

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

- Medical Coverage: Your current benefit elections (if still available) will carry over to the following year. If your current medical benefit option is not available for the following year, you will automatically be enrolled in the CORE Medical Benefit Option. If you previously waived benefits coverage and do not currently have benefits coverage under this plan, you will not have medical coverage for the following year.
- **Health Care FSA and Limited Purpose FSA**
    - If you do not make a HCFSA or LPFSA election during the Annual Enrollment Period for 2022, any amount remaining in your 2021 HCFSA will carry over to a 2022 HCFSA for you, and any amount remaining in your 2021 LPFSA will carry over to a 2022 LPFSA for you. During the last two (2) months of the current benefit year, you cannot change your HCFSA or LPFSA elected amounts or enroll in the HCFSA or LPFSA even if you experience a Life Event. This does not include the elections you make during the Annual Enrollment Period for the next benefit year.
    - If you enroll or are automatically enrolled in the CORE Medical Benefit Option during the Annual Enrollment Period in 2021, any amount remaining in your 2021 HCFSA will carry over to a 2022 LPFSA.

- **Dependent Care FSA**
    - If you do not make a DCFSA election during the Annual Enrollment Period for 2022, any amount remaining in your 2021 DCFSA election will carry over to a 2022 DCFSA for you.
    - During the last two (2) months of the current benefit year, you cannot change your DCFSA elected amounts or enroll in the DCFSA even if you experience a Life Event. This does not include the elections you make during the Annual Enrollment Period for the next benefit year.
    - You cannot carry over your DCFSA balance from 2022 to 2023, but you do have a "grace period" until March 15 of 2023 to use your 2022 balance.

When Coverage Begins as a Current Employee

When you enroll during the Annual Enrollment Period, your selected coverage (or default coverage) begins on January 1 and continues through December 31 (the Plan Year) as long as you continue to be eligible for the Plan as described in the "Employee Eligibility" section and satisfy other Plan requirements, such as Timely Pay premiums. If Proof of Good Health is required, the effective date for coverage, if approved, may be delayed to allow for review of your Proof of Good Health (e.g., to add or increase life insurance coverage in certain circumstances).

How to Enroll

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

The American Airlines Benefits Service Center
The American Airlines Benefits Service Center (the online enrollment tool) on my.aa.com reflects the current benefits coverages available to you and the rates for those coverages. The American Airlines Benefits Service Center is updated during Annual Enrollment with your Benefit Options and the new rates for the upcoming Plan Year – January 1 through December 31.

Benefits continuation if you go on a leave of absence

Eligibility During Leaves of Absence and Disability

You may be eligible to continue certain benefits for yourself and your Eligible Dependents for a period of time during a leave, subject to the specific rules on Jetnet. The type of leave you take determines the cost of your benefits (i.e., whether you and the Company share the cost of the benefits or you pay the full cost of benefits). In addition, for the Medical Benefit Options, Dental, Vision, Health Flexible Spending Account, and Limited Purpose Flexible Spending Account, you may have a COBRA right, as described in the

"COBRA" chapter. In order to continue your benefits during a leave of absence, you must Timely Pay the required contributions for your benefits during your leave. The due date will be noted on your billing statement.

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

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

If you elect not to continue your benefits during your leave of absence or if you fail to Timely Pay for your benefits, your benefits will terminate for the duration of your leave of absence. When you return to active employee status, you may reactivate most of your benefits. However, some benefits will require you to complete the Proof of Good Health form (which must then be reviewed and approved by the applicable Claim Administrator) in order to reactivate (e.g., Voluntary Term Life Insurance, Disability).

Continuation of Coverage for Employees in the Uniformed Services

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

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

If you choose not to continue your medical coverage while on military leave, you are eligible for reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days

The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Domestic U.S. Policies, which is available via Jetnet.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to twelve weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time, at the same contribution level that applied prior to the leave. Other applicable laws (e.g., state laws) may also require the Company to allow employees to continue their elected medical coverage during leave for certain family and medical situations.

In order to continue your benefits during a leave of absence, you must Timely Pay the required contributions for your benefits during your leave.

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. A notification advising you that benefit plan contributions are unable to be collected from your paycheck will be sent once you reach an unpaid balance exceeding $1,000. In the event paychecks continue to be insufficient, and your balance increases to an amount exceeding $1,500, payroll contributions will stop indefinitely and a monthly billing statement will be generated for payment.

Once your billing statement is generated, you must pay the required contributions for your benefits by the due date on each billing statement. If at any time 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 (including Special Enrollment for Medicaid and CHIP) that allows you to enroll, or (ii) the next Plan year.

If you would like to begin having your benefits deducted from your paycheck, contact the American Airlines Benefits Service Center once you have received at least two paychecks that would cover your monthly benefit plan contributions.

Making Changes During the Year

When the new benefit year begins on January 1, you may only change your elections if you experience one of the following events described below: HIPAA Special Enrollment Events (including Special Enrollment for Medicaid and CHIP) and Life Events.

HIPAA Special Enrollment Events – Medical Benefit Option Only

If you declined coverage for you or your dependents under the Medical Benefit Option because you or they have medical coverage elsewhere and one of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your dependents in the Medical Benefit Option, in which case coverage will be effective the date of the event:

- You and/or your dependents lose eligibility for other medical coverage for reasons that include legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause)
- The employer contributions to the other coverage have stopped
- The other coverage was COBRA and the maximum COBRA coverage period ends
    - You and/or one of your dependents exhaust a lifetime maximum in another employer's health plan or other health insurance coverage, where permitted by law
    - You and/or one of your dependents' employers cease to offer benefits to the class of employees through which you (or one of your dependents) had coverage
    - You and/or one of your dependents were enrolled under an HMO or other group or individual plan or arrangement that will no longer cover you (and/or one of your dependents) because you and/or one or your dependents no longer reside, live or work in its service area

In addition, you may enroll yourself and/or your dependents in the Medical Benefit Option if one of the following events occurs:

- You have a new dependent as a result of your marriage, common law marriage, or declaration of a Company-Recognized Domestic Partnership (for the CORE Option), your child's birth, adoption or placement for adoption with you. In the case of these events, coverage is retroactive to the date of the event.

As an employee, you may enroll yourself and request enrollment for your new Spouse, Common Law Spouse, or Company-Recognized Domestic Partner (for the CORE Option) and any new Dependents within 60 days of your marriage or declaration. You may request enrollment for a new Child within 60 days of his or her birth, adoption or placement for adoption. If you miss the 60 day deadline, you are not able to enroll and you will have to wait until the next Annual Enrollment period to enroll yourself and/or your Dependent. In addition, you must submit proof of the dependents' eligibility to American Airlines Benefits Service Center within 31 days of the date the documentation is requested by the American Airlines Benefits Service Center.

You must already be enrolled or enroll yourself in benefits in order to elect coverage for your Dependents. If your Spouse, Common Law Spouse, or Company-Recognized Domestic Partner (for the CORE Option) is not enrolled in a Medical Benefit Option on the date of birth, adoption, or placement for adoption of a Dependent, you may enroll yourself and request enrollment for your Spouse, Common Law Spouse, or Company-Recognized Domestic Partner (for the CORE Option) in a Medical Benefit Option when you enroll a Child due to birth, adoption or placement for adoption. To request special

enrollment or obtain more information, contact American Airlines Benefits Service Center (see "Contact Information" in the Reference Information section).

Special Enrollment for Medicaid and CHIP

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

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

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 or Life Event.

Life Events

You also may change certain elections mid-year if you experience a Life Event and your change is consistent with that event. Allowable changes vary by the type of Life Event you experience.

You must register the Life Event within 60 days of the event with the American Airlines Benefits Service Center. You must submit proof of the dependent's eligibility to the American Airlines Benefits Service Center within 31 days of the date the documentation is requested. Proof of eligibility will not be considered unless it is submitted after the date you receive the request from the American Airlines Benefits Service Center. Note that the request will come in the form of an email and/or a mailing to your address on file. **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 until you experience another Life Event, whichever happens earlier, to make changes to your benefits.

When you experience a Life Event, remember these guidelines:

- Most Life Events are processed online through the American Airlines Benefits Service Center. Visit Life Events on Jetnet for a complete

list of all Life Events and the correct procedures for processing your changes.

- If you register your Life Event within 60 days of the event (as applicable), your changes are retroactive to the date the Life Event occurred (or the date Proof of Good Health is approved, as applicable).
- The Company reserves the right to request documented proof of dependent eligibility criteria for benefits at any time. If you do not provide proof of eligibility when requested, or if any of the information you provide is not true and correct, your actions may result in termination of benefits coverage.
- Any change in your cost for coverage applies on the date the change is effective.

Retroactive contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.

- If you experience a Life Event within 60 days of the end of the Plan Year, you cannot change your election under the HCFSA, LPFSA, and DCFSA, or enroll in these 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, Company-Recognized Domestic Partner or Eligible Dependent Child dies	**Medical[1], Dental, and Vision:** You lose a Spouse/Company-Recognized Domestic Partner or Eligible Dependent Child: Stop coverage for your lost Spouse/ Company- Recognized Domestic Partner/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/Company-Recognized Domestic Partner results in loss of eligibility under your Spouse's/Company-Recognized Domestic Partner plan. You gain a Spouse/Company-Recognized Domestic Partner/Eligible Dependent Child: Start coverage for yourself, your Spouse/Company- Recognized Domestic Partner, and/or your Eligible Dependent Child. Stop coverage for yourself and/or your Company-Recognized Domestic Partner/Eligible Dependent Child if you gain coverage under new Spouse's/Company- Recognized Domestic Partner plan. You may change Medical Benefit Options. Change in your, your Spouse's/Company- Recognized Domestic Partner or your Eligible Dependent Child's employment: If you/your Spouse/Company-Recognized Domestic Partner or your Eligible Dependent Child gain eligibility under the other employer's plan, you can drop yourself, your Spouse/Company-Recognized Domestic Partner, and/or your Eligible Dependent Child. If you/your Spouse/Company-Recognized Domestic Partner or your Eligible Dependent Child lose eligibility or employer contribution under the other employer's plan, you can add yourself, your Spouse/Company-Recognized Domestic Partner, 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, except for the HMO Medical Benefit Options.
You or your Spouse/Company-Recognized Domestic Partner 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 if your name is listed as a parent. You should not wait to receive the baby's Social Security number or official birth certificate. These documents may take more than 31 days to arrive and prevent you from starting coverage effective on the baby's birth date. To add an adopted child to your benefit coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective the date the child is placed with you for adoption and is not retroactive to the child's date of birth.	
You get legally married (including common law marriage), divorced, legally separated, or have your married annulled OR You declare a Company-Recognized Domestic Partner or that relationship ends	
You change your employment with an employer other than the Company OR Change in Spouse's/Company-Recognized Domestic Partner Eligible Dependent Child's employment or other health coverage OR	

[1] *Whenever "Company-Recognized Domestic Partner" is mentioned under the heading "Medical" in this chart, you may only make this change for the CORE Option. You may not make this change for any other Medical Benefit Option.*

If You Experience the Following Life Event…	Then, You May be Able to…
Your Spouse's/Company-Recognized Domestic Partner Eligible Dependent Child's employer no longer contributes toward health coverage OR Your Spouse's/Company-Recognized Domestic Partner Eligible Dependent Child's employer no longer covers employees in your Spouse's/Eligible Dependent Child's position	Contact your HMO for eligibility – eligibility is determined by the HMO. **Optional Short-Term Disability (Flight Attendants, FSEs SimPs, and FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and PAFCA):** Start/Stop coverage for yourself only. If you enroll for the first time, coverage is for a duration of two (2) years **Company-provided Short-Term Disability (for OMSSS):** No changes allowed **Voluntary Term Life Insurance:** Increase/Decrease your coverage (for increase, you may have to provide Proof of Good Health) **Spouse/Company-Recognized Domestic Partner Term Life Insurance:** Start/Stop coverage **Child Term Life Insurance:** Start/Stop coverage **AD&D/VPAI Insurance:** Start/Stop coverage for yourself • Increase/Decrease coverage for yourself **Spouse/Company-Recognized Domestic Partner AD&D Insurance:** Start/Stop coverage for eligible Spouse/Company-Recognized Domestic Partner Increase/Decrease for eligible Spouse/Company-Recognized Domestic Partner **Child AD&D Insurance:** Start/Stop coverage Increase/Decrease coverage **Health Flexible Spending Accounts:** If you lose a Spouse/Eligible Dependent Child: Stop/Decrease contributions If you gain a Spouse/Eligible Dependent Child: Start/Increase contributions (if incentives or contributions have been deposited to an HSA, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision, regardless of the plan selection)

If You Experience the Following Life Event…	Then, You May be Able to…
	If you, your Spouse or your Eligible Dependent Child gain eligibility under another employer's Health FSA plan: Stop/Decrease contributions If you, your Spouse or your Eligible Dependent Child lose eligibility under another employer's Health FSA plan: Start/Increase contributions. Cannot reduce to an amount less than what has already been deducted or paid. **Dependent Care Flexible Spending Account:** Increase/Decrease contributions
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 Benefit Options If the dependent marries and enrolls in his/her Spouse's/Company-Recognized Domestic Partner employer group health plan	**Medical, Dental, and Vision:** Stop coverage for your Spouse/Company- Recognized Domestic Partner/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, except for the HMO Medical Benefit Option. Contact your HMO for eligibility – eligibility is determined by the HMO. **Optional Short-Term Disability (for Flight Attendants, FSEs, SimPs, and FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and PAFCA):** No changes allowed **Company-provided Short-Term Disability (for OMSSS):** No changes allowed **Voluntary Term Life Insurance:** Increase/Decrease your existing coverage (for increase, you must provide Proof of Good Health) **Spouse/Company-Recognized Domestic Partner Term Life Insurance:** Start or stop coverage. **Child Term Life Insurance:** Start or stop coverage. **AD&D/VPAI Insurance:** Start/Stop coverage for yourself • Increase/Decrease coverage for yourself **Spouse/Company-Recognized Domestic Partner AD&D Insurance:** Start/Stop coverage for eligible Spouse

If You Experience the Following Life Event…	Then, You May be Able to…
	Child AD&D Insurance Start/Stop coverage **Health Flexible Spending Accounts:** Stop/Decrease contributions Cannot reduce to an amount less than what has already been deducted or paid Cannot make changes in the last 60 days of the Plan Year **Additionally:** Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible Dependent's address.
Your dependent Child attains age 13 or he or she or no longer requires Dependent Day Care OR Your elderly parent or Spouse/Company-Recognized Domestic Partner who is incapable of caring for himself/herself no longer meets the definition of "dependent" under the Dependent Care FSA or no longer requires Dependent Day Care.	**Dependent Care Flexible Spending Account:** Reduce/Stop Dependent Care Flexible Spending Account contributions. No other changes to benefits are allowed
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.
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, except for the HMO Medical Benefit Option.

If You Experience the Following Life Event…	Then, You May be Able to…
	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. **Health Flexible Spending Accounts:** Start/Increase as long as it is not within 60 days of the end of the Plan Year
You, or your Eligible Dependents enroll in Medicare or Medicaid or CHIP coverage	**Medical, Dental, and Vision:** Stop coverage for you or the affected Eligible Dependent.
You, or your Eligible Dependents lose Medicare, Medicaid or CHIP coverage	**Medical, Dental, and Vision:** Start coverage for yourself and the affected Eligible Dependent.
You, or your Eligible Dependents become eligible for Medicaid or CHIP coverage	**Medical, Dental, and Vision:** Start coverage for yourself and the affected Spouse/Company-Recognized Domestic Partner or Eligible Dependent Child. If you're adding a Spouse/Company-Recognized Domestic Partner 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, except for the HMO Medical Benefit Option.
You, your Spouse/Company-Recognized Domestic Partner or your Eligible Dependent Child become eligible for/lose eligibility for and become enrolled/dis-enrolled 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/Company-Recognized Domestic Partner if he/she loses eligibility Stop coverage for your Spouse/Company-Recognized Domestic Partner 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 home AND alternate/benefit addresses on the *Update my Information* page of Jetnet. Contact other organizations such as the American Airlines Credit Union directly to update your contact information. Provide your new address and current emergency contact numbers to your manager/supervisor, as well. If you are enrolled in the CORE, STANDARD, or HIGH COST COVERAGE Medical Benefit Option and you move to a location where the CORE, STANDARD, or HIGH COST COVERAGE Medical Benefit Option is available, you will stay enrolled in CORE, STANDARD, or HIGH COST COVERAGE 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 CORE, STANDARD or, HIGH COST COVERAGE Medical Benefit Option Network is not available, you must choose another Medical Benefit Option (OUT-OF-AREA), or you may waive coverage if you have other coverage (such as your Spouse's employer- sponsored plan). Contact American Airlines Benefits Service Center and a representative will assist you with your election. If you are enrolled in an HMO or in the CORE, STANDARD, or HIGH COST COVERAGE Medical Benefit Option and you do not process your relocation Life Event within 60 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 CORE. If you move or relocate to a new location within the last two (2) 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. **Optional Short-Term Disability (Flight Attendants, FSEs, SimPs, and FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and PAFCA):** Start coverage for yourself only if you had no access to this coverage in your prior state Stop coverage for yourself if your new state prohibits OSTD coverage **Company-provided Short-Term Disability (for OMSSS):** No changes allowed **Voluntary Term Life Insurance:** No changes allowed **Spouse/Company-Recognized Domestic Partner Term Life:** No changes allowed **Child Term Life:** No changes allowed **AD&D/VPAI Insurance:** No changes allowed **Spouse/Company-Recognized Domestic Partner AD&D/VPAI:** No changes allowed **Child AD&D/VPAI:** No changes allowed **Flexible Spending Accounts:** No changes allowed
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/Company-Recognized Domestic Partner coverage • Stop Eligible Dependent Child coverage **Optional Short-Term Disability (Flight Attendants, FSEs, SimPs, and FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and PAFCA):** Stop coverage **Company-provided Short-Term Disability (OMSSS):** No changes allowed **Voluntary Term Life Insurance:** Stop coverage **Spouse/Company-Recognized Domestic Partner Term Life:** Stop coverage **Child Term Life:** Stop coverage **AD&D/VPAI Insurance Benefit:** Stop coverage **Spouse/Company-Recognized Domestic Partner AD&D/VPAI:** Stop coverage **Child AD&D/VPAI:** Stop coverage **Flexible Spending Accounts:** Stop/Decrease Health FSA contributions Stop/Decrease Dependent Care FSA contributions Cannot reduce any FSA to amount lower than what has been deducted or paid Cannot make changes in the last 60 days of the Plan Year
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; however, you will be required to provide Proof of Good Health for certain benefits (e.g. Voluntary Term Life Insurance, Short Term Disability, etc.).

If You Experience the Following Life Event…	Then, You May be Able to…
	Access the American Airlines Benefits Service Center, register your "Return to Work" Life Event and make selections or changes to your benefits. If you return within 30 days, you will be placed back in the elections you were in prior to your leave unless you experience another change in status event. **Medical, Dental, and Vision:** Start/Resume coverage for yourself Start coverage for your Spouse/Company-Recognized Domestic Partner • Start coverage for your Eligible Dependent Child **Optional Short-Term Disability (Flight Attendants, FSEs, Simps, FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and PAFCA):** Start/Resume coverage for yourself; Proof of Good Health is required **Company-provided Short-Term Disability (OMSSS):** No changes allowed **Voluntary Term Life Insurance:** Start/Resume coverage for yourself; Proof of Good Health is required Increase/Decrease coverage for yourself; for increase, Proof of Good Health is required **Spouse/Company-Recognized Domestic Partner Term Life Insurance:** Start/Resume coverage; Proof of Good Health is required Increase/Decrease coverage; for increase, Proof of Good Health is required **Child Term Life Insurance:** Start/Resume coverage **AD&D/VPAI Insurance:** Start/Resume coverage for yourself • Stop/Decrease coverage for yourself **Spouse/Company-Recognized Domestic Partner AD&D/VPAI Insurance:** Start/Stop coverage Increase/Decrease coverage **Child AD&D/VPAI Insurance:** Start/Stop coverage

If You Experience the Following Life Event…	Then, You May be Able to…
	Flexible Spending Accounts: Start/Increase contributions Stop/Decrease contributions Special rules apply to the Health FSAs if your leave was FMLA leave You can resume contributions without making up contributions you missed (coverage will be correspondingly reduced), or You can resume contributions plus make up contributions you missed (coverage will resume at the level you elected).
You change from part-time to full-time employment or full-time to part-time employment	**Optional Short-Term Disability Insurance (Flight Attendants, FSEs, SimPs, and FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT and PAFCA):** Start coverage for yourself; Proof of Good Health is required • Minimum duration of enrollment is 2 years **Company-provided Short-Term Disability (OMSSS):** No changes allowed **Voluntary Term Life Insurance:** Start/Resume coverage for yourself; Proof of Good Health is required Stop coverage for yourself Increase/Decrease coverage for yourself; for increase, Proof of Good Health is required **Spouse/Company-Recognized Domestic Partner Term Life Insurance:** Start/Resume coverage; Proof of Good Health is required Stop coverage **Child Term Life Insurance:** Start/Resume coverage Stop coverage **AD&D/VPAI Insurance:** Start/Stop coverage for yourself • Increase/Decrease coverage for yourself **Spouse/Company-Recognized Domestic Partner AD&D Insurance:** Start/Stop coverage • Increase/Decrease coverage **Spouse/Company-Recognized Domestic Partner VPAI Insurance:** Start/Stop coverage

If You Experience the Following Life Event…	Then, You May be Able to…
	Increase/Decrease coverage **Child AD&D/VPAI Insurance:** Start/Stop coverage **Flexible Spending Accounts:** No changes allowed
You or your Eligible Dependent are newly eligible for COBRA	**Medical, Dental** Change Medical Benefit Option Change Dental Option **Health Care Flexible Spending Account** Decrease contributions Cannot reduce to an amount less than what has already been deducted or paid
You die	**Continuation of Coverage:** Your Eligible Dependents can either contact your manager/supervisor or 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 *Eligibility and Enrollment* section. **Review:** The information you receive regarding continuation of coverage through COBRA. **Contact:** American Airlines Benefits Service Center for information on retirement.
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/Company-Recognized Domestic Partner 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, except for the HMO Medical Benefit Option. Contact your HMO for eligibility – eligibility is determined by the HMO. **Optional Short-Term Disability (Flight Attendants, FSEs, SimPs, and FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and PAFCA):**

If You Experience the Following Life Event…	Then, You May be Able to…
	Start/Stop coverage for yourself; Proof of Good Health is required • Minimum duration of enrollment is 2 years **Company-provided Short-Term Disability (for OMSSS):** No changes allowed **Voluntary Term Life Insurance:** Increase/Decrease your coverage with Proof of Good Health **Spouse/Company-Recognized Domestic Partner Term Life Insurance:** Start/Stop coverage **Child Term Life Insurance:** Start/Stop coverage **AD&D/VPAI Insurance:** Start/Stop coverage for yourself • Increase/Decrease coverage for yourself **Spouse/Company-Recognized Domestic Partner AD&D Insurance:** Start/Stop coverage for eligible Spouse/Company-Recognized Domestic Partner Increase/Decrease for eligible Spouse/Company-Recognized Domestic Partner **Child AD&D Insurance:** Start/Stop coverage **Health Flexible Spending Accounts:** Changes are allowed only to the extent that the change in workgroup affects Health Flexible Spending Account eligibility Start/ Stop Health Flexible Spending Accounts Increase/Decrease contributions (if incentives or contributions have been deposited to an HSA, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision, regardless of the plan selection) Cannot reduce to an amount less than what has already been deducted or paid **Dependent Care Flexible Spending Account:** Increase/Decrease contributions
You, your Spouse, Company-Recognized Domestic Partner 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:	**Medical Coverage:** Start coverage for yourself Note that you must enroll in the coverage in order to elect coverage for your

If You Experience the Following Life Event…	Then, You May be Able to…
• 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	Spouse/Company-Recognized Domestic Partner and/or Eligible Dependent Child. Start coverage for your affected Spouse/Company-Recognized Domestic Partner 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.
The cost of dependent care changes (only if the change is imposed by a dependent care provider who is not your relative)	**Dependent Care Flexible Spending Account:** Increase/decrease contributions
You, your Spouse/Domestic Partner, or your Eligible Dependent Child enroll in other employer-sponsored coverage.	You may make the following changes if they are on account of, and correspond with, the change made under the other employer-sponsored coverage: **Medical, Dental, and Vision:** Stop coverage for yourself, Spouse/Domestic Partner, and Eligible Dependent Child **Optional Short-Term Disability (Flight Attendants, FSEs, SimPs, and FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and PAFCA):** Stop coverage for yourself **Company-provided Short-Term Disability (for OMSSS):** No changes allowed **Voluntary Term Life Insurance:** Stop or Decrease your existing coverage **Spouse/Domestic Partner Term Life Insurance:** Stop coverage **Child Term Life Insurance** Stop coverage **AD&D/VPAI Insurance:** Stop or decrease coverage for yourself **Spouse/Domestic Partner AD&D Insurance:**

If You Experience the Following Life Event…	Then, You May be Able to…
	Stop or decrease coverage for your eligible Spouse/Domestic Partner **Child AD&D Insurance:** Stop or decrease coverage **Health Flexible Spending Accounts:** No changes allowed **Dependent Care Flexible Spending Account** Stop or Decrease contributions
You, your Spouse/Domestic Partner, or your Eligible Dependent Child stop coverage under other employer-sponsored coverage.	You may make the following changes if they are on account of, and correspond with, the change made under the other employer-sponsored coverage: **Medical, Dental, and Vision:** Start coverage for yourself, Spouse/Domestic Partner, and Eligible Dependent Child **Optional Short-Term Disability (Flight Attendants, FSEs, SimPs, and FCTIs represented by the TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT, and PAFCA):** Start coverage for yourself **Company-provided Short-Term Disability (for OMSSS):** No changes allowed **Voluntary Term Life Insurance:** Increase your existing coverage (Proof of Good Health may be required) **Spouse/Domestic Partner Term Life Insurance:** Start coverage (Proof of Good Health may be required) **Child Term Life Insurance** Start coverage **AD&D/VPAI Insurance:** Start or increase coverage for yourself **Spouse/Domestic Partner AD&D Insurance:** Start or increase coverage for your eligible Spouse/Domestic Partner **Child AD&D Insurance:** Start or increase coverage **Health Flexible Spending Accounts:** No changes allowed **Dependent Care Flexible Spending Account** Increase contributions

If Your Dependent(s) Lose Eligibility Under the Plan But You Process Your Life Event after the Deadline

If your dependent(s) lose eligibility under the Plan (e.g. divorce), you must register a Life Event or contact American Airlines Benefits Service Center to remove the ineligible Dependent(s) from your coverage — even if you have missed the 60 day deadline.

If you contact American Airlines Benefits Service Center after the 60 day deadline, you will be able to remove your dependent(s) from coverage, but the effective date is the loss of eligibility date (e.g. legal effective date of the divorce).

You will not receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified American Airlines Benefits Service Center of their ineligibility. In addition, the coverage for your dependent(s) will be retroactively terminated and any claims paid under the Plan will be reversed.

Important: If you do not register a Life Event, notify American Airlines Benefits Service Center of your dependent(s) losing eligibility and request your dependent(s) be solicited for COBRA within the 60 day time frame, the dependent(s) will lose their right to continue coverage under COBRA, so it is important that you are timely in registering your dependent(s)' removal from coverage within the 60 day time frame.

If Your Dependents Gain Eligibility Under the Plan But You Process Your Life Event after the Deadline

If you miss the 60 day deadline and the event occurred in the current year, you must wait until the next Annual Enrollment Period to add your dependents or experience another Life Event.

If you miss the 60 day deadline and the event occurred in the previous year, you may add dependents to your file but you may not cover them under your benefits, make any changes to existing dependents, or make any Benefit Option changes. (Adding the dependent to your file lists the dependent as eligible to be enrolled at the next Annual Enrollment, but does not enroll him or her in benefits currently.)

When Coverage Ends

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

- The day that your employment ends;
- The date a Plan or Benefit Option terminates;
- The last day for which required contributions were paid;
- The date you or a dependent is no longer eligible for this coverage;
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan.

Your surviving Spouse will be ineligible for coverage on the date he or she remarries. Your surviving Company-Recognized Domestic Partner will be ineligible for coverage on the date he or she enters into a new domestic partnership or marries.

If you have elected medical coverage for your Spouse/Company-Recognized Domestic Partner and Children and you die as an active employee, your dependents' medical coverage will continue for 90 days at no contribution cost. Your covered dependents are also eligible to continue Medical, Dental, and Vision Benefit Option coverage for up to 36 months under COBRA Continuation Coverage at the full COBRA rate, if they had these benefits at the time of your death. The 90 days of coverage are part of the 36 months of COBRA coverage. See the "COBRA" section for further information.

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

In addition to the above rules, if you are covered under an HMO, your HMO coverage terminates on the date when:

- **Your employment terminates.** If your employment terminates, you may be eligible to continue HMO coverage under COBRA. You may also apply for individual HMO coverage. You will automatically be solicited for continuation of your HMO coverage under COBRA by Alight Solutions, the COBRA administrator.
- **You leave the service area.** You must register this move as a Life Event on the Benefits Service Center and enroll in another HMO (if available) or self-funded Medical Benefit Option. Contact American Airlines Benefits Service Center within 60 days of your move. If you do not notify American Airlines Benefits Service Center of your move, you will be enrolled in the default Medical Benefit Option for your workgroup and will receive a confirmation statement indicating your new coverage.
- **You retire.** If you retire while covered by an HMO, your coverage will change.

See the Retiree Medical Benefit Guide for your workgroup eligibility. HMO membership is not currently available to retirees unless you live in Puerto Rico. Retirees in Puerto Rico may enroll in the Triple-S HMO.

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

Note: If you or your covered Eligible Dependent reaches age 65 or becomes eligible for Medicare while covered under an HMO, most HMOs allow you to continue coverage.

Coordination of benefits with Medicare applies. The HMO is primary and Medicare is secondary as long as you are an active employee (see "Coordination of Benefits" in the Additional Health Benefit Rules section).

Medical Benefits

Medical Benefits Options Overview

Network/Claim Administrator

How the CORE, STANDARD, and HIGH COST COVERAGE Medical Benefit Options Work

How the OUT-OF-AREA Medical Benefit Option Works

How the HMO Medical Benefit Option Works

Cost-Sharing by Medical Benefit Option

Covered Expenses

Excluded Expenses

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

Filing Claims

Pre-Certifying Care for Certain Medical Services

Wellness Resources

Employee Assistance Program (EAP)

Additional Rules that Apply to Your Medical Coverage

Medical Benefit Options Overview

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

The Plan includes the following Medical Benefit Options:

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

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

You may choose from the following coverage levels:

- Employee Only
- Employee + Spouse (or Employee + Company-Recognized Domestic Partner, for the CORE Option)
- Employee + Child(ren)
- Employee + Family

Your dependents must be enrolled in the same Medical Benefit Option that you are enrolled in. If you waive coverage, your dependents cannot be enrolled in coverage. See the Eligibility section for additional rules. Note: You may choose to enroll your Company-Recognized Domestic Partner and his/her Children into the CORE Medical Benefit Option only.

Network/Claim Administrator

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

Network/Claim Administrator Responsibilities

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

Your Network/Claim Administrator offers a Network of Physicians, hospitals and other medical service Providers that have agreed to charge negotiated rates for medical services. The negotiated rates save you and the Company money when you or your covered dependent needs medical care and chooses an In-Network Provider.

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

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, access your Accolade member portal or call Accolade.

Continuity of Care (Keeping a provider you go to now)

You may have to find a new provider when:

(1) The Plan's network changes and the provider you have now is not in the new network; or

(2) You are already enrolled in the Plan and your provider stops participating in the Plan's network.

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care. A continuing care patient is an individual who is undergoing treatment for one of the following: a serious and complex condition; institutional or inpatient care; pregnancy; terminal illness; or scheduled to undergo nonelective surgery. If you are pregnant and have entered your second trimester, this will include the time required for postpartum care directly related to the delivery. Routine procedures, minor Illnesses and elective Surgical Procedures generally are not covered under this provision.

You will be notified if you become entitled to continuity of care, and you will be given the opportunity to submit a request for continuity of care. If your request is approved to keep going to your current provider, you will be informed how long you can continue to see the provider. Generally, you will receive such continuity of care for a period of 90 days or the date on which you are no longer a continuing care patient, whichever is earlier. Reimbursement for approved continuity of care will be at the applicable In-Network Provider benefit level.

Who is my Network/Claim Administrator

The Plan's CORE, STANDARD, and HIGH COST COVERAGE Medical Benefit Options are administered by two Network/Claim Administrators:

- Blue Cross and Blue Shield of Texas (BCBS)
- UMR

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

Your Network/Claim Administrator is determined by the ZIP code of your alternate/benefits address on record. If you do not have an alternate/benefits address listed in the Update my Information page of Jetnet, your Network/Claim Administrator is based on your home address on record. The map of the Network/Claim Administrators by state can be found on my.aa.com.

Relocation and my Network/Claim Administrator

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

When you move from one Network/Claim Administrator to another, you may have a need for transition of care. If your Network/Claim Administrator changes and you or a covered family member has a serious illness, or you or your Spouse is in the 14th (or later) week of pregnancy, you can ask your new Network/Claim Administrator to evaluate your need for transition of care. This allows you to continue with your current Provider at the In-Network benefit level for a period of time, even if that Provider is not part of the Network for your new Network/Claim Administrator. Contact your Accolade Health Assistant for more information. Go to my.aa.com to learn more.

Accolade

Accolade is an independent, healthcare concierge company partnering with the Plan to provide eligible employees and their Eligible Dependent(s) enrolled in the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options with the support needed to make good healthcare choices, navigate a complex healthcare system, and get the most from their Plan benefits.

Accolade's phone number is on the back of your medical ID card if you are enrolled in the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options. Accolade does not replace BlueCross BlueShield or UMR as your Network/Claim Administrator; however, if you need customer service support related to your medical benefits, you will call Accolade.

Accolade Health Assistant

Beyond the above, Accolade offers the **Accolade health assistant program**. This program will provide personalized support:

- Your own health assistant: Accolade delivers a confidential, personalized health care experience through its Accolade health assistant program. You and your Eligible Dependent(s) enrolled in CORE, STANDARD, HIGH COST COVERAGE, and OUT- OF-AREA Medical Benefit Options will have your own dedicated Accolade health assistant who will be your single point-of-contact for all of your questions about benefits under the Plan. Your Accolade health assistant is also an expert in helping you navigate the health care system generally and helping with your specific health decisions. So, your Accolade health assistant can help with your health care questions, big or small, including helping you find an In-Network Provider or help answer questions like:
    - Will this procedure be covered?
    - Why was I billed for this test?
    - I just got diagnosed with diabetes, what should I do next?
    - Where is the closest In-Network pharmacy?
    - What does my prescription drug benefit cover?
    - How do I file a claim for benefits?
    - What questions should I ask my doctor?
    - What other American Airlines benefit programs might be helpful in my situation?

This program is provided at no additional cost to you.

- **Experts:** Supporting Accolade's health assistants is an even bigger team of professionals, including behavioral health clinicians, registered nurses, provider search specialists, claims specialists, pharmacists and a medical director. All this expertise readily available to your health assistant means you'll get the answers you need quickly and easily. Accolade does not practice medicine or provide patient care. So, if you have a medical emergency, you should still contact 911 immediately.
- **Outreach:** Your Accolade dedicated health assistant may reach out to you. For example, your Accolade health assistant may reach out to

offer help before and after a hospital stay, or ask how they can help with your health care needs. It may be an occasional check-in or something more regular depending on your health needs and what you're comfortable with. All communications are handled in strict confidence. If you would prefer Accolade not contact you, then let them know.

Contacting Accolade

Accolade is here to help you find your way. So, if you are ever unsure of who to contact or where to go with a Plan or health related question, Accolade should be your first call.

- Accolade health assistants can be reached Monday-Friday, 7 a.m.-10 p.m. CST at 1(833) 346 3929 (FIND-WAY). You can also visit your Accolade member portal via my.aa.com or download the Accolade mobile app to contact Accolade via secure message at any time, and they'll return your message during their normal business hours.
- If your need is urgent and outside of Accolade's normal business hours, you can still connect with the team via the 24/7 nurse line using the same number 1(833) 346 3929 (FIND-WAY). Nurses are on call to help you with any urgent care questions during those unexpected hours. Of course, you should always call 911 in an emergency.

Confidentiality, Privacy and Other Important Information About Accolade

Accolade is a service provider of the Plan retained to help you and your family navigate your health benefits and to assist the Plan Administrator in promoting efficient use of Plan resources in accordance with Plan terms. Accolade does not work for BCBS or UMR, or any of the providers in their networks. To deliver a highly personalized service, your Accolade health assistant will have access to your BCBS, UMR and CVS Caremark information, including medical and prescription drug claims. Accolade is bound by HIPAA and other federal and state privacy laws to safeguard your information and use it only for the purposes for which it was disclosed. See the "Notice of Privacy Rights" section for information about how your protected health information or PHI may be used or disclosed under the privacy and security rules of HIPAA.

Accolade is NOT your Network/Claim Administrator. Accolade does not process health care claims or determine Medical Necessity. Although Accolade is available to assist you, Accolade is not ultimately responsible for claims decisions, claims payment or medical necessity determinations. The official Plan Documents and claims decisions by the Network/Claim Administrator will govern in the event of a conflict between (1) any oral or written representations by Accolade and (2) official plan documents or claims decisions by the Network/Claim Administrator.

Accolade is not a medical provider and does not provide medical care. Statements that Accolade makes about medical conditions or treatments or about health providers are not, and should not be construed or relied upon as, medical advice, medical care, or

recommendations to seek treatment with a particular provider. If you have a medical emergency, please call 911 immediately.

Accolade might contact you about its services or offerings, invite you to participate in surveys concerning its performance, or for other purposes. For some purposes, you have the right to ask Accolade not to contact you.

Centers of Excellence Surgery

SurgeryPlus is a network of high-quality surgery providers, known as centers of excellence, partnering with the Plan to provide eligible employees and their Eligible Dependents enrolled in the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options with access to surgery providers. Benefits of SurgeryPlus also include payment consolidation and one-on-one guidance and support as you prepare for, undergo and recover from surgery.

How the CORE, STANDARD and, HIGH COST COVERAGE Medical Benefit Options Work

The CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options offer a Network of preferred Physicians, hospitals and other medical service Providers that have agreed to charge negotiated rates for covered medical services. However, you may use any qualified licensed Physician.

If you use an In-Network Provider, the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF- AREA Medical Benefit Options will pay your covered medical expenses at a higher level of benefit. When you use an In-Network Provider, you pay only a (i) Co-Pay or (ii) Deductible and Co-Insurance for most services. Your Accolade Health Assistant can help you find In-Network Providers.

Because In-Network Providers may change at any time, you should confirm that your Provider or facility is part of the Network when you make an appointment and before you receive services. Your Accolade Health Assistant can also confirm that a Provider remains In-Network.

If you choose to use an Out-of-Network Provider, the payment will be calculated based on the Maximum Out-of-Network Charge (MOC), and the CORE, STANDARD, and HIGH COST COVERAGE Medical Benefit Options will pay your covered medical expenses at a lower level of benefit compared to the In-Network rate. If you are in the OUT-OF-AREA Medical Benefit Option, your Co-Insurance percentage remains the same for In-Network or Out- Of-Network services. After you meet the annual Out-of-Network Deductible, the CORE, STANDARD, and HIGH COST COVERAGE Medical Benefit Options pay 60 percent of Out-of-Network eligible expenses, up to the MOC, for most Medically Necessary services. The MOC is the amount that your Network/Claims Administrator will use in determining how much the Plan will pay toward out of Network services. The MOC applies to the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options.

Out-of-Network Provider Exceptions

Covered Expenses rendered by an Out-of-Network Provider are subject to special payment rules described below when a:

(1) Covered Person receives emergency services for an Emergency Medical Condition.

(2) Covered Person receives services by an Out-of-Network Provider in an In-Nework facility.

(3) Covered Person receives covered air ambulance services.

Specifically, Covered Expenses rendered by an Out-of-Network Provider are generally paid at the "Surprise Billing Reimbursement Rate" (i.e., a rate calculated in accordance with ERISA § 716) when a:

(1) Covered Person receives emergency services for an Emergency Medical Condition. In this case, the cost share will be based on the recognized amount calculated in accordance with ERISA § 716. The cost share will not be greater than the amount that would have been charged if such services were provided by an In-Network Provider. If you receive these services, the Out-of-Network Providers cannot balance bill you.

(2) Covered Person receives certain items and services by an Out-of-Network Provider in an In-Network facility. In this case, the cost share will generally be based on the recognized amount calculated in accordance with ERISA § 716. The cost share will generally not be greater than the amount that would have been charged if such services were provided by an In-Network Provider. If you receive these services, the Out-of-Network Providers cannot balance bill you, unless you give written consent.

(3) Covered Person receives covered air ambulance services. In this case, the cost sharing will be based on the lesser of the qualifying payment amount (calculated in accordance with ERISA § 716) or the billed amount for the services. The cost share requirements will be the same requirements that would apply if the services were provided by an In-Network Provider of air ambulance services. If you receive these services, the Out-of-Network Providers cannot balance bill you.

- **MOC for Out-of-Network Providers:** Except as provided under ERISA section 716, which applies to certain emergency services and certain charges by nonparticipating providers practicing at in-network facilities, the MOC for individual Out-of-Network Providers is either a rate negotiated by the Network/Claims Administrator, or, if no negotiated rate exists, 140 percent of the rate that the federal Medicare program would pay for the service.
- **MOC for Out-of-Network Facilities:** Except as provided under ERISA section 716, which applies to certain emergency services and certain charges by nonparticipating providers practicing at in-network facilities, the MOC for Out-of-Network facilities will be limited to 140

percent of the amount the federal Medicare program would have paid for the same service, or an amount based on 60 percent of the reasonable and customary charge as determined by your Claims Administrator using its internal claims databases.

Your Network/Claims Administrator will determine the MOC based on this formula. In addition to the percentage of Co-Insurance you must pay under the terms of the Plan, you may be responsible for any amount your Out-of-Network Provider or facility charges over the MOC.

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

- If the claim is for care in an Emergency Medical Condition (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options will treat the Out-of-Network Provider's full billed charge as an eligible expense.
- If the claim is for care in a "network gap" (where the nearest source of appropriate medical treatment is greater than the Network/Claim Administrator's Network gap mile limit), and the covered person has received prior approval from the Network/Claim Administrator, the Medical Benefit Option will treat the Out-of- Network Provider's full billed charge as an eligible expense.
- If the claim is for care in a "clinical gap", the Medical Benefit Option will treat the Out-of-Network Provider's full billed charge as an eligible expense, as long as In- Network Providers in the area with the same credentials cannot provide the specific treatment that a patient needs.
- If the Network/Claim Administrator is unable to determine the MOC based on Medicare reimbursements, the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Option will treat 75 percent of the Network/Claim Administrator's contracted In-Network rate (i.e. the average for the region/market) as an Eligible Expense for an Out-of-Network Provider.
- A claim for certain charges by nonparticipating providers practicing at in-network facilities and for air ambulance charges will be paid pursuant to ERISA section 716.

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

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

- Care received for certain services from nonparticipating providers practicing at in-network facilities will be paid pursuant to ERISA section 716.

Go online or call Accolade for more information and to access a list of In-Network Providers.

How the OUT-OF-AREA Medical Benefit Option Works

Employees who do not have access to Network Providers that meet the guidelines determined by the Network/Claim Administrator will have OUT-OF-AREA coverage as a Medical Benefit Option. OUT-OF-AREA coverage offers a preferred Provider Network of Physicians, hospitals and other medical service Providers that have agreed to charge negotiated rates for medical services. You may use any qualified licensed Physician, but you will only receive the negotiated rate discount if you use a preferred Provider. This negotiated rate is automatic when you present your medical ID card to a preferred Provider. In addition to negotiated rates, preferred Providers, in most cases, will file your claims for you. You receive a bill for only the remaining amount that you are responsible for paying, such as your Deductible or Co-Insurance amounts.

Because preferred Providers may change at any time, you should confirm that your Provider or facility is part of the Network when you make an appointment and before you receive services. Your Accolade Health Assistant can help find a preferred Provider and also confirm that a Provider remains In-Network.

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

- If you go to an In-Network hospital but receive services from a Provider who is not a preferred Provider, you will receive the In-Network negotiated rate for hospital charges; however, the Physician's fee (which is separate from the hospital charges) is not eligible for the In-Network negotiated rate with the exception of certain services described in ERISA section 716.
- If you use an In-Network Physician or hospital, charges for your lab or X-ray services may not be eligible for the In-Network negotiated rate if your Physician or hospital uses a lab that is not part of the Network. Note, some lab and X-ray services performed in a hospital may be contracted out to an Out-of-Network Provider.

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

How the HMO Medical Benefit Option Works

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

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

HMOs are entities separate from the Company that contract with the Company to provide medical benefits under the Plan. Because each HMO is an independent organization, the benefits, restrictions and conditions of coverage vary from one HMO to another. The Company cannot influence or dictate the coverage provided.

If you enroll in an HMO, you will receive information from the HMO describing the services and exclusions of that HMO. Review this material carefully. Benefits provided by the HMO often differ from benefits provided under the other Medical Benefit Options offered by the Company.

In general, features of HMOs include:

- A Network of Providers,
- A PCP who coordinates your covered medical care,
- Covered preventive care, and
- No claims to file.

If you elect an HMO, you will not receive medical coverage through the CORE, STANDARD, HIGH COST COVERAGE, 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. In addition, Accolade services that are available to participants in the self-funded Medical Benefit Options are generally not available to you or your dependents while you are enrolled in an HMO.

Cost-Sharing by Medical Benefit Options

Note: All of the medical services and supplies described in the Schedule of Medical Benefits chart below must be Medically Necessary in order to be covered by the Plan. See the Glossary for the definition of Medically Necessary.

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

Important Facts For You To Know About The Medical Benefit Options Chart...	
Co-Insurance	This is the percentage of covered expenses that you're required to pay. When you see a percentage referenced in the Medical Benefit Options chart, it is the Co-Insurance that is your financial responsibility. **Medical Co-Insurance applies once the Deductible has been met**.
Co-Payment, Co-Pay	This is the flat dollar amount of covered expense that you're required to pay. When you see a flat dollar amount in the Medical Benefit Options chart ($200 or less, and associated with Physician's visits, maternity care, emergency room expense, etc.), it is the Co-Pay that is your financial responsibility. This amount is applied to your Out-of-Pocket Maximum, but not your Deductible.

Deductible	For most covered expenses, you must meet your elected Medical Benefit Option's annual (calendar year) Deductible amount before you start receiving benefits. Certain covered expenses, however, may be payable even if you haven't yet met your Deductible for the calendar year. This includes preventive services and Co-Pays, except Co-Pays for the emergency room. The Medical Benefit Options chart references those particular expenses that are payable whether or not you've met your Deductible. Unless the covered expenses in the chart specifically state that benefits are payable even if you haven't met your Deductible for the calendar year, you should know that you have to meet your Deductible before benefits can be paid. Only covered expenses can be used to meet your Deductible amount. Co-Pays for covered expenses (for Physician visits, emergency room, maternity care), and Prescription drug Co-Insurance amounts do NOT count toward your satisfaction of the Deductible for the calendar year. **Facts about the family annual Deductible:** The family Deductible limits apply if more than one person is covered in the Medical Benefit Option. **STANDARD/HIGH COST COVERAGE/OUT-OF-AREA Medical Benefit Option:** The family Deductible is satisfied when you have paid all your, and your covered dependents', covered expenses equal to the individual Deductible for each covered person. If there are two (2) people covered then, each person must reach the individual Deductible amount before the family Deductible is satisfied and then the Medical Benefit Option will begin to pay its percentage of the covered expenses If there are three (3) or more people covered under your family coverage, three (3) members of your family have to reach the individual Deductible amount before the family Deductible is satisfied and then the Medical Benefit Option will begin to pay its percentage of the covered expenses. You do not have to meet the family Deductible amounts under the STANDARD, HIGH COST COVERAGE or OUT-OF-AREA Medical Benefit Options in order for your Medical Benefit Option to begin paying its percentage for a family member that has met his/her individual Deductible. **CORE Medical Benefit Option:** If more than one (1) person is covered under the CORE Medical Benefit Option, the family Deductible must be met before the CORE Medical Benefit Option starts to pay benefits. Covered expenses from any and all covered persons can be used to meet the annual Family Deductible.

Medical Necessity	ALL of the medical services and supplies described in the Medical Benefit Options chart must be Medically Necessary in order to be determined to be covered expenses. If those services and supplies are not Medically Necessary, they cannot be covered by the Plan. See the Glossary for the definition of Medical Necessity.
Out-of-Pocket/Out-of-Pocket Maximum	This is the portion of covered expenses that you have to pay each Plan Year before expenses are payable at 100 percent. Out-of-Pocket Maximum never includes expenses that are excluded from coverage, or expenses that exceed the Maximum Out-of-Network Charge limits for Out-of-Network services. For the STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options, your Co-Pays and Co-Insurance count toward your Out-of-Pocket Maximum. Your Deductible does not count toward your Out-of-Pocket Maximum. In- Network and Out-of-Network Out-of-Pocket Maximums are accumulated separately. For the CORE Medical Benefit Option, the Deductible and any applicable Co-insurance count toward your Out-of-Pocket Maximum. In-Network and Out-of-Network Out-of-Pocket Maximums are accumulated separately. **Facts about the individual Out-of-Pocket Maximum:** Only each covered individual's portion of covered expenses can be used to meet his/her individual annual Out-of-Pocket Maximum. **Facts about the family Out-of-Pocket Maximum:** In families consisting of two (2) members, each person must reach the individual Out-of-Pocket Maximum before his or her expenses are payable at 100 percent. In families consisting of three (3) or more members, if the family Out-of- Pocket Maximum is met cumulatively, expenses are payable at 100 percent for all members of the family even if the individual Out-of-Pocket Maximums have not been met by each member.

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		High Cost Coverage Medical Benefit Option		OOA Medical Benefit Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network		
Annual (Calendar Year) Deductibles, Out-of-Pocket Limits, and Maximum Medical Benefit								
Individual Coverage Annual Deductible[2]	$850	$3,000	$1,500	$4,000	$400	$1,550	$850	
Family Coverage Annual Deductible[3]	$2,550	$9,000	$3,000	$8,000	$1,200	$4,650	$2,550	
Individual Coverage Out-of-Pocket Maximum	$2,850	$9,000	$4,000	$12,000	$2,400	$7,550	$2,850	
Family Coverage Out-of-Pocket Maximum	$7,550	$24,000	$8,000	$24,000	$6,200	$19,650	$7,550	
Individual medical maximum benefit	*Unlimited*							
Preventive Care								
Annual routine physical exams	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you	
Well-Child care	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you	
COVID-19 Preventive Services See Covered Expenses section for details and limitations. *This information is current during the public health emergency declared by the*	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you	

[2] Co-pays do not apply to Deductible
[3] There is an individual out-of-pocket maximum of $6,850 under family coverage.

Secretary of Health and Human Services as a result of COVID-19.								
Medical Care								
Physician's office visit (including x-ray and lab work)	$30 per visit (deductible does not apply)	40%	20%	40%	$25 per visit (deductible does not apply)	40%	20%	
Telehealth office visit provided by Doctor on Demand	$20 per visit (deductible does not apply)	Not covered	$59 per visit until deductible is satisfied, then 20%.	Not covered	$20 per visit (deductible does not apply)	Not covered	$20 per visit (deductible does not apply)	
Specialist's office visit	20%	40%	20%	40%	$60 per visit (deductible does not apply)	40%	20%	
Retail/Convenience clinic	$30 per visit (deductible does not apply)	40%	20%	40%	$25 per visit (deductible does not apply)	40%	20%	
Urgent Care Clinic, lab, x-ray, and other charges made by the Urgent Care clinic	20%	40%	20%	40%	$100 per visit (deductible does not apply)	40%	20%	
Gynecological care *(see* **Mammogram** *for coverage information on routine screening or diagnostic mammograms, See* **Pregnancy** *for coverage information on pregnancy and maternity care)*	No cost to you for annual preventive exam; $30 per visit to an OB/GYN diagnostic visit (deductible does not apply)	40% for treatment of illness/injury and preventive exam	No cost to you for annual preventive exam; 20% for treatment of illness/injury	40% for treatment of illness/injury and preventive exam	No cost to you for annual preventive exam; $25 per visit to an OB/GYN diagnostic visit (deductible does not apply)	40% for treatment of illness/injury and preventive exam	No cost to you for annual preventive exam; 20% for an OB/GYN diagnostic visit	

Preventive Pap tests: routine screening	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you	
Diagnostic Pap tests: test performed for a medical problem	No cost to you if performed in the Physician's office. Otherwise 20%	40%	20%	40%	No cost to you if performed in the Physician's office. Otherwise 20%	40%	No cost to you if performed in the Physician's office. Otherwise 20%	
Preventive Mammogram/Colonoscopy: routine screening done according to national age and frequency specific guidelines and regardless of where the service is performed	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you	
Non-Preventive/Diagnostic Mammogram/Colonoscopy: screening not done according to national age and frequency specific guidelines or test performed for a medical problem	No cost to you if part of office visit or at an independent facility. 20% if performed in Outpatient hospital setting	40%	No cost to you if part of office visit or at an independent facility. Otherwise 20%	40%	No cost to you if part of office visit or at an independent facility. 20% if performed in Outpatient hospital setting	40%	No cost to you if part of office visit or at an independent facility. 20% if performed in Outpatient hospital setting	
Pregnancy and Maternity Care: <u>OB-GYN's Charges Only.</u> *Includes prenatal and postnatal care, and delivery charges*	Routine prenatal care, no cost to you. All other services, 20%	40%	Routine prenatal care, no cost to you. All other services, 20%	40%	Routine prenatal care, no cost to you. All other services, $150 per pregnancy (deductible does not apply)	40%	Routine prenatal care, no cost to you. All other services, 20%	

Pregnancy and Maternity Care: *Hospital and Other Ancillary Charges Only.* *Includes labor/delivery and postnatal expenses*	20%	40%	20%	40%	20%	40%	20%	
Second surgical opinions in a Physician's office No cost if ordered by the Plan or Network/ Claim Administrator	20% if elected by participant	40% if elected by participant	20% if elected by participant	20% if elected by participant	$60 per visit if elected by participant (deductible does not apply)	20% if elected by participant	20% if elected by participant	
Expert Medical Opinion *provided by Second MD*	No cost to you	Not Covered	No cost to you	Not Covered	No cost to you	Not Covered	No cost to you	
Chiropractic Care *Maintenance care is not covered*	20%	40%	20%	40%	$60 per visit (deductible does not apply)	40%	20%	
Speech, physical, occupational, restorative and rehabilitative therapy, if Medically Necessary *Educational Services are not covered*	20%	40%	20%	40%	20%	40%	20%	
COVID-19 Tests and Related Services See Covered Expenses section for details and limitations. *This information is current during the public health emergency declared by the Secretary of Health and Human Services as a result of COVID-19	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you	No cost to you
Allergy Care								

Physician's office visit for allergy care	PCP: $30 per visit (deductible does not apply) Specialist: 20%	40%	20%	40%	PCP: $25 per visit (deductible does not apply) Specialist: $60 per visit (deductible does not apply)	40%	20%	
Allergy testing, shots or serum	No cost to you if administered in physician's office	40%	20%	40%	No cost to you if administered in physician's office	40%	No cost to you if administered in physician's office	
Outpatient Services								
Diagnostic X-ray and lab (for non-urgent, non-immediate and non-emergent care)	No cost to you if performed at Physician's office or non-hospital imaging center/lab 20% if at hospital	40%	20%	40%	No cost to you if performed at Physician's office or non-hospital imaging center/lab 20% if at hospital	40%	No cost to you if performed at Physician's office or non-hospital imaging center/lab 20% if at hospital	
Outpatient surgery in Physician's office Pre-determination is recommended to ensure Medical Necessity; see "Predetermination"	PCP: $30 per visit (deductible does not apply) Specialist: 20%	40%	20%	40%	PCP: $25 per visit (deductible does not apply); Specialist: $60 per visit (deductible does not apply)	40%	20%	

Outpatient surgery in a hospital or free standing surgical facility Prior-authorization is recommended to ensure Medical Necessity; see "Prior Authorization"	20%	40%	20%	40%	20%	40%	20%	
Pre-Admission Testing	No cost to you if performed at a lab or Physician's office; 20% if at hospital	40%	20%	40%	No cost to you if performed at lab or in Physician's office; 20% if at hospital	40%	No cost to you if performed at lab or in Physician's office; 20% if at hospital	
Hospital Services – Preauthorization required for Out-of-Network Hospitalization. If you fail to get Pre-authorization you will pay a $250 penalty.								
Inpatient room and board	20%	40%	20%	40%	20%	40%	20%	
Intensive care unit and special care unit	20%	40%	20%	40%	20%	40%	20%	
Ancillary services, including radiology, pathology, operating room and supplies	20%	40%	20%	40%	20%	40%	20%	
Newborn Nursery care	20%	40%	20%	40%	20%	40%	20%	
Surgery and related expenses (such as anesthesia and Medically Necessary assistant surgeon)	20%	40%	20%	40%	20%	40%	20%	
Blood transfusions	20%	40%	20%	40%	20%	40%	20%	
Organ transplants Pre-authorization required *(no coverage without Pre-authorization)*	20%	40%	20%	40%	20%	40%	20%	

Emergency ambulance	20%	20%	20%	20%	20%	20%	20%	
Emergency Room	$100 co-pay PLUS 20%	$100 co-pay PLUS 20%; Non-emergency: $100 co-pay PLUS 40%	20%	20%; Non-emergency 40%	$200 co-pay PLUS 20%;	$200 co-pay PLUS 20%; Non-emergency: $200 co-pay PLUS 40%	20%	
Facts about Emergency Room Claims **STANDARD, PLUS, CORE, HIGH COST COVERAGE, OUT-OF-AREA Medical Benefits Options:** If you're admitted to the Hospital as an inpatient directly from the Emergency Room, the co-pay (varies by Medical Benefit Option) is waived, and you are only required to pay any amount needed to meet your Deductible and your percentage of the Covered Expense.								
Out-of-Hospital Care								
Convalescent and Skilled Nursing Facilities following hospitalization Within 15 days of hospitalization. Maximum of 60 days per illness/injury for In- Network and Out-of-Network facilities combined.	20%	40%	20%	40%	20%	40%	20%	
Home Health Care	20%	40%	20%	40%	No cost to you when approved by your Network Administrator	40%	20%	
Hospice Care	20%	40%	20%	40%	20%	40%	20%	
Other Services								
Tubal Ligation	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you	
Vasectomy	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you	
Erectile Dysfunction Medications	Covered under the Prescription Drug benefit, up to six (6) pills per month.							

Infertility medications or medications promoting fertility	Prescription medications to treat infertility are covered under the Prescription Drug benefit. The maximum benefit is $15,000 for the entire time the person is covered under an American Airlines Medical Plan.							
Infertility Treatment or Treatment promoting fertility (see Covered Expenses section for details) The maximum benefit is $25,000 for the entire time the person is covered under an American Airlines Medical Plan.	If PCP: $30 per visit (deductible does not apply) Otherwise 20%	Not covered	20%	Not covered	PCP: $25 per visit (deductible does not apply) Specialist: $60per visit (deductible does not apply)	Not covered	20%	
Radiation therapy and chemotherapy	20%	40%	20%	40%	No cost to you if in Physician office; Otherwise 20%	40%	20%	
Proton beam therapy *(*See Covered Expenses section for details) The maximum benefit is $50,000 per episode, as long as the individual is enrolled in an American Airlines Medical Plan.	20%	Not Covered	20%	Not Covered	20%	Not Covered	20%	
Kidney dialysis *(Participants on kidney dialysis may apply for Medicare on the basis of end-stage renal disease. The Plan will pay primary for the first 30 months. See the "Coordination of Benefits" section.)*	20%	40%	20%	40%	No cost to you if in Physician office; Otherwise 20%	40%	20%	
Supplies, equipment and Durable Medical Equipment (DME)	20%	40%	20%	40%	20%	40%	20%	

Facts about Supplies, Equipment, DME: Your cost is the percentage shown above, regardless of where the device is purchased, and is in addition to any Physician's visit costs you're required to pay								
Gender Reassignment Benefit								
Surgery One bilateral mastectomy or bilateral augmentation mammoplasty AND One genital revision surgery. This limit applies for the entire time the person is covered under an American Airlines Medical Plan.	20%	Not Covered	20%	Not Covered	20%	Not Covered	20%	
Non-Surgical Treatments Physician's visits Specialist visits Outpatient mental health care X-rays and lab work Retail Prescription drugs Mail order Prescription drugs	PCP: $30 per visit (deductible does not apply); Otherwise 20%	Not Covered	20%	Not Covered	PCP: $25 per visit (deductible does not apply) Specialist: $60 per visit (deductible does not apply)	Not Covered	20%	
Travel and Lodging Reimbursement								
Travel Expenses for Surgery at Center of Excellence for Transplant, Cancer, Congenital Heart Disease, or Bariatric For yourself and one caregiver to travel to the Center of Excellence and for time while you're hospitalized/receiving Medically Necessary Outpatient care following surgery.	No cost to you, up to $10,000 – see Covered Expenses section for details	Not Covered	No cost to you, up to $10,000 – see Covered Expenses section for details	Not Covered	No cost to you, up to $10,000 – see Covered Expenses section for details	Not Covered	No cost to you, up to $10,000 – see Covered Expenses section for details	

The maximum benefit described in this row applies for the entire time the person is covered under an American Airlines Benefit Plan.								
Mental Health Benefits								
Inpatient mental health care	20%	40%	20%	40%	20%	40%	20%	
Alternative Mental Health Care Center — residential treatment	20%	40%	20%	40%	20%	40%	20%	
Alternative Mental Health Care Center – intensive Outpatient and partial hospitalization	20%	40%	20%	40%	20%	40%	20%	
Outpatient mental health care	No cost to you for PCP or Specialist office visits; 20% for all other Outpatient services	40%	20%	40%	PCP: $25 per visit (deductible does not apply); Specialist: $60 per visit (deductible does not apply) 20% Outpatient services	40%	No cost to you for PCP or Specialist office visits; 20% for all other Outpatient services	
Marriage/ Couple/ Family Therapy	No cost to you for PCP or Specialist office visits; 20% for all other Outpatient services	40%	20%	40%	PCP: $25 per visit (deductible does not apply); Specialist: $60 per visit (deductible does not apply)	40%	No cost to you for PCP or Specialist office visits; 20% for all other Outpatient services	

					20% Outpatient services			
Chemical Dependency Benefits								
Inpatient chemical dependency rehabilitation	20%	40%	20%	40%	20%	40%	20%	
Outpatient chemical dependency rehabilitation	No cost to you for PCP or Specialist office visits; 20% for all other Outpatient services	40%	20%	40%	PCP: $25 per visit (deductible does not apply); Specialist: $45 per visit (deductible does not apply) 20% Outpatient services	40%	No cost to you for PCP or Specialist office visits; 20% for all other Outpatient services	

Covered Expenses

The Plan pays benefits for covered expenses, which are charges for procedures, services, equipment and supplies that are defined under the Plan as:

- Medically Necessary (as defined in the Glossary)
- Not excluded under the Plan – see "Excluded Expenses" later in this chapter, and
- Not in excess of Plan limits.

Some covered expenses may also require prior authorization. See "Prior Authorization" later in this chapter for more details. Some services are also subject to specific restrictions and limitations in addition to Co-Pay/Co-Insurance requirements, as described below. Please note that the services listed below are not an exhaustive list of covered services. Covered services include, but are not limited to, the services listed below. If you have a question on the coverage of a particular service, please contact Accolade (1-833-346-3929). The limitations and restrictions described below are in addition to other Plan rules, including Co-Pay/Co-Insurance and exclusions.

- **Applied Behavior Analysis (ABA) Therapy**: ABA Therapy is an Educational Service under the Plan. The Plan covers ABA Therapy for autism spectrum disorder. Even though these are educational in nature, these services must be Medically Necessary. In the case of ABA Therapy, the Plan will cover services that are provided by a licensed ABA provider, that are habilitative in nature and that are backed by credible research demonstrating that the services have a measurable and beneficial effect on the patient's health outcomes. You are required to obtain a Prior Authorization for ABA Therapy.
- **Acupuncture**: Treatment for illness or injury (performed by a certified acupuncturist) for diagnosed illness or injury, only when acupuncture treatment has been proven to be both safe and effective treatment for such diagnosed illness or injury. (Coverage does not include acupuncture treatment for conditions in which the treatment has not been proven safe and effective such as: glaucoma, hypertension, acute low back pain, infectious disease and allergies.)
- **Allergy care:** Charges for Physician's office visits, allergy testing, shots and serum are covered.
- **Ambulance:** Professional ambulance services and air ambulance to and from:
    - The nearest hospital qualified to provide necessary treatment in the event of an Emergency
    - The nearest hospital or convalescent Inpatient care

- An In-Network hospital, if you are covered under any Medical Benefit Option and your Network/Claim Administrator authorizes the transfer

Note: Ambulance services are only covered in an Emergency and only when care is required en-route to or from the hospital. Air ambulance services are covered when Medically Necessary services cannot be safely and adequately performed in a local facility and the patient's medical condition requires immediate medical attention for which ground ambulance services might compromise the patient's life.

- **Ancillary Charges:** Ancillary Charges, including charges for hospital services, supplies and operating room use.
- **Anesthesia expenses:** Anesthetics and administration of anesthetics. Expenses are not covered for an anesthesiologist to remain available when not directly attending to the care of a patient.
- **Assistant surgeon:** To determine whether an assistant surgeon is considered Medically Necessary, use the CheckFirst Pre-determination procedure.
- **Bariatric Surgery:** The Plan covers Bariatric Surgery. Prior Authorization is required. If you do not pre-authorize you might be subject to a $250 penalty, and you may be responsible for the full amount of the charges for the procedure or service if you do not meet the requirements for the surgery. This is a limited, one- time benefit for the entire time the patient is covered under an American Airlines Medical Plan. Bariatric Surgery includes Gastric Bypass (Roux-en-Y), Lap band, Gastric Sleeve and Duodenal Switch. To be eligible for Bariatric Surgery, the patient must be 18 years of age or older.
- **Blood:** Coverage includes blood, blood plasma and expanders. Benefits are paid only to the extent that there is an actual expense to the participant.
- **Chiropractic Care:** Coverage includes services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered.
- **Clinical Trials.** Routine patient costs otherwise covered by the Plan that are associated with participation in phases I-IV of Approved Clinical Trials (as further defined in the Glossary) (i.e., clinical trials that are federally funded and certain drug trials) to treat cancer, ALS 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 or otherwise payable or reimbursable by another party.

- **Colonoscopies (non-preventive – not within the U.S. Preventive Task Force A or B recommendations/diagnostic – required as part of a work-up for symptoms or a medical conditions):** Non-preventive/diagnostic colonoscopies are covered, regardless of age, under all Medical Benefit Options both In-Network and Out-of-Network.
- **Colonoscopies (preventive)**: In-Network, routine screening colonoscopies are covered under all Medical Benefit Options at 100 percent, as described in the

U.S. Preventive Services Task Force A or B recommendations. Note that the guidelines may be specific to gender, age, or your personal risk factors for a disease or condition. Please click here to view those recommendations.

- **Complications from Non-Covered Services**. Medical treatments and/or procedures to treat medical complications (i.e. diseases and/or illnesses) arising from non-covered services under the Plan are an Eligible Expense if they are otherwise an Eligible Expense under the Plan
- **Convalescent or Skilled Nursing Facilities**: To be eligible, the confinement in a Convalescent or Skilled Nursing Facility must begin within 15 days after release from the hospital for a covered Inpatient hospital confinement and be recommended by your Physician for the condition that caused the Hospitalization. Eligible expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a Convalescent or Skilled Nursing Facility, are under the continuous care of a Physician, and require 24-hour nursing care. Your Physician must certify that this confinement is an alternative to a hospital confinement and your Network/Claim Administrator must approve your stay. Maximum benefit is 60 days per illness or injury for Network and Out-of-Network facilities. Custodial Care, defined as care that assists the person in the normal activities of daily living and does not provide any therapeutic value in the treatment of an illness or injury, is not covered under the American Airlines Medical Plan.
- **Cosmetic surgery**: Expenses for cosmetic surgery are covered only if they are incurred under one of the following conditions:
    - As a result of a non-work-related injury.
    - For replacement of diseased tissue surgically removed.
    - As described in Gender Reassignment/Sex Changes section.

  Other cosmetic surgery is not covered. See Excluded Expenses.
- **COVID-19 Preventive Services: *** Any "qualifying coronavirus preventive service" (within the meaning of 29 CFR § 2590.715-2713) with no cost-sharing. A qualifying coronavirus preventive services means an item,

service or immunization that is intended to prevent or mitigate coronavirus disease 2019 and has a rating of A or B in the recommendation of the USPSTF or is recommended by the Advisory Committee on Immunization Practices of the CDC. The Plan will cover any qualifying coronavirus preventive service within 15 business days after the date of the recommendation.

- **COVID-19 Tests and Related Items and Services Ordered By an Attending Provider:***
    - COVID-19 Test(s): If your primary care provider or other medical professional orders or performs a COVID-19 test(s) because you have symptoms of COVID-19, because you were (or suspect you were) exposed to someone with COVID-19, or to confirm that you have an asymptomatic infection, such test(s) will be covered, as long as the test(s) has been approved by the Food & Drug Administration (FDA) or satisfies alternative standards under applicable law. However, COVID-19 Tests conducted to screen for general workplace health and safety, for public surveillance for SARS-COV-2, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 or another health condition, including periodic work or school testing, or for purposes of travel, are not covered.
    - Related Items and Services: The part of any office visit (including telehealth visits), urgent care or emergency room visit related to testing and/or diagnosis of COVID-19, but only if the visit results in an order for, or administration of, COVID-19 diagnostic testing.
    - Payment will be made for 100% of the negotiated rate (or if there is no negotiated rate, the cash price for such service that is listed by the provider on a public website) for COVID-19 Tests and Related Items and Services.

- **COVID-19 At Home Tests Not Ordered By An Attending Provider***
    - COVID-19 At Home Tests not ordered by an attending provider purchased on or after 1/15/22 for individual diagnosis or treatment (up to 8 tests per month per covered individual). For COVID-19 At Home Tests purchased during the period in which the Plan has a direct coverage program in place (i.e., a program under which participants may obtain Covid-19 Tests for free from a participating pharmacy by visiting in person or receiving direct shipment), reimbursement for tests that are purchased from other sources is limited to $12 per test ($24 if two tests are in a box). In all circumstances, COVID-19 At Home Tests must be purchased from an established retailer to be covered.

*This information is current during the public health emergency declared by the Secretary of Health and Human Services as a result of COVID-19.

- **Dental expenses for Dental examination, diagnosis, care and treatment of one or more teeth, the tissue around them, the alveolar process or the gums, only when care is rendered for:**
    - Accidental Injury(ies) to Sound Natural Teeth, in which both the cause and the result are accidental, due to an outside and unforeseen traumatic force,
    - Dental treatment due to Accidental Injury must begin within 12 months of the date of the accident, unless the member is under the age of 18 at the time of the injury.
    - If the Accidental Injury requires that you have Dental implants, the maximum benefit is $15,000 for the entire time the person is covered under an American Airlines Medical Plan.
    - Fractures and/or dislocations of the jaw, or
    - Cutting procedures in the mouth (this does not include extractions, Dental implants, repair or care of the teeth and gums, etc., unless required as the result of Accidental Injury, as stated in the first bullet above)
    - Dental procedures that are necessitated by either severe disease (including but not limited to cancer) or traumatic event, as long as the dental service is medically necessary and the service is incidental to and an integral part of service covered under the medical benefits of the Plan. Examples of services include, but are not limited to, the extraction of teeth prior to or following chemotherapy or radiation therapy of the head and neck. Treatment of oral tissues related to chemotherapy must be supported by documentation of a direct link between the destroyed bone or gums and the chemotherapy.
    - If the severe disease requires that you have Dental implants, there must be no other treatments, such as dentures or a bridge, available.
- **Dental anesthesia**: Dental anesthesia or sedation in conjunction with a dental procedure is covered if patient meets the following criteria:
    - Is under the age of five; or
    - Has a physical, developmental, intellectual, cognitive, or medically compromising condition or disability for which dental treatment under local anesthesia cannot be expected to provide a successful and safe result
    - Preauthorization is required. See QuickReview for Preauthorization procedures.

- **Detoxification**: Detoxification is covered as a chemical dependency condition.

Contact your Network/Claim Administrator for details.

- **Dietician services:** In-Network Dieticians services (i.e., consultations and training) are covered.
- **Durable Medical Equipment (DME):** Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Medical Benefit Option may, in its discretion, approve the purchase of such items instead of rental. Replacement of DME is covered only for mobility-related DME (i.e. wheelchairs) 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 (improved or deterioration) or due to the natural growth of a Child.

  Replacement of DME and/or components (such as batteries or software) resulting from normal wear and tear is not covered. Examples of DME are items such as CPAP or BiPAP machines, wheelchairs, hospital beds, nebulizers, oxygen concentrators, TENS units, passive range of motion devices, joint cooling devices, bone stimulators, custom orthotics, etc.

- **Emergency Medical Condition**: A medical condition involving acute symptoms (including severe pain) that are severe enough so a prudent layperson, with average knowledge of health and medicine, could reasonably expect that lack of immediate medical attention will result in:
  - Placing the person's health (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
  - Serious impairment to bodily functions; or
  - Serious dysfunction of any body organ or part.

  Treatment for an Emergency Medical Condition shall include coverage for emergency services as defined in ERISA section 716 and its underlying regulations, including items and services required for medical screening examinations, stabilization, and additional services, as medically necessary as required under ERISA.
- **Emergency room**: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. You must call your Network/Claim Administrator for QuickReview approval within 48 hours of an Emergency resulting in admission to the hospital.
- **Eyeglasses or contact lenses**: If cataract surgery is performed, coverage is available for the first pair of eyeglasses or contact lenses required after cataract surgery. For all other vision care, see the Vision Insurance Benefit Option section.

- **Facility charges:** Charges for the use of an Outpatient surgical facility when the facility is either an Outpatient surgical center affiliated with a Hospital or a freestanding surgical facility.
- **Family/Marriage/Couples Therapy**:
    - The Plan will cover counseling visits for you and your family (family therapy) or you and your Spouse (marriage therapy). Family therapy is a type of psychological counseling that can help family members improve communication and resolve conflicts. Marriage therapy is a type of psychological counseling that helps couples recognize and resolve conflicts and improve their relationships.
    - Only the employee needs to be a Plan participant in order for the service to be covered.
- **Gender Reassignment/Sex Changes:**
    - The Gender Reassignment Benefit (GRB) provides coverage for gender reassignment for the treatment of gender dysphoria.
    - If no In-Network provider is available within a reasonable distance of an employee's residence, a gap exception will need to be obtained. Contact Accolade for more information.
    - 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 an American Airlines Medical 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
    - $30,000 lifetime maximum benefit (for the entire time you are covered under an American Airlines Medical Plan).
    - $10,000 travel reimbursement (for the entire time you are covered under an American Airlines Medical Plan).
    - **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.
- **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 covered if Medically Necessary.
- **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-authorization for the GRB.** You must have approval from the Network/Claim Administrator **both** at the time you begin your treatment and at the time you are admitted for surgery. Your failure to obtain Prior Authorization **both** at the time you begin treatment and at the time you are admitted for surgery will result in denial of your claims. See "Prior Authorization" for additional information.

- **Hearing care:** Covered expenses include hearing exams performed by an audiologist or Physician and hearing aids, subject to a maximum benefit of $3,500 per hearing aid. Replacement hearing aids are allowed once every 36 months and the maximum benefit for replacement is $3,500 per hearing aid (as long as you are enrolled in an American Airlines Medical Plan). Cochlear implants and/or osseointegrated hearing systems are also covered.
- **Hemodialysis:** Coverage provided for hemodialysis.
- **Home Health Care:** Home Health Care, when your Physician certifies that the visits are Medically Necessary for the care and treatment of a covered illness or injury. Custodial Care is not covered. You should call your Network/Claim Administrator to initiate the QuickReview process.
- **Hospice Care:** Eligible expenses for the care and treatment of a terminally ill covered person. Expenses in connection with Hospice Care include both facility and Outpatient care. Hospice Care is covered when approved by your Network/Claim Administrator. You should contact your Network/Claim Administrator to initiate the QuickReview process.
- **Infertility Testing and Diagnosis:** Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease.
- **Infertility Treatment services or treatment promoting fertility (other than testing and diagnosis)**
    - This benefit is subject to an overall $25,000 maximum per person for the entire time the person is covered under an American Airlines Medical Plan
    - Infertility Treatment or treatment promoting fertility includes the following services and procedures, if prescribed by your attending physician:
        - Artificial Insemination (AI), Intrauterine Insemination (IUI), In-vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), Assisted Reproductive Technologies (ART), Intra Cytoplasmic Sperm Injection (ICSI) and other similar infertility procedures or procedures promoting fertility that are recommended by your attending physician.
        - Egg, embryo, and sperm cryopreservation, thawing, transfer and storage, as requested by the member. There is to be no limit on the number of months of storage, subject to the $25,000 maximum for the entire time the person is covered under an American Airlines

Medical Plan. Coverage is to be available for these services whether or not Medically Necessary.

- Reversal of a tubal ligation or vasectomy.

- The following limitations apply:
  - The service or procedure must be prescribed by the patient's In-Network Physician.
  - The service or procedure must be performed by an In-Network Provider (unless a network gap exception has been approved by the Network/Claim Administrator).
  - Expenses incurred by a donor or surrogate who is not the covered employee or the covered Eligible Dependent under the Plan are not Eligible Medical Expenses.
- There is no coverage for Pre-implantation Genetic Screening (PGS). However, there is coverage for Pre-implementation Genetic Diagnosis (PGD).
- See the "Excluded Expenses" section for Infertility Treatment services or services promoting fertility that are excluded from coverage.

- **Infertility medications:** Medications used to treat infertility or to promote fertility are covered by the self-funded Medical Benefit Options, subject to an overall maximum of $15,000 per person, for the entire time such person is covered under an American Airlines Medical Plan.
- **Inpatient room and board expenses:** Eligible expenses are based on the negotiated rates with that particular In-Network Hospital. For Out-of-Network, Eligible Expenses are determined based on the most common semiprivate room rate in that geographic area. Pre-certification is required for all Out-of-Network Hospitalizations. Failure to do so will result in a $250 penalty.
- Intensive care, coronary care or special care units (including isolation units): Coverage includes room and board and services and supplies.
- **Intrauterine Device (IUD):** Insertion or removal of an IUD. Covered as a contraceptive method, described under "Prescription Drugs" later in this section.
- **Laboratory or pathology expenses:** Coverage is provided for diagnostic laboratory tests. In-Network coverage depends on whether the care is received in a Hospital based setting or a Physician's office or laboratory facility. If you use an In-Network, non-hospital facility (Physician's office, lab, etc.), then these services are covered at 100 percent.

- Mammograms (including 3-D mammograms) (non-preventive – not within the U.S. Preventive Services Task Force A or B recommendations/ diagnostic - required as part of a work-up for symptoms or a medical condition): Non-preventive/diagnostic mammograms are covered, regardless of age, under all Medical Benefit Options both In-Network and Out-of-Network.
- **Mammograms (including 3-D mammograms) (preventive):** In-Network, routine screening mammograms are covered under all Medical Benefit Options at 100 percent, as described in the U.S. Preventive Services Task Force A or B recommendations. Note that the guidelines may be specific to gender, age, or your personal risk factors for a disease or condition. Please click here to view those recommendations:
- Mastectomy: Mastectomy and certain reconstructive and related services after a mastectomy are covered. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:
    - Reconstruction of the breast on which a mastectomy was performed,
    - Surgery or reconstruction of the other breast to produce a symmetrical appearance,
    - Services in connection with other complications resulting from a mastectomy, such as lymphedemas, and
    - Prostheses.
- **Medical supplies**: Covered medical supplies include, but are not limited to:
    - Oxygen, blood and plasma
    - Sterile items including sterile surgical trays, gloves and dressings
    - Needles and syringes
    - Colostomy bags
    - Diabetic supplies, including needles, chem-strips, lancets and test tape covered under the Prescription Drug benefit
    - Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered.
- **Mental health and chemical dependency care:** The Medical Benefit Options cover the following mental health and chemical dependency care:
    - **Inpatient mental health care**: When you use In-Network Providers under the Medical Benefit Options for

Hospitalization for a Mental Health Disorder, expenses during the period of Hospitalization are covered the same as Inpatient hospital expenses (see "Covered Expenses" in this section).

- **Alternative Mental Health Care Center – residential treatment**.

  Residential treatment is covered if:

  - The stay satisfies the criteria for Medical Necessity; or
  - The stay is required for successful completion of a program designed to satisfy FAA Regulations (14 CFR 67.401) pertaining to special issuance of medical certificate.

- **Outpatient mental health care**
  - Chemical dependency rehabilitation
    - Chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be Inpatient, Outpatient or a combination. There are no limits on the number of chemical dependency rehabilitation programs a participant may attend (regardless of whether the program is Inpatient or Outpatient).
    - You must obtain approval from the American Airlines On-Site Employee Assistance Program for all cases resulting from regulatory or Company policy violations. In all other instances, American Airlines On-Site Employee Assistance Program approval is not required for an Inpatient or Outpatient chemical dependency rehabilitation treatment.
    - The Medical Benefit Options do not cover expenses for a family member to accompany the patient being treated, although many Chemical Dependency Treatment Centers include family care at no additional cost.
  - **Detoxification**: Treatment is covered in the same way that other mental health and chemical dependency benefits are covered depending upon the type of services (i.e., Outpatient, In-Network; Outpatient, Out-of-Network; Inpatient, In-Network; Inpatient, In-Network; Inpatient, Out-of-Network; emergency services and pharmacy services).

- **Multiple Surgical Procedures**: Reimbursement for simultaneous Multiple Surgical Procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. In-Network surgeries are based on the Network Provider's contractor rates. Out-of-Network surgeries are based on Maximum Out-of-

Network Charge (MOC) Fee Limits. To determine the amount of coverage, contact Accolade to use the Pre-determination procedure.

- **Newborn Nursery care**: The hospital expenses for a newborn baby are considered under the baby's coverage, not the mother's. Therefore, the baby must be enrolled in coverage for his/her newborn claims to be covered. The hospital expenses for a newborn baby are covered, provided you timely process a Life Event. To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. If you miss the 60day deadline you will not be able to add your baby to your coverage until the next Annual Enrollment Period unless you experience another qualifying Life Event, even if you already have other Children enrolled in coverage. The filing or payment of a maternity claim does not automatically enroll the baby.
- **Penile prosthesis:** Surgical implantation of a penile prosthesis will be covered if the following conditions are met. All penile prosthesis require pre-authorization
    - Erectile dysfunction is due to one of the following:
        - Penile trauma
        - Spinal cord injuries
        - Sexual dysfunction as a result of treatment for prostate cancer, and
    - The following treatment has been exhausted:
        - Erectile dysfunction persisting for at least 6 months and,
        - A comprehensive history and physical exam has been completed, including appropriate lab work to determine the cause of the erectile dysfunction and,
        - There is a failure, contraindication or intolerance to FDA approved pharmacological remedies
- **Oral surgery:** Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process, only if it is Medically Necessary to perform oral surgery in a hospital setting rather than in a Dentist's office. The Medical Benefit Option will pay room and board, anesthesia and miscellaneous Hospital charges. Oral surgeons' and Dentists fees are not covered under the Medical Benefit Options. However, they may be covered under the Dental Benefit Options.
- **Outpatient surgery**: Charges for services and supplies for a surgical procedure performed on an Outpatient basis at a Hospital, Freestanding Surgical Facility or Physician's office. You should pre-

authorize the surgery through your Network/Claim Administrator to initiate the QuickReview process.

- **Physical or occupational therapy**: Restorative and Rehabilitative Care by a licensed physical or occupational therapist when ordered by a Physician.

Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered.

- **Physician's services**: Office visits and other medical care, treatment, surgical procedures and post-operative care for diagnosis or treatment of an illness or injury. The Medical Benefit Options cover office visits for certain preventive care, as explained under "Preventive Care," below.
- **Pregnancy**: Charges in connection with pregnancy, for employees, Spouses, Common Law Spouses, Company-Recognized Domestic Partners (for the CORE Option only), and covered Dependents of the employee. Prenatal care and delivery are covered when provided by a Physician or midwife who is registered, licensed or certified by the state in which he or she practices.
    - Routine prenatal expenses are covered at 100 percent In-Network. Labor, delivery and post-natal expenses are covered by the applicable Co-Insurance percentage.
    - Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority.
    - Prescription prenatal vitamin supplements are covered by Medical Benefit Options.
    - Federal law prohibits the Plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery. However, federal law does not require you to stay any certain length of time. If, after consulting with your Physician, you decide on a shorter stay, benefits will be based on your actual length of stay.
    - Employees enrolled in an HMO should contact their HMO.
- **Prescription drugs**: Prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a Physician or Dentist for treatment of your condition.
    - This includes preventive Over-the-Counter medications covered with a Prescription if required by PPACA. Please click here to view the PPACA preventive services requirements:

- The Plan is not required to cover preventive medications until the first Plan year (which begins on January 1) beginning on or after the date that is one year after the new recommendation or guideline is issued. For example, if the US Preventive Services Tasks Force issues an “A” or “B” recommendation for a preventive medication on February 15, 2020, the Plan is not required to cover the medication until January 1, 2022.
- Please call CVS Caremark for the most up-to-date list of preventive Over-the-Counter medications that are covered by the Plan.

- Prescriptions for the treatment of obesity or weight control are covered only for the diagnosis of morbid obesity.
- Oral contraceptive drugs, patches, implants, transdermal, and intravaginal contraceptives are covered if purchased through mail order or at any local CVS or Safeway-owned retail pharmacies.
- Medications provided, administered and entirely consumed in connection with care rendered in a Physician’s office are covered as part of the office visit with the exception of certain specialty medications that are only covered under the Prescription Drug benefit.
- Medications that are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy are covered as part of the facility’s Ancillary Charges.
- Medications that are administered as part of Home Health Care.
- Diabetic supplies, including insulin, needles, chem-strips, lancets and test tape. These diabetic supplies are covered up to 100 percent if you or your covered dependents are participating in the StayWell Rx Prescription Program, and you purchased them from Mail Order or the Smart 90 Program.
- Medications or products used for smoking or tobacco use cessation. 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).
- Prescription medications that treat infertility or promote fertility are covered, subject to an overall $15,000 maximum per

covered person for the entire time the person is covered by an American Airlines Medical Plan.

- Certain Hypertension, Diabetes and Asthma medications are covered at discounted rates if you or your covered Dependents are participating in the StayWell Rx Prescription Program.
- Certain types of medicines and drugs that are not covered by the Medical Benefit Options may be reimbursed under the Health Care Flexible Spending Accounts (see "Covered Expenses" in the *Health Care Flexible Spending Account* section).

- **Preventive care:** Covers preventive care, including well-child care, immunizations, routine screening mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages. Non- routine tests for certification, sports or insurance are not covered.
  - The Plan is a non-grandfathered group health plan that complies with the PPACA preventive care requirements.
  - Preventive care focuses on evaluating your current health status when you are symptom free.
  - Preventive services include those performed if you:
    - do not have symptoms and/or an existing condition that the screening is intended to diagnose
    - have had diagnostic screenings that were normal after which your Physician recommends future preventive screening
    - have a preventive service done that results in a therapeutic service done at the same time (e.g. polyp removal during a preventive colonoscopy)
  - The Company follows the USPSTF Grade A & B recommendations, CDC and HRSA guidelines for preventive care. To get a full list of In-Network preventive care covered at no cost to you, visit: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b- recommendations/ or https://www.healthcare.gov/preventive-care-benefits/
    - Except as otherwise noted, the Plan is not required to cover preventive services until the first Plan year (which begins on January 1) beginning on or after the date that is one year after the new recommendation or guideline is issued. For example, if the US Preventive Services Tasks Force issues an "A" or "B" recommendation for a

preventive service on February 15, 2020, the Plan is not required to cover it until January 1, 2022.

- Please call your Network/Claim Administrator for the most up-to-date list of preventive services that are covered by the Plan.

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

- **Private duty nursing care**: Coverage includes care by a licensed Nurse in a home setting.
- **Prostheses**: Prostheses (such as a leg, foot, arm, hand or breast) necessary because of illness, injury or surgery. Replacement prostheses are allowed once every 36 months unless 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) is covered for the treatment of prostate cancer and other diagnoses as determined by the Network/Claim Administrators' medical policy.
    - This benefit is subject to an overall maximum of $50,000 per episode when used to treat prostate cancer (as long as the individual is enrolled in an American Airlines Medical Plan). 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 charges.

- The following limitations apply:
  - The service or procedure must be performed by an In-Network Provider and be administered in 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 Prior Authorization. See "Prior Authorization" for additional information.
- Services received at an Out-of-Network Provider or Out-of-Network facility are excluded. See the "Excluded Expenses" section, "Proton Beam Therapy" for details.

- **Radiology (X-ray):** Examination and treatment by X-ray or other radioactive substances, imaging/scanning (MRI, PET, CAT and ultrasound), diagnostic laboratory tests and routine Mammography screenings for women (see "Mammograms" in this section for guidelines).
  - In-Network coverage depends on whether the care is received in a Hospital- based setting or a Physician's office or laboratory facility. If you use an In- Network, non-hospital facility (Physician's office, imaging center, etc.), then these services are covered at 100 percent.
- **Reconstructive surgery**: Surgery following an illness or injury, including contralateral reconstruction- to correct asymmetry of bilateral body parts, such as breasts or ears. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:
  - Reconstruction of the breast on which a mastectomy was performed,
  - Surgery or reconstruction of the other breast to produce a symmetrical appearance,
  - Services in connection with other complications resulting from a mastectomy, such as lymphedemas, and
  - Prostheses.
- **Retail Clinic Visits**: If you go to an In-Network retail clinic inside of retail pharmacies, the eligible expense is subject to the Physician's office visit Co-pay, or Deductible and Co-Insurance.
- **Sleep Studies:**
  - For employees: The Plan will cover sleep studies that are either home-based or facility-based/supervised, at your Physician's discretion.

- For Eligible Dependents: The Plan will cover sleep studies that are home- based or unsupervised. The Plan will only cover sleep studies that are facility-based/supervised if the Eligible Dependent attempts a home-based or unsupervised sleep study first. After that, the Plan may approve a facility-based/supervised sleep study.

- **Speech therapy:** Restorative and Rehabilitative Care and treatment for Loss or Impairment of Speech due to an illness, injury, or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered.
- **Spinal Fusion Surgery:** You must obtain prior authorization before the Plan will cover spinal fusion surgery.
- **Stand-by Surgeon**: Only covered when the procedure makes it Medically Necessary to have a stand-by surgeon, and when the stand-by surgeon is physically present at the facility. See the Pre-determination procedure for additional information.
- **Surgery:** When performed in a hospital, Freestanding Surgical Facility or Physician's office.
- **Telehealth**: The Plan will offer 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.
- **Temporomandibular joint dysfunction (TMJD):** Eligible expenses under the Medical Benefit Options include only the following:
    - Injection of the joints
    - Bone resection
    - Application of splints, arch bars or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion
    - Manipulation or heat therapy
    - Temporomandibular joint replacement, ONLY if ALL of the following conditions are met:
    - It is the treatment of last resort ("salvage" treatment)
    - It has been documented by clinical records that all other medically appropriate lesser treatments have been performed and have failed (and the failure is not due to patient non-compliance)

- The prosthetic implant system being used is a total implant system manufactured by either TMJ Concepts, Inc. or Walter Lorenz Surgical, Inc.
- The patient meets all generally accepted medical/surgical criteria for total replacement of the TMJ
- The TMJ replacement is not used on an Experimental or Investigational basis
- Note that crowns, bridges or orthodontic procedures for treatment of TMJD are **not** covered.

Transplants: Expenses for transplants or replacement of tissue or organs if they are not Experimental, Investigational, or Unproven Services. Benefits are payable for natural or artificial replacement materials or devices. Keep in mind that transplants must be Pre-authorized. The transplant will not be covered if Pre-authorization is not obtained.

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

However, use of an Out-of-Network facility will be covered at the Out-of- Network rate.

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

possible for Pre- authorization before contemplating or undergoing a proposed transplant.

- **Travel Reimbursement.** See "Travel and Lodging Reimbursement" for information about when travel and lodging expenses may be reimbursed.
    - **Artificial Cervical Disc Implantation.** Although disc implantation uses artificial disc materials, it is replacing the damaged natural disc tissue in the space between vertebrae in the spine and is categorized here as a transplant. It is subject to the same requirements as all other covered transplants. All of the following criteria must be met for the procedure to be covered:
        - The patient must use an FDA-approved prosthesis (if a two adjacent level implantation is planned, the prosthesis must be FDA-approved for use in a two-level procedure);
        - Implantation must be a either a single level in the cervical spine or two adjacent levels in the cervical spine;
        - Patient must be diagnosed with Degenerative Disc Disease with intractable radiculopathy (nerve root pain with weakness, numbness, movement difficulties) and/or myelopathy (inflammation causing neural deficit in the spinal cord);
        - Patient must be skeletally mature;
        - Patient must have either a herniated disc OR osteophyte formation;
        - Patient must have documented history of neck and/or arm pain and/or functional impairment at the corresponding cervical level; and
        - Patient must have failed at least six weeks of non-operative treatment.

The following transplants are covered if they are not Experimental, Investigational, Unproven or otherwise excluded from coverage under the Medical Benefit Options, as determined in the sole discretion of the Plan Administrator and its delegate, the Network/Claim Administrator:

Artery or vein Artificial Cervical Disk Implantation (see information above) Bone Bone marrow or hematopoietic stem cell Cornea Heart Heart and lung Heart valve replacements Implantable prosthetic lenses in connection with cataract surgery Intestine	Kidney Kidney and pancreas Liver Liver and kidney Liver and intestine Lung Pancreas Pancreatic islet cell (allogenic or autologous) Prosthetic bypass or replacement vessels Skin
This is not an all-inclusive list. It is subject to change. Contact Accolade for more information.	

- **Transportation expenses**: Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide Inpatient treatment not locally available. Only one round-trip is covered for any illness or injury and will be covered only if medical attention is required en-route.
    - For information on ambulance services, see “Ambulance” in this section.
- **Travel and Lodging Reimbursement:**
    - Travel and lodging assistance is only available if:
        - (1) You receive care at an eligible Center of Excellence (COE) for one of the following:
            - 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 Network/Claims

Administrator, even if you change administrators. This $10,000 maximum benefit applies for the entire time the person is covered under an American Airlines Medical Plan. To be eligible for reimbursement, travel must be over 50 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 Network/Claims Administrator. Contact your Network/Claim Administrator for instructions on receiving reimbursement for your expenses.

- **Tubal ligation and vasectomy**: These procedures are covered; Reversal of these procedures is covered under the infertility benefit only. See “Infertility Treatment services (other than testing and diagnosis),” above.
- **Urgent/Immediate Care**: Charges for services and supplies provided at an Urgent Treatment Clinic are covered.
- **Well-Child care**: Initial Hospitalization following birth, immunizations, and well- child care visits.
- **Wigs and hairpieces**: The wig must be prescribed by a Physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery or severe burns. This benefit is subject to the MOC Fee Limits, Deductibles, Co-Pays, Co-Insurance and Out-of-Pocket limits of the selected Medical Benefit Option. The maximum benefit available for wigs and hairpieces is $1,000 per episode (as long as the individual is enrolled in an American Airlines Medical Plan). Hair transplants, styling, shampoo and accessories are excluded.

Excluded Expenses

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

- **Allergy testing**: Specific testing (called provocative neutralization testing or therapy), which involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.
- **Alternative and/or Complementary Medicine**: Evaluation, testing, treatment, therapy, care and medicines that constitute Alternative or

Complementary Medicine, including but not limited to herbal, holistic and homeopathic medicine.

- **Claim forms**: The Plan will not pay the cost for anyone to complete your claim form.
- **Care not Medically Necessary**: All services, procedures, and supplies considered not Medically Necessary.
- **Cosmetic surgery**: Unless Medically Necessary and required as a result of Accidental Injury, surgical removal of diseased tissue, or as provided under the Gender Reassignment/Sex Changes benefit.
- **Cosmetic treatment**: Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction and sclerotherapy for varicose veins or spider veins).
- **Custodial Care**: Custodial Care is not covered.
- **Custodial Care items**: Custodial Care items such as incontinence briefs, liners, diapers and other items when used for custodial purposes are not covered, unless provided during an Inpatient confinement in a hospital or Convalescent or Skilled Nursing Facility.
- **Dietician services**: Dietician services are excluded if you use an Out-of- Network Provider. Contact your In-Network Provider to determine the services that are covered.
- **Ecological and environmental medicine**: See “Alternative and/or Complementary Medicine” in this section.
- **Educational Services**: The Plan does not pay the cost of Educational Services (except for ABA Therapy). This exclusion applies regardless of the condition being treated.
- **Experimental, Investigational, or Unproven Treatment**: Medical treatment, procedures, drugs, devices or supplies that are generally regarded as Experimental, Investigational, or Unproven Treatments.
- **Eye care**: Eye exams, refractions, eyeglasses, or the fitting of eyeglasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training and vision therapy.
- **Foot care**: Diagnosis and treatment of weak, strained, or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses, or toenails. (This exclusion does not apply to the removal of nail roots.)
- **Free care or treatment**: Care, treatment, services or supplies for which payment is not legally required.
- **Government-paid care**: Care, treatment, services or supplies provided or paid by any governmental plan or under any law when the coverage is not restricted to the government’s civilian employees

and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

- **Infertility Treatment services**: The following Infertility Treatment services or services promoting fertility are not covered:
    - Expenses related to a donor or surrogate, unless the donor or surrogate is a covered member of the Plan.
    - Experimental or Investigational Services or Supplies.
    - Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
- **Lenses:** No lenses are covered except the first pair of Medically Necessary contact lenses or eyeglasses following cataract surgery.
- **Massage therapy:** All forms of massage and soft-tissue therapy, regardless of who performs the service.
- **Medical records:** Charges for requests or production of medical records.
- **Missed appointments:** If you incur a charge for missing an appointment, the Plan will not pay any portion of the charge.
- **Non-Emergency or Non-Urgent Care While Traveling Outside the United States:** Any non-emergency or non-Urgent Care such as routine Physician care or preventive care, or care, treatment, or procedures that you arrange before you arrive in a foreign country, is not covered when you travel abroad, for employees on the U.S. payroll. Note that this exclusion does not apply to expatriates who are living abroad. Please see the section "Care While Traveling Out of the Country" for more information.
- **Nursing care**:
    - Care, treatment, services, or supplies received from a Nurse that do not require the skill and training of a Nurse
    - Private duty nursing care (at home) that is not Medically Necessary, or if medical records establish that such care is within the scope of care normally furnished by hospital floor Nurses
    - Certified Nurse's aides
- **Organ donation:** Expenses incurred as an organ donor when the recipient is not covered under the Plan. For additional information, see "Transplant" under "Covered Expenses."
- **Over-the-Counter-medication (OTC):** Over-the-Counter medications are not covered under the Medical Benefit Options, except preventive Over-the-Counter- medications covered with a prescription if required by PPACA.

- **Prescription Drugs**:
    - Drugs that are not required to bear the legend “Caution-Federal Law Prohibits Dispensing Without Prescription.”
    - Covered drugs in excess of the quantity specified by the Physician or any refill dispensed after one year from the Physician’s order.
    - Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy, if there is a prescription); however the Plan does provide coverage for folic acid and oral fluoride supplements in accordance with PPACA, if prescribed by a physician.
    - Drugs prescribed for cosmetic purposes (such as Minoxidil).
    - Drugs labeled “Caution-Limited by Federal Law to Investigational Use,” drugs not approved by the Food and Drug Administration (FDA), or Experimental drugs, even though the individual is charged for such drugs
    - Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis
    - Additional medications or products used for smoking or tobacco use cessation beyond the two, 90-day courses.
    - Prescription medications not FDA approved for the condition being treated
    - Prescription medications compounded with ingredients not approved by the US Food and Drug Administration (FDA); Prescription medications prescribed and/or utilized or administered in a manner other than what has been FDA-approved for the medication; Prescription medications utilized or administered with quantities, dosages, or routes of administration not approved by the FDA
- **Preventive care**: Not all preventive care may be covered. Consult with your Accolade Health Assistant to learn what preventive care is not covered.
- **Proton Beam Therapy**: Proton beam therapy is excluded if you use an Out-of-Network Provider or if you do not receive pre-certification approval from the Network/Claim Administrator. Coverage is also excluded when metastases are present.
- **Relatives**: Coverage is not provided for treatment by a medical practitioner (including, but not limited to: a Nurse, Physician, physiotherapist or speech therapist) who is a close relative (Spouse,

Child, brother, sister, parent or grandparent of you or your Spouse, including adopted and step relatives).

- **Reversal of tubal ligation and vasectomy**: Reversal of these procedures is not covered unless related to the infertility or fertility promotion benefit. See “Infertility Treatment services (other than testing and diagnosis),” under “Covered Expenses.”
- **Services related to occupation**: including, but not limited to: physical or Federal Aviation Administration exams, Department of Transportation exams, Occupational Health and Safety testing, performance testing and work hardening programs.
- **Speech therapy**: Except as described in “Covered Expenses,” expenses are not covered for losses or impairments caused by conditions such as learning disabilities, developmental disorders or progressive loss due to old age. Speech therapy of an educational nature is not covered.
- **Temporomandibular joint dysfunction (TMJD)**: Except as described in “Covered Expenses,” diagnosis or treatment of any kind for temporomandibular joint disease or disorder (TMJD), or syndrome by a similar name, including orthodontia, crowns, bridges or orthodontic procedures to treat TMJD.
- **Transportation**: Transportation by regularly scheduled airline, air ambulance or train for more than one round trip per illness or injury.
- **War-related**: Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.
- **Weight reduction**: Hospitalization, surgery, treatment and medications for weight reduction other than for approved treatment of diagnosed morbid obesity.
- **Wellness items**: Items that promote well-being and are not medical in nature and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas and health club memberships). Also excluded are:
    - Services or equipment intended to enhance performance (primarily in sports- related or artistic activities), including strengthening and physical conditioning
- **Wilderness/adventure therapy programs, residential or non-residentia**l: Programs of group and/or individual therapy (irrespective of whether the diagnosed conditions or psychiatric, substance use/abuse, relationship issues, or other behavioral issues) focused on outdoor therapy, adventure therapy, wilderness therapy, “survival” therapy, “boot camp” therapy, and/or similar type of treatment protocols and programs.

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

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

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

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

In the event that this does occur, your Deductibles and Out-of-Pocket Maximums **may or may not** carry over to your new Medical Benefit Option or Network/Claim Administrator. Please contact the American Airlines Benefits Service Center for more information. These are the general guidelines. **Note: They may differ based on your individual situation.**

If…	Your Deductible and Out-of-Pocket Maximum…
You transfer/relocate and you do not have to select a new Medical Benefit Option because your existing Medical Benefit Option is offered in your transfer/relocation area	**will** carry over
You transfer/relocate and you have to select a new Medical Benefit Option because your existing Medical Benefit Option is not offered in your transfer/relocation area	**will not** carry over
You declined coverage because you or your dependents had coverage elsewhere, and then that coverage was lost You want to add medical coverage for yourself and/or your dependents as a result of your marriage, birth/adoption of a Child Your other medical coverage was COBRA and you exhausted your COBRA coverage; Your other coverage was lost due to that Plan Sponsor's termination of its plan or if contributions were no longer paid for the other coverage Your other medical coverage was lost because you no longer lived in the service area.	**will not** carry over
You retire and move from active coverage to retiree coverage	**will not** carry over

If…	Your Deductible and Out-of-Pocket Maximum…
You or your dependent(s) move from active to COBRA continuation coverage	**will** carry over

Filing Claims

How to File a Claim

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

- Complete a Medical Benefit Claim Form. It is very important that you fully complete the 'other coverage' section of the form. Examples of other coverage include a Spouse's group health plan, Workers' Compensation, Medicare, TRICARE and no-fault motor vehicle insurance.
- Submit the completed form to your Network/Claim Administrator, along with all original itemized receipts from your Physician or other health care Provider. A cancelled check or credit card receipt is not acceptable. Each bill or receipt submitted to your Network/Claim Administrator must include the following:
    - Name of patient,
    - Date the treatment or service was provided,
    - Diagnosis of the injury or illness for which treatment or service was given,
    - Itemized description and charges for the treatment or service, and
    - Provider's name, address and tax ID number.
        - Make copies of the original itemized bill or receipt provided by your Physician, hospital or other medical service Provider for your own records.

All medical claims payments are provided to you with an Explanation of Benefits (EOB) explaining the amount paid. In most cases, the EOB will be mailed to you and the payment mailed to your Provider. EOBs are also available on your Network/Claim Administrator's website.

If you have questions about your coverage or your claim under your enrolled Medical Benefit Option, contact your Accolade Health Assistant (see "Contact Information" in the Reference Information section).

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

Claims Filing Deadline

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

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

Predetermining Care for Certain Medical Services

Predetermination of Benefits

A Pre-determination allows you and your provider to find out if:

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

To obtain a Predetermination, your provider may either submit a CheckFirst Pre-determination of Medical Benefits form before your proposed treatment or you may call Accolade for assistance to obtain a Pre-determination of benefits by phone or to request the Pre-determination form.

Please note that even if you or your provider, obtain a Predetermination, your Network/Claim Administrator reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different than the information submitted for Pre-determination of benefits. Claims are processed in order of receipt. Payment of a claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

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

For hospital stays, the Pre-determination does not pre-authorize the length of a hospital stay or determine Medical Necessity. Your provider must request pre-authorization for

the length of a hospital stay or medical necessity. Please call Accolade for assistance obtaining Prior Authorization. (see “Prior Authorization”).

The Predetermination list is determined by your Network/Claim Administrator and is subject to change based on their respective medical policies.

Prior Authorization

You or your Provider acting on your behalf may be required to request a Prior Authorization from your Network/Claim Administrator. If you are using In-Network Providers, your Provider will call for you. If you need assistance in requesting Prior Authorization, contact Accolade.

If you are using Out-of-Network Providers, you must call yourself (or a family member can call on your behalf). If your Physician recommends surgery or Hospitalization, ask your Physician for the following information if you intend to call yourself:

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

If your illness or injury prevents you from personally requesting Prior Authorization, any of the following may call on your behalf:

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

Your Network/Claim Administrator will tell you:

- Whether the proposed treatment is considered Medically Necessary and appropriate for your condition
- The number of approved days of Hospitalization

If you obtain Prior Authorization, your expenses are still subject to review and if not Medically Necessary, will not be covered under the Plan**. Failure to request a Prior Authorization will result in a $250 penalty per Out-of-Network Hospitalization.** For assistance requesting Prior-Authorization, contact Accolade. If you are covered by an HMO, contact your HMO before any Hospitalization.

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

If you are not discharged from the hospital within the authorized number of days, your Network/Claim Administrator consults with your Physician and hospital to verify the need for any extension of your stay. If you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness, you must contact your Network/Claim Administrator again to authorize any additional Hospitalization.

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

Care While Traveling Out of the Country

As part of your U.S. enrolled medical and dental coverage, emergency and Urgent Care will be covered under your elected Benefit Option when you travel out of the country.

Before leaving the country, contact Accolade or your Network/Claim Administrator for details on coverage and services:

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

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

Urgent or Immediate Care: If you need urgent or immediate (non-emergent) care, you should call Accolade for assistance. If it is after hours, seek treatment and call Accolade.

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

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

Biometric Screening

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

Employee Assistance Programs (EAP)

Employee Assistance Program (EAP)

The American Airlines EAP provides private, 24/7 resources to help you and your family with change, challenges, coping or crisis. All U.S.-based American Airlines 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, telephonic, or virtual counseling sessions per issue or concern per year. If you would like to continue to meet with your counselor after your four free sessions, please contact Accolade before beginning your counseling to ensure they are an in-network provider.

American Airlines On-Site Employee Assistance Program (EAP)

This program is primarily for employees to obtain care for substance abuse cases that involve Company policy or regulation violations. EAP management is required for all substance abuse cases that involve Company policy or governmental regulation violations.

For EAP managed cases, Medical Necessity is determined by the EAP. In these cases the EAP will work with your Network/Claim Administrator to locate an In-Network facility. The Medical Benefit Options will provide benefits for eligible Medically Necessary treatment and rehabilitation programs, regardless of whether 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 may be eligible from

the Medical Benefit Options. However, your job status may be impacted. See the EAP Policy.

For cases that are not EAP managed, Medical Necessity will be determined by your Network/Claim Administrator. This includes cases not related to Company policy or regulation violations, such as Spouse/Company-Recognized Domestic Partner and dependent cases. The benefit will be paid at the Medical Benefit Option benefit level. See "Mental Health Benefits" in the "Cost-Sharing by Medical Benefit Option" chart in Medical Benefit Options Overview section.

To contact the on-site EAP, call 1-833-721-2322.

Additional Rules That Apply to Your Medical Coverage

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

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

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

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

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

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

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

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

These benefits will be provided subject to the same Deductibles and Co-Insurance applicable to other medical and surgical benefits provided under this Plan. See the Cost-Sharing by Medical Benefit Option for further information.

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

Prescription Drug Program

[How the Prescription Drug Benefit works]
[Retail Drug Coverage]
[CVS Maintenance Choice Program]
[CVS Mail Order]

How the Prescription Drug Benefit Works

Prescription drug coverage is based upon a formulary. The amount of Co-Insurance you pay under the STANDARD, HIGH COST COVERAGE and OUT-OF-AREA Medical Benefit Options is based upon whether the medication is a generic drug, a preferred brand drug or a non- preferred brand drug.

Generic drugs are drugs that are chemically and therapeutically equivalent to the corresponding brand name drug, but cost less.

Preferred brand name drugs are CVS Caremark formulary drugs.

Non-preferred are brand names that are CVS Caremark non-formulary. They have preferred alternatives (either generic or brand) that are in the CVS Caremark formulary.

CVS Caremark is the Prescription drug administrator for the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options. Drugs prescribed by a Physician or Dentist may be purchased either at retail pharmacies or through the Mail Order Prescription Drug benefit. CVS Caremark has a broad Network of pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the https://www.caremark.com or call them at 1.844.758.0767.

The Plan has adopted guidelines for prescription drug coverage that were developed by CVS Caremark. Information regarding the applicable guidelines for the requested prescription drug may be obtained from CVS Caremark.

For the STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options, prescription drugs are payable before you've met your Deductible. For the CORE Medical Benefit Option, you must meet your Deductible before prescription drugs are payable.

Please note that for the STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options, if you select a brand name drug when a generic is available, you will pay the generic Co-Insurance plus the cost difference between generic and brand name prices.

For the CORE Medical Benefit Option, if you select a brand name drug when a generic is available and you have not yet met your Deductible, you will pay the cost of the generic drug plus the cost difference between generic and brand name. If you select a brand name drug when a generic is available and you have met your Deductible, you will pay generic Co-Insurance plus the cost difference between generic and brand name.

Retail Drug Coverage

Overview

To maximize your prescription drug benefit under the Plan, always try to have your Prescriptions filled at a Network pharmacy or through Mail Order. You must present your CVS Caremark ID card when you purchase Prescription drugs in order to receive the discounted medication rates and to have your pharmacy claim processed at the time of

purchase. If you do not present your CVS Caremark ID card at the time of purchase, you will have to pay the full cost. By showing your CVS Caremark ID card, the pharmacy will process your claim at the time of purchase and you will only pay your Co- Insurance portion. Showing your CVS Caremark ID card also allows your Out-of- Pocket pharmacy expense to be applied toward satisfaction of your annual Out-of- Pocket Maximum.

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

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

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		HIGH COST COVERAGE Medical Benefit Option		OOA Medical Benefit Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
Prescription Medication							
RETAIL Pharmacy[4] (typically a 30-day supply)	**Generic:** 20% Co-insurance ($10 min / $40 max) **Preferred Brand:** 30% Co-insurance ($30 min / $100 max) **Non-Preferred Brand:** 50% Co-insurance ($45 min / $150 max)		**In-Network:** 20% after Deductible **Out-of-Network:** 40% after Deductible		**Generic:** 20% Co-insurance ($10 min / $40 max) **Preferred Brand:** 30% Co-insurance ($20 min / $75 max) **Non-Preferred Brand:** 50% Co-insurance ($35 min / $90 max)		**Generic:** 20% Co-insurance ($10 min / $40 max) **Preferred Brand:** 30% Co-insurance ($30 min / $100 max) **Non-Preferred Brand:** 50% Co-insurance ($45 min / $150 max)
	Prescriptions are not subject to Deductible		**Certain preventive medications are not subject to Deductible**		**Prescriptions are not subject to Deductible**		

[4] You will pay the lesser of the Co-Insurance or full cost for all prescription purchases.

Filling Prescriptions for Retail Drugs

Follow these steps to fill Prescriptions:

- Network pharmacies**:**
    - Present your CVS Caremark ID card at the In-Network pharmacy
    - Pay your portion of the cost for the Prescription
    - For the CORE Medical Benefit Option: CVS Caremark will notify your Network/Claim Administrator of all amounts applied to the Deductible and Out-of-Pocket Maximum if you present your CVS Caremark prescription ID card when you fill your prescription.
    - For the STANDARD AND HIGH COST COVERAGE Options: CVS Caremark will notify your Network/Claim Administrator of all amounts applied to the Out-of-Pocket Maximum, if you present your CVS Caremark prescription ID card when you fill your prescription.
    - For OUT-OF-AREA Medical Benefit Option: CVS Caremark reports the claim for your Network/Claim Administrator. Any eligible amounts will be applied to your Out-of-Pocket Maximum.
- **Out-of-Network pharmacies**: To fill Prescriptions at an Out-of-Network pharmacy and file for reimbursement:
    - At the time of purchase, you will pay the full retail Prescription cost and obtain a receipt when you pick up your Prescription.
    - File a claim for reimbursement of your covered expenses through CVS Caremark. See Filing Claims for Prescriptions below for more information on how to file a claim.
    - **Note:** If you purchase Prescription drugs at an Out-of-Network pharmacy, you will be reimbursed based on the CVS Caremark discount price, **not** the actual retail cost of the medication, which means the amount you'll have to pay for your Prescription will be greater than if you used an In-Network retail pharmacy.
    - For OUT-OF-AREA Medical Benefit Option: CVS Caremark reports the claim to your Network/Claim Administrator. Any eligible amounts will be applied to your Out-of-Pocket Maximum.

Reimbursement of Out-of-Pocket Expenses

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

Retail Refill Allowance – Long-Term Medications

You and your covered dependents will pay 50 percent of the drug cost for long-term Prescription medications at a retail pharmacy after your third purchase unless you utilize retail pharmacies that are part of the CVS Maintenance Choice Program (see below for additional information). Maximums do not apply to long-term medications beginning with your fourth purchase. Short-term medications should continue to be purchased at a retail pharmacy and you will pay your retail pharmacy Co-Payment or Co-Insurance.

Long-term Prescriptions include medications taken on an on-going basis for conditions such as high cholesterol, high blood pressure, depression, diabetes, arthritis and other conditions. To determine if your Prescription medications fall within the long-term medications listing, go to the https://www.caremark.com or call 1-844-7580767.

Retail Prescription Clinical Programs

CVS Caremark uses a number of clinical programs that help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, they are subject to change. Some medications may require Prior Authorization (pre-approval), some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period), and some medications may require step therapy. For example, erectile dysfunction medications are covered up to a maximum of six (6) pills per month.

When a Prescription for a medication requiring Prior Authorization or step therapy, or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these clinical programs and the specific drugs subject to these programs can be obtained from CVS Caremark (see "Contact Information" in the Reference Information section).

Generic Drugs

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

Prior Authorization

To be eligible for benefits, certain covered Prescriptions require Prior Authorization by CVS Caremark to determine Medical Necessity before you can obtain them at a participating pharmacy or through the Mail Order Prescription Drug benefit. Examples of medications requiring prior authorization include growth hormones and rheumatoid arthritis drugs. CVS Caremark will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

When you fill your Prescription, your pharmacist will call CVS Caremark. Your pharmacist and a CVS Caremark pharmacist will review the request for approval. CVS Caremar will send you and your Physician a letter with the authorization review determination and the length of approval, if applicable. When the renewal date approaches, you should contact CVS Caremark for renewal instructions.

Ask your Physician to contact CVS Caremark or to complete CVS Caremark Prior Authorization Form with the following information:

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

If the pharmacy does not fill a Prescription because there is no Prior Authorization on file, the pharmacy's denial will not be treated as a claim for benefits. You must submit the request for Prior Authorization toCVS Caremark. If the Prior Authorization is denied, you must file a first level appeal through CVS Caremark to be considered for coverage for that medication.

Specialty Pharmacy Services

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

CVS Specialty pharmacy provides Rx management and personalized support for patients with complex or chronic conditions. CVS Caremark also has specialty pharmacists trained in specific medical conditions (e.g., diabetes, cardiovascular, cancer, etc.). If you would like to talk to a pharmacist, call the Member Services phone number on your pharmacy ID card.

Whether these Prescriptions are self-administered or administered in a Physician's office, the Prescriptions to treat the above conditions are not reimbursed through your Medical Benefit Option and must be filled a through Mail Order Prescription Drug benefit for you to receive Prescription Drug benefits. Mail Order Prescription Drug benefit can ship the Prescription to your home for self-administration or to your Physician's office for medications which are to be administered by a Physician. If you are taking a specialty medication and do not fill through Accredo your medication will not be covered.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled through CVS Specialty:

- Anemia
- Growth hormone
- Hemophilia
- Hepatitis C
- Metabolic disorders
- Multiple Sclerosis
- Oral cancer drugs
- Osteoporosis
- Pulmonary/Pulmonary Arterial Hypertension
- Rheumatoid Arthritis or other autoimmune conditions
- Other various indications

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

The applicable Co-Insurance associated with the Prescription Drug benefit will apply to the Specialty Pharmacy Prescriptions.

Specialty Pharmacy Copay Assistance Program

The STANDARD, HIGH COST COVERAGE and OOA Medical Benefit Options include a specialty pharmacy copay assistance program[5] to help offset the cost of **select specialty pharmacy medications**. These specialty pharmacy medications will be reimbursed by the manufacturer at no cost to participants enrolled in these Medical Benefit Options once you enroll through Prudent RX. Manufacturer-funded copay assistance for widely distributed specialty drugs are considered "non-essential health benefits" under the Plan and will not be considered an out-of-pocket cost for participants. Therefore, these amounts will not count toward the annual Deductible or Out-of-Pocket Maximum. Only the amount you pay will be applied to your Deductible and/or Out-of-Pocket Maximum.

If you enroll in the CORE Medical Benefit option, you will continue to pay your regular deductible and co-insurance, which will be applied to the out-of-pocket maximum.

Maintenance Choice Program

As part of your prescription drug benefit, you and your covered dependents are eligible for the Maintenance Choice Program. You may use this option to purchase a 90-day

[5] "Copay assistance" may also be referred to as financial assistance, manufacturer coupons, discount programs, and/or coupon programs.

supply of the Prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You can order medications on a 90-day supply basis through the Maintenance Choice Program at a local CVS or Safeway-owned pharmacy, such as Tom Thumb, Randall's, or Vons. Ordering medications on a 90-day supply basis will save you more money than if you fill your Prescriptions at other retail pharmacies not affiliated with the Maintenance Choice Program.

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

StayWell Rx

Individuals can receive a 90-day supply of asthma, diabetes and blood pressure drugs when they enroll in StayWell Rx (free for generic drugs, or $30 for brand name drugs), if the medication qualifies. Individuals must call Accolade every 12 months to re-enroll in the program and to make sure the medication qualifies.

CVS Caremark Mail Order Prescription Drug Benefit

Overview

You and your covered Dependents are also eligible for Mail Order Prescription Drug benefit, which is an alternative to the Maintenance Choice Program. You may use this mail service option to order Prescription drugs you take on an ongoing basis such as allergies, arthritis, contraceptives, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration. A registered pharmacist fills your Prescription. Ordering medications on a 90-day supply basis through Mail Order Prescription Drug benefit will often save you more money than if you fill your Prescriptions at a retail pharmacy on a 30-day basis.

You may order up to a 90-day supply of your Prescription drug (but no more than the number of days prescribed by your Physician). If you are enrolled in the Standard or HIGH COST COVERAGE plan, you pay Co-Insurance (with no annual Deductible) for each Prescription or refill. If you are enrolled in the Core plan, you will pay full cost until you have reached your deductible. Please see the chart below for Co-Insurance requirements.

For Mail Order Prescriptions, you must purchase through Mail Order Prescription Drug benefit; otherwise, you'll have to pay 100 percent of the cost yourself and the Plan will not pay any of the cost. As an alternative to Mail Order, you can utilize the Maintenance Choice Program, discussed above.

There are no Out-of-Network Mail Order benefits.

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100 percent under the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options through Mail Order Prescription Drug benefit, when filled at a

local CVS or Safeway-owned pharmacy, or if purchased from a retail pharmacy not affiliated with the Maintenance Choice program (for up to three fills only). If you are taking contraceptives specifically for the purpose of preventing pregnancy, please be aware some services have age and frequency limitations. These limitations can be based on Medical Necessity, which is determined by medical review boards of the carriers in which we partner with to provide health care services and PPACA. If you purchase contraceptives for reasons other than the prevention of pregnancy, the appropriate Co-Insurance will apply.

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		HIGH COST COVERAGE Medical Benefit Option		OOA Medical Benefit Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
MAIL ORDER[8] (typically a 90-day supply)	**Generic:** 20% Co-insurance ($5 min / $80 max) **Preferred Brand:** 30% Co-insurance ($60 min / $200 max) **Non-Preferred Brand** 50% Co-insurance ($90 min / $300 max)	Not covered	20% Co-insurance after Deductible	Not covered	**Generic:** 20% Co-insurance ($5 min / $80 max) **Preferred Brand:** 30% Co-insurance ($40 min / $150 max) **Non-Preferred Brand** 50% Co-insurance ($70 min / $180 max)	Not covered	**Generic:** 20% Co-insurance ($5 min / /$80 max) **Preferred Brand:** 30% Co-insurance ($60 min / $200 max) **Non-Preferred Brand** 50% Co-insurance ($90 min / $300 max)

Mail Order Prescription Clinical Programs

CVS Caremark uses a number of clinical programs to help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, the drugs subject to these clinical programs may change. Some medications may require Prior Authorization (pre- approval), some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period), and some medications may require step therapy. For example, erectile dysfunction medications are covered up to a maximum of eight (8) pills per month.

When a Prescription for a medication requiring Prior Authorization or step therapy, or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these programs may be obtained from CVS Caremark (see "Contact Information" in the Reference Information section).

Generic Drugs

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

Ordering Prescriptions by Mail

- **Initial order via Caremark.com**: To place your first order for a Prescription through mail order, follow these steps:
    - Visit Caremark.com/Rxdelivery
    - Log in to account or register if not already completed
    - Choose to order a previously filled prescription or search for a new medication
    - Once the medication is selected, click Request a New Prescription
    - Proceed to checkout and Review your Order
        - Update address if necessary
        - Add payment method
        - Select prescriber or search for your prescriber if it is a new prescription
    - Submit your order and CVS Caremark will contract the prescriber for approval and then process your order

Manufacturer Discount Cards/Coupons

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

Claims Filing Deadline

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

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

Reimbursement of Co-Insurance

Your mail order Prescription Drug Co-Insurance is the Out-of-Pocket amount you must pay when you fill your Prescription Drugs. It is not eligible for reimbursement under the CORE, STANDARD, HIGH COST COVERAGE, or OUT-OF-AREA Medical Benefit Option. However, if you elected to participate in the Health Care Flexible Spending Account (HCFSA) (for STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options) or the Health Savings Account (HSA) (for CORE Medical Benefit Option), your Co-Insurance may be eligible for reimbursement. See the Health Care Flexible Spending Account section for more information.

If you have exhausted your HCFSA or did not elect an HCFSA and have funds in your Health Reimbursement Account (HRA), you can receive reimbursement for your Co-Insurance from your HRA.

Dental Benefits

Dental Benefits
Covered Expenses
Excluded Expenses
Filing Claims

Dental Benefits for Ground and Flight Employees

How the Dental Benefit Option Works

The Dental Benefit Option offers a Network of participating Dentists and Specialists nationwide who provide fee discounts to Dental Benefit participants.

You are not required to use Preferred Dentist Program (PDP) Network Dentists, but may benefit from cost savings when you do. You can request a customized directory of participating Dentists in your area by visiting the MetLife website or calling MetLife at 1-866-838-1072.

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

MetLife's Role

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

Eligibility

Eligible Employees and their Eligible Dependents can enroll in the Dental Benefit Option, even if they do not elect coverage under a Medical Benefit Option. You must enroll yourself in the Dental Benefit Option if you would like to cover any dependents under the Dental Benefit Option.

There are two Dental Benefit Options for Employees to choose from-- the Plus Dental Benefit Option and the Basic Dental Benefit Option as described below.

If you enroll in the Plus Dental Benefit Option, you and your dependents will be required to remain enrolled in that plan for a minimum of 2 years unless you or your eligible dependents become ineligible as defined by the Plan. (i.e. divorce or child reaching age 26)

Coverage Levels

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

Cost-Sharing by Dental Benefit Option

The following chart describes cost-sharing under the Dental Benefit Options.

Feature	Plus		Basic	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (per covered person)	$50	$75	$50	$75
Annual Maximum Benefit (per covered person)	$2,000	$1,500	$1,000	$750
Orthodontia Lifetime Maximum (Orthodontia care)	$2,000 Per covered person	$1,500 Per covered person	$1,000 Per covered person	$1,000 Per covered person
Dental Services				
Preventive Service	No cost to you	20%	No cost to you	20%
Basic & Major Services	20%	50%	50%	50%
Orthodontia				
Orthodontia Services (annual Deductible does not apply)	50%	50%	50%	50%

Special Provisions

- **Alternative treatment**: If you undergo a more expensive treatment or procedure when a less expensive alternative is available, the Dental Benefit Option pays benefits based on the less expensive procedure that is consistent with generally accepted standards of appropriate Dental care.
- **Coordination of benefits**: If you or a covered dependent has coverage under any other group dental plan, the Dental Benefit Option coordinates benefits with the other plan. (see “Coordination of Benefits” in the Additional Health Benefit Rules section for additional information.)
- **Medically Necessary**: Only Dental services that are Medically Necessary are covered by the Dental Benefit Option. Cosmetic services are not covered.
- **Pre-determination of benefits**: If your Dentist estimates that charges for a procedure will be substantial, you should request Pre-determination of benefits before you receive treatment. You also have the option to request a Pre-determination for any proposed procedure. To request a Pre-determination, ask your Dentist to complete the Dental Plan Claim Form and indicate that it is for Pre-determination of benefits.
- **Usual and Prevailing Fee Limits**: The amount of benefits paid for eligible expenses is based on the Usual and Prevailing Fee Limits for that service in that geographic location.
- **When expenses are incurred**: For purposes of determining Dental Benefit Option coverage and benefits, the Dental expense is deemed to be incurred at the time of the initial treatment or preparation of the tooth.

Covered Expenses

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

There are two types of Covered Expenses:

- Preventive Services
- Basic and Major Services

Preventive Services:

- Exams twice per calendar year
- Routine X-rays

        - Bitewings (Adults) – Once per calendar year
        - Bitewings (Children) – Twice per calendar year
        - Full mouth – Once every five year
- Teeth cleaning twice per calendar year
- Fluoride treatments
    - Twice per calendar year to age 19
- Sealants
    - Under age 16
- Space maintainers

Basic and Major Services

The following Dental services and supplies are covered by the Dental Benefit Option:

- **Replacement of Cast Restorations**: Replacement of cast restorations (e.g. inlays, onlays, crowns, veneers, etc.) if the appliance is more than five years old and cannot be repaired.
- **Dentures and bridgework**: Full and partial dentures and fixed or removable bridgework, including:
    - Installation of the initial appliance to replace natural teeth extracted, including adjustments within six months of installation.
    - Replacement if the appliance is more than five years old and cannot be repaired. (Appliances that are over five years old but can be made serviceable will be repaired, not replaced.)
    - Installation of the appliance for teeth missing as a result of a congenital condition. (Charges are limited to the allowance for a standard prosthetic device.)

The total allowance for both a temporary and permanent denture or bridge is limited to the maximum benefit for a permanent denture or bridge. Charges are determined from the date the first impression is taken.

- **Extractions, surgery and anesthetics**: These services are considered covered Dental treatments. Treatment of certain injuries and conditions may be covered under Medical Benefit Options. See “Covered Expenses” in the Medical Benefits Options Overview section.
- **Fillings and crowns**: Gold, silver, porcelain or composite fillings and plastic restorations, subject to the following:

- Porcelain crowns are covered only for the 10 front upper and 10 front lower teeth.
- Porcelain or plastic facings on crowns posterior to the second bicuspid are not covered.
- Gold fillings and crowns are covered only when the tooth cannot be restored with other materials.
- Crowns may only be replaced if the existing crown is more than five years old, regardless of the reason for the replacement.

- **Night guards:** Also referred to as occlusal guards and bruxism appliances.
- **Dental implants, implant restorations**: If the tooth or teeth cannot be restored by any other means and approved by independent dental consultants selected by the Company.
- **Inlays and onlays**: Only if approved by independent dental consultants selected by the Company.
- **Oral examinations, X-rays and laboratory tests**: These are covered if needed to determine course of treatment.
- **Oral surgery**: If you have oral surgery and it requires Hospitalization, the expenses for the Hospitalization are payable under the Medical Benefit Option. See “Covered Expenses” in the Medical Benefits Option Overview section.
- **Periodontal treatment**: Periodontal treatment of the gums and supporting structures of the teeth and anesthetics are covered, with the frequency of treatment based on generally accepted standards of good periodontal care. Examples are scaling and root planing and gingivectomy.
- **Root canals:** Root canals and other endodontic treatments are covered. The charge for root canal therapy is considered to have been incurred on the date the tooth is opened.
- **Orthodontia**.
  - Orthodontic coverage includes:
    - Examinations
    - X-rays
    - Laboratory tests
    - Other necessary treatments and appliances
  - There is no Deductible for orthodontic treatments, and payments for orthodontia do not reduce the annual maximum benefit for other services.

The following explains additional information about orthodontia coverage:

- **Ongoing orthodontic coverage:** To remain eligible for coverage of orthodontic treatments that extend into a new coverage period (for example, the next calendar year), you must continue to cover the patient under your Dental Benefit Option during each Annual Enrollment Period.
    - **Paying orthodontia claims:** Payment is made according to the following procedures (regardless of the payment method you arrange with your Provider):
        - The Provider of service (orthodontist) should submit one billing that reflects the total cost of the patient's orthodontic treatment – even if the duration of treatment moves across calendar years. The Dental Benefit Option will pay up to the maximum benefit based upon the selected option in one lump sum, based upon the orthodontist's lump-sum billing for orthodontia treatment (provided the treatment is determined to be an eligible expense under the Dental Benefit Option).
        - Coordination of benefits applies if the patient has other orthodontia coverage. If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the lifetime maximum benefit

Excluded Expenses

The following expenses are not eligible for reimbursement under the Dental Benefit Option:

- **Anesthesia**: General anesthetics (unless required for oral surgery or periodontics).
- **Cosmetic treatment**: Treatment or services partly or completely for cosmetic purposes or characterization or personalization of dentures or appliances for specialized techniques.
- **Crowns or appliances**: Crowns, adjustments or appliances used to splint teeth, increase vertical dimensions or restore occlusion. Replacement of crowns less than five years old will not be covered, regardless of the reason for replacement.
- **Education or training**: Education, training or supplies for dietary or nutritional counseling, personal oral hygiene or Dental plaque control.
- **Free care**: Charges for services or supplies that you are not legally required to pay.

- **Medical expenses**: Any charge for Dental care or treatment that is an eligible expense under your Medical Benefit Option.
- **Prescription drugs**: Dental Prescriptions are covered under your Prescription Drug benefit, not under your Dental Benefit Option. If you are enrolled in an HMO, check with your HMO to find out if your HMO covers Dental Prescriptions.
- **Relatives**: Treatment by a Dentist or Physician who is a close relative, including your Spouse/Company-Recognized Domestic Partner, Children, adopted and step relatives, sisters and brothers, parents and grandparents of you or your Spouse/Company-Recognized Domestic Partner.
- **Replacement dentures or bridges**: Replacement charges for full or partial dentures or a fixed or removable bridge that is less than five years old. Appliances that are over five years old but can be made serviceable will be repaired, not replaced. Also excluded are any charges that exceed the cost of a standard prosthetic appliance.
- **Services not provided by Dentist, Orthodontist or Physician**: Any service not provided by a Dentist, orthodontist or Physician, unless performed by a licensed dental hygienist under the supervision of a Dentist or Physician or for X-ray or laboratory tests ordered by a Dentist or Physician.
- **Temporary dentures, crowns or bridges after 12 months**: A temporary fixture, such as a temporary denture, crown or bridge that remains in place for 12 months or more is considered permanent and the cost of replacement is only covered when the item is more than five years old.
    - A temporary fixture means a fixture that is not intended to be permanent and is intended to be replaced by a permanent fixture.
    - Notwithstanding this rule, the cost of replacement for temporary fixtures that remain in place for 12 months or more is covered if there is a congenital condition that requires a temporary fixture to remain in place for 12 or more months.
- **Temporomandibular joint dysfunction (TMJD)**: TMJD is considered a medical condition and has limited coverage only under the Medical Benefit Options.
- **U.S. government services or supplies**: Charges for services or supplies furnished by or for the U.S. government.
- **Usual and prevailing**: Charges that exceed the Usual and Prevailing Fee Limits.
- **War-related**: Services or supplies received as a result of a declared or undeclared act of war or armed aggression.

- **Work-related claims**: Dental care received because of a work-related injury or illness sustained by you or your covered dependent, whether or not it is covered under Workers' Compensation, occupational disease law or similar law.

Filing Claims

MetLife is the Network/Claim Administrator for the Dental Benefit Option. To file claims for Dental expense benefits:

- Complete the top portion of the Dental Plan Claim Form. Follow the instructions on the form and provide the form to your dental Provider, who should complete the remaining portion.
- You or your Provider, if completing the form on your behalf, will mail the completed claim form to MetLife at the address on the form.
- You will receive an Explanation of Benefits (EOB) detailing the amount paid for each Dental claim submitted.
- Payments may be sent to you or to your Dentist or other dental Provider.
- Claims are processed in order of receipt. Payment of claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

Please see the "Claims Procedures" section for a detailed description of the claims procedures that apply to your Dental Benefit Option.

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

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

Claim Filing Deadline

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

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

Vision Benefit

[How the Vision Insurance Benefit Works]
[Using In-Network Providers]
[Using Out-of-Network Providers]
[Covered Expenses]
[Claims Procedure]
[Complaint Procedure]

How the Vision Insurance Benefit Works

The Vision Benefit Option, insured and administered by EyeMed, provides coverage for routine vision exams, as well as eyeglasses and contact lenses.

The insurance certificate is available on the Vision page of my.aa.com. As with all insured benefits, with respect to the Vision Benefit Option, the terms of the insurance certificate control when describing specific benefits that are covered or insurance- related terms.

EyeMed's Role
Your Vision Benefit Option is insured and administered by EyeMed. EyeMed is the Network/Claim Administrator for the Vision Benefit Option. Visit the EyeMed website or contact EyeMed at 1-844-714-5678 for more information on the Vision Benefit Option. EyeMed's Customer Care Center can be reached Monday through Saturday 6:30 am to 10:00 pm CT and Sunday 10:00 am to 7:00 CT.

Eligibility

Eligible employees and their Eligible Dependents can enroll in the Vision Benefit Option, even if they do not elect medical coverage. You must elect the Vision Benefit Option 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/Company-Recognized Domestic Partner
- 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 (e.g., 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 Benefit Option includes the following services, at the following cost-sharing amounts:

Feature	Your In-Network Cost	Your Out-of-Network Reimbursement[6]
Exam with Dilation as necessary	$10 Co-Pay	Up to $40
Retinal Imaging	Up to $39	Not Covered
Exam Options – Contact Lenses		
Standard Fit and Follow-Up	Up to $55	Not Covered
Premium Fit and Follow-Up	10% off retail price	Not Covered
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
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

[6] *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.*

Tier 2	$63 Co-Pay	Up to $3 Up to $3
Feature	**Your In-Network Cost**	**Your Out-of-Network Reimbursement[9]**
Tier 3	80% of charge	Up to $3
Polarized	20% off retail price	Not Covered
Photocromatic / Transitions Plastic	$65	Up to $5
Other add-ons and services	20% off retail price	Not Covered
Contact Lenses[7]		
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	Not Covered
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.	Not Covered
Frequency - based on calendar		
Exam	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frames	Once every 12 months	

[7] *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 (Photo Refractive Keratectomy). 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 1-877-552-7376.

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 1-877-552-7376 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 ends, 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 $140:	you pay **$0.00**
One pair of bifocal lenses:	you pay **$25.00**
Ultraviolet coating:	you pay **$0.00**
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 Benefit Option.

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 CustomerCare

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 below. You may also include written comments or supporting documentation.

FAA/EyeMed Vision Care

Attn: Quality Assurance Dept.

4000 Luxottica Place

Fax# 1-513-492-3259

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

Spending Accounts

Overview
Health Care Flexible Spending Account (HCFSA)
Limited Purpose Flexible Spending Account (LPFSA)
Dependent Care Flexible Spending Account (DCFSA)
Health Savings Account (HSA)
Health Reimbursement Account (HRA)

Overview

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

The Spending Accounts apply as follows:

Account	Applicable Medical Benefit Option	Notes
Health Care Flexible Spending Account (HCFSA)	STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA options under this Plan, the Plus Plan for Active Employees, the DFW ConnectedCare Plan in certain zip codes, and the PPO Plan.	You do not have to be enrolled in an American Medical, Dental, or Vision Benefit Option to enroll.
Limited Purpose Flexible Spending Account (LPFSA)	CORE	It is ONLY for Dental and Vision expenses.
Dependent Care Flexible Spending Account (DCFSA)	STANDARD, HIGH COST COVERAGE, OUT-OF-AREA options under this Plan, the Plus Plan for Active Employees, the DFW Connected Care Plan in certain zip codes, and the PPO Plan	You do not have to be enrolled in an American Medical, Dental, or Vision Benefit Option to enroll.
Health Savings Account (HSA)	CORE	If you would like to contribute to the HSA, you must enroll in the CORE option and may not enroll in any other, non-high deductible health plan coverage (dental, vision and preventive care coverage are all permissible coverage, however).
Health Reimbursement Account (HRA)	STANDARD, HIGH COST COVERAGE, OUT-OF-AREA options under this Plan, the DFW ConnectedCare Plan in certain zip codes, the Plus	If you would like to use earned HRA credits, you must be enrolled in either the STANDARD, HIGH COST COVERAGE, OUT-OF-AREA Medical Benefit Options, DFW

	Plan, and the PPO Plan	ConnectedCare Plan in certain zip codes, Plus Plan, and PPO and OUT-OF-AREA options under the PPO Plan.

Using Your Spending Accounts

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

1. Smart-Choice Accounts Card

If you are currently enrolled in a Flexible Spending Account (FSA) or Health Savings Account (HSA), you will use the Smart-Choice Accounts debit card to access both FSA/HSA funds and your HRA. Always be sure to save your receipts, as all Spending Accounts may require you to submit documentation.

2. Automatic Reimbursement

If you select the automatic reimbursement method, your HRA and FSAs will automatically reimburse you (via check or direct deposit) whenever you have a claim for eligible Medical, Dental, Prescription, or Vision expenses under the Plan. Note that automatic reimbursement cannot be used for the HSA.

3. Submit Manual Claims

You may submit eligible Medical, Dental, Prescription, and Vision claims for reimbursement online, by mail, or by fax. Visit the American Airlines Benefits Service Center Smart-Choice Accounts site or call Smart-Choice Accounts at 888-860-6178 for instructions and claim submission information.

Health Care Flexible Spending Account (HCFSA)

How the Health Care Flexible Spending Account (HCFSA) Works

The HCFSA allows you to set aside money on a pre-tax basis to pay for eligible health care expenses. Paying for these expenses pre-tax helps reduce your taxes.

Benefit Overview		
Option	**Who Can Be Reimbursed**	**Key Features**
HCFSA-Health Care FSA	You can be reimbursed for expenses for: You Your Spouse Your natural, step, adopted or foster children who will be below age 27 at the end of the year Any individual (including your Company-Recognized Domestic Partner): who has the same residence as you is a member of your household, and for whom you provide over half of his or her support for the year.	Deposit up to $2,750 in 2022. Pre-tax contributions Have until June 15 to file claims for previous year's eligible expenses For your 2022 HCFSA, you have until December 31, 2022 to incur eligible claims Up to $550 remaining in your 2022 HCFSA will be carried over to the 2023 plan year Eligible Dependents do not have to be covered under your Medical, Dental or Vision Benefit Option to be eligible for reimbursement If both you and your Spouse/Company-Recognized Domestic Partner are employed by American Airlines, both employees may each deposit up to $2,750 in an HCFSA during 2022

Contributions

You can contribute through payroll deduction up to $2,750 in 2022 in your HCFSA. A minimum annual election amount of $120 is required to complete enrollment.

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

Deadline to Incur Claims

For your 2022 HCFSA, you have until December 31, 2022 to incur eligible claims and until June 15, 2023 to request reimbursement for those claims.

$550 Carryover of Remaining Account Balance

If you had a HCFSA in 2020 and/or 2021, the Plan allows you to carryover the entire amount remaining unused balance into the following Plan Year. Such carryover amount may be used to pay or reimburse medical expenses during all of 2021 or 2022, as applicable.

If you have an HCFSA in 2022, the Plan will allow you to carry over any unused balance up to $550 into the following Plan Year. Such carryover amount may be used to pay or

reimburse eligible expenses incurred during all of 2023. Any unused amount of more than $550 remaining in your 2022 HCFSA at the end of the 2022 will be forfeited.

If you were a participant in the CORE Medical Benefit Option in the prior Plan Year and you do not elect to participate in the CORE Medical Benefit Option for the current Plan Year, and you have a remaining balance from the previous Plan Year in your Limited Purpose Health Care Flexible Spending Account, the remaining balance from the previous Plan Year (of up to $550) will be credited to a HCFSA for you. For example, if you are enrolled in the CORE Medical Benefit Option in year one, and have a Limited Purpose Health Care Flexible Spending Account balance of $400, and you elect the STANDARD Medical Benefit Option in year two, $400 will be credited to a HCFSA for you, even if you do not elect to enroll in a HCFSA.

If you elect to participate in the CORE Medical Benefit Option for a Plan Year and have a remaining balance from the prior Plan Year from your HCFSA, the remaining balance from the previous Plan Year (of up to $550) will be credited to a LPFSA for you, even if you do not elect to enroll in a LPFSA. For example, if you were enrolled in the HIGH COST COVERAGE Medical Benefit Option in year one, and you have a HCFSA balance of $300, and you elect the CORE Medical Benefit Option in year two, $300 will be credited to a LPFSA for you, even if you do not elect to enroll in a LPFSA.

Account Administrator

The HCFSA administrator is Smart-Choice Accounts. The Smart-Choice Accounts website allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access “Frequently Asked Questions (FAQs),” and manage direct deposit.

Special Provisions

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

- You can only stop or change your election mid-year if you experience certain Life Events. If you experience a Life Event and decide to reduce the amount of your HCFSA, you cannot stop or reduce your account balance to an amount that is less than the claims that have already been paid, or the amount already contributed to the account.
- If you incur expenses after your Life Event, your claims are payable up to the amount of your newly elected deposit amount.
- If you decide to stop the amount of your HCFSA deposits mid-year, this will affect how your claims are paid. If your eligible health care expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your HCFSA. You cannot receive reimbursement for expenses incurred after the date you stopped making contributions to your HCFSA; however, you can submit claims up to the amount in your account, provided they were incurred before the date you stopped.

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

- As described in the COBRA chapter, you may elect to continue your HCFSA as part of your COBRA continuation of coverage options, for the remainder of the calendar year in which you became eligible for continuation of coverage. In addition, the Plan allows you to carryover up to $550 of any amount remaining in your HCFSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the COBRA continuation period (i.e. 18, 29, or 36 months, as applicable). Any unused amount of more than $550 remaining in your HCFSA at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.
- If you do not continue your HCFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any contributions that were made and not used before your termination date.

Covered Expenses

Expenses that can be reimbursed through an HCFSA include the following:

- Out-of-Pocket expenses, Deductibles, Co-Insurance, Co-Pays, Prescription Drugs and supplies not paid by your Medical, Dental or Vision Benefit Options, whether your coverage is under a Company-sponsored Plan or any other health plan.
- Prescription drugs.
- Over-the-Counter medicine/drugs used to alleviate or treat personal injuries or sickness (e.g., pain relief, antacid, allergy medicine, cold medicine), or insulin.
- Menstrual care products (e.g., a tampon, pad, liner, cup, sponge, or similar product).
- Medical devices or items you may purchase such as bandages, crutches, and contact lens solution.

Reimbursable Medical Expenses.

Some medical expenses may not be covered at all by your Medical Benefit Option. However, some of those expenses may be reimbursed under your HCFSA. For a full list of covered medical expenses, go to the IRS website.

- **Reimbursable Hearing and Vision Expenses.** For a full list of covered hearing and vision expenses, go to the IRS website.

- **Reimbursable Dental Expenses.** Some medical expenses may not be covered at all by your Dental Benefit Option. However, they may be reimbursed under your HCFSA. For a full list of covered Dental expenses, go to the IRS website.

Excluded Expenses

Some expenses may not be reimbursed through your HCFSA, including, but not limited to the following:

- Medical insurance premiums/contributions
- Cosmetic medical treatment, surgery, and Prescriptions and cosmetic Dental procedures, such as cosmetic tooth bonding or whitening
- Electrolysis
- Health club fees and exercise classes (except in rare cases for treatment of medically diagnosed obesity where weight loss is part of the program)
- Massage therapy
- Personal care items including cosmetics and toiletries
- Vitamins and nutritional supplements, unless prescribed by a doctor
- Weight loss programs (unless for treatment of medically diagnosed morbid obesity)
- Wheelchair ramps
- Whirlpools

For a full list of excluded expenses, go to the IRS website.

Filing Claims

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

Participants who have a Health Care Flexible Spending Account (HCFSA) may file claims on the Smart-Choice Accounts website, by fax, or through the U.S.P.S. Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the direct deposit link on the Smart-Choice Accounts website.

Please see the "Claims Procedures" chapter for a detailed description of the claims procedures that apply to your HCFSA benefits.

Limited Purpose Flexible Spending Account (LPFSA)

How the Limited Purpose Flexible Spending Account (LPFSA) Works

The LPFSA allows you to set aside money on a pre-tax basis to pay for eligible Vision and Dental expenses. Paying for these expenses pre-tax helps reduce your taxes.

Benefit Overview		
Option	**Who Can Be Reimbursed**	**Key Features**
LPFSA-Limited Purpose Health Care FSA (Dental and vision expenses only) Must be enrolled in CORE Medical Benefit Option	You can be reimbursed for expenses for: You Your Spouse Your natural, step, adopted or foster children who will be below age 27 at the end of the year Any individual (including your Company-Recognized Domestic Partner): who has the same residence is a member of your household, and for whom you provide over half of his or her support for the year.	Deposit up to $2,750 in 2022 Pre-tax contributions Have until June 15 to file claims for previous year's eligible expenses For your 2022 LPFSA, you have until December 31, 2022 to incur eligible claims Up to $550 remaining in your 2022 LPFSA will be carried over to the 2023 Plan Year If both you and your Spouse/Company-Recognized Domestic Partner are employed by American Airlines, both employees may each deposit up to $2,750 in an LPFSA during 2022.

Contributions

You can contribute through payroll deduction up to $2,750 in 2022 in your LPFSA. A minimum annual election amount of $120 is required to complete enrollment.

At the beginning of each Plan Year, thefull amount of your elected LPFSA amount for the entire year is available for your use, regardless of the actual balance in your account.

Deadline to Incur Claims

For your 2022 LPFSA, you have until December 31, 2022 to incur eligible claims and until June 15, 2023 to request reimbursement.

$550 Carryover of Remaining Account Balance

If you have a LPFSA in 2022, the Plan will allow you to carry over any unused balance up to $550 into the following Plan Year. Such carryover amount may be used to pay or reimburse medical expenses incurred during all of 2023. Any unused amount of more than $550 remaining in your 2022 LPFSA at the end of the 2022 will be forfeited.

If you were a participant in the CORE Medical Benefit Option in the prior Plan Year and you do not elect to participate in the CORE Medical Benefit Option for the current Plan Year, and you have a remaining balance from the previous Plan Year in your LPFSA, the remaining balance from the previous Plan Year (of up to $550) will be credited to a HCFSA for you. For example, if you are enrolled in the CORE Medical Benefit Option in year one, and have a LPFSA balance of $400, and you elect the STANDARD Medical Benefit Option in year two, $400 will be credited to a HCFSA for you, even if you do not elect to enroll in a HCFSA.

If you elect to participate in the CORE Medical Benefit Option for a Plan Year and have a remaining balance from the prior Plan Year from your HCFSA, the remaining balance from the previous Plan Year (of up to $550) will be credited to a LPFSA for you, even if you do not elect to enroll in a LPFSA. For example, if you were enrolled in the HIGH COST Coverage Medical Benefit Option in year one, and you have a HCFSA balance of $300, and you elect the CORE Medical Benefit Option in year two, $300 will be credited to a LPFSA for you, even if you do not elect to enroll in a LPFSA.

If you experience a Qualifying Event (as described in the COBRA chapter), your LPFSA terminates. As described in the COBRA chapter, you may elect to continue your LPFSA as part of your COBRA continuation of coverage options, for the remainder of the calendar year in which you became eligible for continuation of coverage. In addition, the Plan allows you to carryover up to $550 of any amount remaining in your LPFSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the COBRA continuation period (i.e. 18, 29, or 36 months, as applicable). Any unused amount of more than $550 remaining in your HCFSA at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.

Account Administrator

The LPFSA administrator is Smart-Choice Accounts. The Smart-Choice Accounts website allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access “Frequently Asked Questions (FAQs),” and manage direct deposit.

Reimbursable Expenses

IRS rules specify the types of expenses eligible for reimbursement for Dental and Vision expenses.

- You cannot use an LPFSA for copays, deductibles, coinsurance or other out-of- pocket expenses you may owe for claims submitted under a medical plan. If you are enrolled in the CORE Medical Benefit Option, you may use an HSA to pay for such expenses. See the CORE Medical Benefit Option section for more information. In addition, if deposits are made to an HSA and you later change plans, you will be enrolled in a LPFSA, which can only be used for Dental and Vision, regardless of the benefit option selection.

Filing Claims

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

Participants who have a LPFSA may file claims on the Smart-Choice Accounts website, by fax, or through U.S.P.S. Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the direct deposit link on the Smart-Choice Accounts website.

Please see the "Claims Procedures" chapter for a detailed description of the claims procedures that apply to your LPFSA benefits.

Dependent Care Flexible Spending Account (DCFSA)

How the Dependent Care Flexible Spending Account (DCFSA) Works

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

Benefit Overview		
Option	**Reimbursement**	**Key Features**
Dependent Care FSA	You can be reimbursed for: Licensed child and adult day care centers Private kindergarten (used for day care rather than education) Babysitters Au pairs	Contribute up to $5,000 a year Pre-tax contributions Have until March 15 of the benefit year to use your prior year's balance Have until June 15 to file claims for previous year's eligible expenses You cannot use your funds until they are deposited in your account

Contributions

Your family and tax filing status determine the maximum amount you can contribute per calendar year:

- A single employee may contribute up to $5,000.
- A couple filing a joint income tax return, where both Spouses participate in DCFSAs, may contribute a combined amount of up to $5,000.
- A couple filing separate income tax returns may each contribute up to $2,500.
- A couple (if both individuals are employed) may contribute up to $5,000 or the income amount of the lower-paid Spouse (if it is less than $5,000).
- If you are a Highly Compensated Employee, as defined by the Internal Revenue Code, your allowable annual pre-tax contribution may be less than $5,000 per calendar year. For example, as defined by the Internal Revenue Code, for the 2022 Plan Year a Highly Compensated Employee is an individual who has an annual income of $130,000 or more in 2021. This amount may be subject to change, and you will be notified if your maximum contribution changes. For more information about Highly Compensated Employee limits, go to the IRS website.

If both you and your Spouse work for American Airlines, your combined DCFSA total contribution cannot exceed $5,000. A minimum annual election amount of $120 is required to complete enrollment.

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

Deadline to Incur Expenses

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

Account Administrator

The DCFSA administrator is Smart-Choice Accounts. The Smart-Choice Accounts website allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access “Frequently Asked Questions (FAQs),” and manage direct deposit.

Special Provisions

As funds are deposited into your account, you can pay for eligible day care expenses.

You and your Spouse must be employed, actively seeking employment, or a full-time student for at least five months of the year to be eligible to receive reimbursement from your DCFSA.

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

- You can only stop or change your election mid-year if you experience certain Life Events.
- If you experience a Life Event and decide to reduce the amount of your DCFSA, you cannot stop or reduce your account balance to an amount that is less than the claims that have already been paid.
    - If you incur expenses after your Life Event, your claims are payable up to the amount of your newly elected deposit amount.
- If you decide to stop the amount of your DCFSA deposits mid-year, this will affect how your claims are paid.
- If your eligible expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your DCFSA.

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

Who is Covered

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

- Children under age 13 (note that a special rule applied to children who attained age 13 during the 2020 or 2021 Plan Year, allowing reimbursement for 13 year old children in those years).
- An individual who satisfies all of the requirements to be your dependent under the Internal Revenue Code (except for the requirements pertaining to the individual's claimed dependents, marital status and gross income), if the person meets both of the following criteria:
    - Lives with you for over half of the calendar year, and
    - Is physically or mentally incapable of self-care
- Your Spouse who meets both of the following criteria:
    - Lives with you for over half of the calendar year, and
    - Is physically or mentally incapable of self-care

Covered Expenses

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

- Incurred for your Eligible Dependents described under "Who is Covered," or for related household services;
- Paid or payable to a Dependent Care Service Provider described below; and

- Incurred to enable you and your Spouse to be gainfully employed or to be in active search of gainful employment.

Expenses incurred for services outside your household for the care of an Eligible Dependent described above under "Who is Covered," may only be reimbursed through your DCFSA if the Eligible Dependent is:

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

A Dependent Care Service Provider means a person who provides care or other services for an Eligible Dependent described above under "Who is Covered" or related household services. A Dependent Care Service Provider does **not** include:

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

CARRYOVER OVER REMAINING ACCOUNT BALANCE

If you had a DCFSA in 2020 and/or 2021, the Plan allows you to carryover the entire amount remaining unused balance into the following Plan Year. Such carryover amount may be used to reimburse eligible day care expenses for your eligible adult and Child dependents during all of 2021 or 2022, as applicable.

Filing Claims

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

Participants who have a Dependent Care Flexible Spending Account may file claims on the Smart-Choice Accounts website, by fax, or through U.S.P.S. Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the direct deposit link on the Smart-Choice Accounts website.

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

If You Elect Both an HCFSA/LPFSA and a DCFSA

Your FSA and DCFSA funds are managed separately.

Health Savings Account (HSA)

Overview

A Health Savings Account (HSA) is a tax-favored medical savings account available only to enrollees in the CORE Medical Benefit Option, a qualifying high-deductible health plan per IRS regulations. If you are enrolled in the CORE Medical Benefit Option and you do

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

Contributions

You elect to deduct pre-tax dollars from payroll when you enroll in an HSA with Smart-Choice Accounts on the American Airlines Benefits Service Center. You can change your election amount anytime during the year.

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

The amounts noted below are the maximum amounts you can contribute to your HSA during 2022,. If you are age 55 or over, your maximum annual contribution increases by $1,000.

Coverage Options	Maximum HSA Contributions
Employee Only	$3,650
Employee + Spouse/Company-Recognized Domestic Partner	$7,300
Employee + Family	$7,300
Employee + Child(ren)	$7,300

HSA Funds

You must have the money in your HSA before the funds are available or qualify for the HSA Advance to pay for Eligible Expenses. In addition, there is no “use it or lose it” rule with an HSA. Your funds remain in your account, until you choose to withdraw them.

You may enhance account growth through investment earnings such as mutual funds, money markets or other investment type products. See "HSA Advance" below for information regarding the HSA advance feature.

Setting up an HSA

The rules for setting up and using an HSA are determined by the IRS.

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

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

For example:

- My annual HSA deduction is $5,000
- I get paid every 2 weeks = 26 times a year.
- My pre-tax per pay period payroll deduction = $192.31

You do not have to open an HSA account with Smart-Choice. You can select another financial institution that manages HSAs. However, your contributions will not be pre-tax. You will need to make the contributions on an post-tax basis (you can generally then deduct those contributions on your Form 1040) instead of through payroll deductions. Keep in mind that banking institutions offer a variety of arrangements when it comes to account fees, management and investment options.

If you are no longer enrolled in the CORE Medical Benefit Option, you may still access your HSA funds to pay for Eligible Medical Expenses on a tax-free basis. You may not, however, contribute to the HSA if you are not enrolled in the CORE Medical Benefit Option, or other HSA-compatible medical coverage.

Using Your HSA Funds

After enrollment, you will automatically receive a health care debit card to access your HSA funds during the year. You can use your card at the point of purchase to pay for eligible Medical, Prescription, Dental and Vision Expenses.

At the same time you receive your card, you will receive instructions on how to access your Smart-Choice online account. When you are logged onto your account you can review your account payment history, request to be reimbursed for Eligible Expenses paid Out-of- Pocket, and learn more about how to manage your HSA.

You may need to prove to the IRS that distributions from your HSA were for eligible expenses and not otherwise reimbursed. It is an IRS requirement that participants keep all receipts when using an HSA to pay for eligible expenses. If you use your HSA to

purchase non-eligible expenses, the distribution will be subject to income tax and may be subject to a 20 percent penalty.

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

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

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

You do not have to pay account management fees with Smart-Choice as an employee when you initiate your HSA and continue to elect pre-tax contributions year after year without a break. If you have an HSA from the previous year and elect not to contribute to the HSA the following year, you will be responsible for any account fees for each future year in which you elect not to contribute to the HSA.

HSA Advance

American offers an advance feature to those who make a HSA contribution election for 2022. This notional advance allows you to access all or part of your goal amount beginning on January 1, rather than having to wait until actual payroll deductions are made to fund your HSA.

American will advance your HSA goal amount up to $1,000 for Employee Only coverage or $2,000 for Employee + Dependent Coverage. For example, if you are enrolled in the employee-only tier and elect $500, your notional advance for eligible expenses will be $500.

If you choose to enroll in the CORE plan during Annual Enrollment and elect to open an HSA with a goal amount, you will be eligible to receive the advance. If you have eligible expenses and have not contributed enough to your HSA account, American will automatically make the funds available (up to $1,000 for employee only coverage or

$2,000 for employee + dependent coverage).

HSA advance funds can be used for all HSA-eligible expenses. For the full list of eligible expenses, visit the IRS website

Funds will not be available in your HSA until you have re-paid the advance through paycheck contributions. Once the advance has been re-paid, your paycheck contributions will be deposited into your HSA. You are only able to earn interest on funds that are deposited in your HSA. The advance will not be deposited into your HSA, so you are unable to receive investment earnings on the advance.

You can pay for eligible expenses out of your advance with your Smart-Choice debit card only. If you have made sufficient contributions to no longer need the advance you can be reimbursed the same way that you would with other spending accounts.

There is no interest or penalty for accessing the advance, and you do not have to take any extra steps in order to pay it back. Your HSA contributions are simply deducted from your paycheck and are applied against the amount you accessed. In other words, your HSA balance will not increase until your scheduled HSA contributions pay off the amount you used to pay for eligible expenses.

You can increase your HSA contributions up to the IRS limit. Please note that if you have already used the advance, you cannot reduce your HSA goal amount to less than the amount you have spent.

Health Reimbursement Arrangement (HRA)

Overview

Any remaining credits that were earned by completing activties in the former Well-Being Rewards program are still available for use in your HRA. The balance in your HRA rolls over from year to year, as long as you remain an active Employee and enrolled in an American Airlines medical plan. Your HRA is an account on the Company's records; it is not funded and does not bear interest or accrue earnings of any kind.

Covered Expenses

You can use your HRA to reimburse you for the same expenses listed under the "Covered Expenses" section of the "Health Care Flexible Spending Account (HCFSA)" section of this chapter. However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. The HRA will reimburse you for the actual amount of Covered Expenses incurred by you or your dependent, up to the amount in your HRA. No payment will be made to the extent that it would reduce your HRA below zero.

Life Insurance Benefits

Overview
Ground Employees Life Insurance
Pilot Term Life Insurance
Flight Attendant Life Insurance
Child Term Life Insurance
Filing a Claim for Spouse or Child Term Life Insurance
Designating Beneficiaries
Coverage If You Become Disabled
Special Provisions
Accelerated Benefit Option
Filing Claims

Overview

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

- Basic Term Life Insurance
- Voluntary Term Life Insurance
- Pilot Additional Life Insurance (Pilots only)
- Spouse/Company-Recognized Domestic Partner Term Life Insurance
- Child Term Life Insurance

Please note that Term Life Insurance pays a benefit in the event of your death, but has no cash value and remains in effect only during the time premiums are being paid.

Certain exclusions apply such as self-inflicted death. Please review the certificates for all exclusions.

The insurance certificates are available on my.aa.com. As with all insured benefits, with respect to the life insurance benefits, the terms of the insurance certificates control when describing specific benefits that are covered or insurance-related terms.

Important Note Regarding Proof of Good Health: Please note that enrollment may be denied based upon the presence of certain health conditions as determined by MetLife and the Plan.

MetLife's Role

Your Term Life Insurance benefits are insured and processed by MetLife. You pay the cost of any voluntary coverage you elect, through payroll deduction. Visit the MetLife website or contact MetLife at 1-800-638-6420 for more information.

Ground Employees Life Insurance

Basic Term Life Insurance Benefit – Ground Employees

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

The life insurance benefits of Employees of American Airlines, Inc. who were covered by collective bargaining agreements entered into between Legacy U.S. Airways, Inc. and the International Association of Machinists and Aerospace Workers ("IAM"), were converted from life insurance benefis under the American Airlines, Inc. Group Life and Disability Plan for Certain Legacy Employees, to life insurance benefits under this Plan.

Therefore, all references to "Ground Employees" shall be deemed to include Employees of American Airlines, Inc. who are covered by collective bargaining agreements entered into between the TWU/IAM Association covering Mechanics & Related, Material Logistics Specialists, Maintenance Training Specialists, Maintenance Control Technicians, and Fleet Service.

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

If you are an eligible employee not represented by the TWU-IAM Association, the Company provides coverage equal to two times your pay up to a maximum of $70,000, at no cost to you. You may elect a level of coverage lower than the amount you are eligible for, and may receive a credit for this lower amount. If you are an employee represented by the TWU-IAM Association, you will receive $70,000 in basic life insurance.

Benefit	Coverage Levels
Basic Term Life Insurance For Employees represented by CWA-IBT, PAFCA, TWU, and Management and Support Staff	2 times your pay up to a maximum of $70,000 (only if your annual pay is less than $35,000) 1 times pay (if annual salary is less than $70,000) $15,000
Benefit	**Coverage Level**
Basic Term Life Insurance For Employees represented by TWU-IAM Association	**$70,000**

Voluntary Term Life Insurance Benefit – Ground Employees

In addition to Basic coverage, Ground Employees may elect to purchase one of eight levels of Voluntary Term Life Insurance at your expense. When you are first eligible for benefits, you may elect up to 3 times your pay or $500,000 (whichever is less) without providing Proof of Good Health. You must complete a Proof of Good Health form from MetLife if you wish to elect a higher level of coverage (in excess of 3 times your pay or $500,000, whichever is less). You can complete the form online within 7 days after your election or a Proof of Good Health form will be mailed to you. If you do not complete the form online, then forward the completed form to MetLife for review within 30 days of your election. Upon approval from MetLife, coverage will be added or increased. Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction. This means that as a new employee you can elect any level of coverage with a Proof of Good Health.

At Annual Enrollment, you can make the following changes:

- If you are currently enrolled in Voluntary Term Life Insurance, you can increase your coverage up to 3 times your pay or $500,000 (whichever is less) without providing Proof of Good Health. You must complete a Proof of Good Health form from MetLife if you wish to increase your coverage in excess of 3 times your pay or $500,000, whichever is less. You must also complete a Proof of Good Health

form from MetLife if you increase your coverage in excess of 2 times your pay.

- If you are not currently enrolled in Voluntary Term Life Insurance, you can enroll in Voluntary Term Life Insurance, but you must complete a Proof of Good Health form from MetLife.

Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution either directly or through payroll deduction.

Below are the available Voluntary options:

Coverage for Ground Employees
1 times your pay
2 times your pay
3 times your pay
4 times your pay
5 times your pay
6 times your pay
7 times your pay
8 times your pay

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

to drop or adjust your election pursuant to Life Event procedures. Contact the American Airlines Benefits Service Center if you have questions.

Definition of "Pay" for Employee Term Life Insurance

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

Employee Status	Definition of Pay
Regular Full-time Employees	Base annual salary or annualized hourly pay plus market rate differentials, but excluding bonus and overtime
Converted Part-time Employees	Annualized hourly pay
Regular Part-time, Part-time Extendable and Job Share Employees	Average base salary
Commissioned Employees	Annual target earnings

Spouse/Company-Recognized Domestic Partner Term Life Insurance – Ground Employees

You may cover your Spouse/Company-Recognized Domestic Partner under Spouse/Company-Recognized Domestic Partner Term Life Insurance. The Spouse/Company-Recognized Domestic Partner Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse/Company-Recognized Domestic Partner Term Life Insurance for Ground Employees	Option 1 – One times your pay
	Option 2 – Two times your pay
	Option 3 – Three times your pay

To add or increase Spouse/Company-Recognized Domestic Partner Term Life Insurance, your Spouse/Company-Recognized Domestic Partner must complete a Proof of Good Health Form online within seven days after your election. If you do not complete the form online within seven days after your election, a Proof of Good Health form will be mailed to you. If you do not complete the form online, then forward the completed form to MetLife for review within 30 days of your election. Upon approval from MetLife, coverage will be added or increased. Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction. New employees may elect any of the three levels of Spouse/Company-Recognized Domestic Partner Term Life Insurance with Proof of Good Health.

If you do not enroll in Spouse/Company-Recognized Domestic Partner Term Life Insurance as a new employee, you will only be eligible to elect Option 1 at a later date with Proof of Good Health and then will only be eligible to increase coverage by one level per year thereafter, with Proof of Good Health.

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

Pilot Term Life Insurance

Basic Term Life Insurance Benefit – Pilots

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

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

The Company provides Basic Term Life Insurance coverage at a $70,000 coverage level.

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

Voluntary Term Life Insurance Benefit – Pilots

In addition to Basic Term Life Insurance coverage, Pilot employees may elect to purchase one of eight levels of Voluntary Term Life Insurance at your expense. When you are first eligible for benefits, you may elect up to and including the first 3 levels or $500,000 (whichever is less) of coverage without providing Proof of Good Health. You must complete a Proof of Good Health form from MetLife if you wish to elect a higher level of coverage (in excess of 3 levels or $500,000, whichever is less). You can complete online within 7 days after your election or a Proof of Good Health form will be mailed to you. If you do not complete the form online, then forward the completed form to MetLife for review within 30 days of your election. Upon approval from MetLife, coverage will be added or increased. Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction.

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

At Annual Enrollment, you can make the following changes:

- If you are currently enrolled in Voluntary Term Life Insurance, you can increase your coverage up to the third level or $500,000 (whichever is less) without providing Proof of Good Health. You must complete a Proof of Good Health form from MetLife if you wish to increase your coverage in excess of 3 levels or $500,000, whichever is less. You must also complete a Proof of Good Health form from MetLife if you increase your coverage in excess of 2 levels times your pay.
- If you are not currently enrolled in Voluntary Term Life Insurance, you can enroll in Voluntary Term Life Insurance, but you must complete a Proof of Good Health form from MetLife.

Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution either directly or through payroll deduction.

Below are the available Voluntary Term Life Insurance options:

Coverage for Pilots
½ times Basic (up to $35,000)
One times Basic (up to $70,000)
One and a half times Basic (up to $105,000)
$200,000
$400,000
$500,000
$600,000
$800,000
$1,000,000

Coverage does not reduce due to age.

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

Pilot Additional Life Insurance Benefit

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

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

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

Spouse/Company-Recognized Domestic Partner Term Life Insurance – Pilots

You may cover your Spouse/Company-Recognized Domestic Partner under Spouse/Company-Recognized Domestic Partner Term Life Insurance. The

Spouse/Company-Recognized Domestic Partner Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse/Company-Recognized Domestic Partner Term Life Insurance for Pilots	$25,000
	$50,000
	$100,000

To add or increase Spouse/Company-Recognized Domestic Partner Term Life Insurance, your Spouse/Company-Recognized Domestic Partner must complete a Proof of Good Health form online within seven days after your election. If you do not complete the form online within seven days after your election, a Proof of Good Health form will be mailed to you. You must then forward the completed form to MetLife for review within 30 days of your election. Upon approval from MetLife, coverage will be added or increased. Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction. New employees may elect any of the three levels of Spouse/Company-Recognized Domestic Partner life with Proof of Good Health.

If you do not enroll in Spouse/Company-Recognized Domestic Partner Term Life Insurance as a new employee, you will only be eligible to elect the lowest level of coverage ($25,000) at a later date with Proof of Good Health and then will only be eligible to increase coverage by one level per year thereafter, with Proof of Good Health.

Flight Attendant Term Life Insurance

Definition of "Pay" for Flight Attendant Life Insurance Options

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

Basic Term Life Insurance Benefit – Flight Attendants

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

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

The Company provides Basic Term Life Insurance coverage at no cost to you based on your salary. You are eligible for 2 times your base annual salary, up to a maximum of

$70,000. Benefit amounts may increase or decrease during the year if your salary changes.

If you were a member of the Retirement Benefit Plan of American Airlines, Inc. for Flight Attendants on or before December 31, 1995, and die while you are an active employee, you are insured for an additional $1,000.

Voluntary Term Life Insurance Benefit – Flight Attendants

In addition to Basic coverage, you may elect to purchase one of eight levels of Voluntary Term Life Insurance at your expense. When you are first eligible for benefits, you may elect up to 3 times your pay or $500,000 (whichever is less) without providing Proof of Good Health. You must submit a Proof of Good Health form if you wish to elect a higher level of coverage (in excess of 3 times your pay or $500,000, whichever is less). You can complete the Proof of Good Health form online within seven days after your election or a Proof of Good Health form will be mailed to you. If you do not complete the form online during this time, you must forward the completed form to MetLife for review within 30 days of your election. Upon approval from MetLife, coverage will be added or increased. Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction.

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

At Annual Enrollment, you can make the following changes:

- If you are currently enrolled in Voluntary Term Life Insurance, you can increase your coverage up to 3 times your pay or $500,000 (whichever is less) without providing Proof of Good Health. You must complete a Proof of Good Health form from MetLife if you wish to increase your coverage in excess of 3 times your pay or $500,000, whichever is less. You must also complete a Proof of Good Health form from MetLife if you increase your coverage in excess of 2 times your pay.
- If you are not currently enrolled in Voluntary Term Life Insurance, you can enroll in Voluntary Term Life Insurance, but you must complete a Proof of Good Health form from MetLife.

Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution either directly or through payroll deduction.

Below are the available Voluntary Term Life Insurance options:

Coverage for Flight Attendants
1 times your pay
2 times your pay
3 times your pay
4 times your pay
5 times your pay
6 times your pay
7 times your pay
8 times your pay

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

Spouse/Company-Recognized Domestic Partner Term Life Insurance – Flight Attendants

You may cover your Spouse/Company-Recognized Domestic Partner under Spouse/Company-Recognized Domestic Partner Term Life Insurance. The Spouse/Company-Recognized Domestic Partner Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse/Company-Recognized Domestic Partner Term Life Insurance for Flight Attendants	Option 1 - One times your pay
	Option 2 - Two times your pay
	Option 3 - Three times your pay

To add or increase Spouse/Company-Recognized Domestic Partner Term Life Insurance, your Spouse/Company-Recognized Domestic Partner must complete a Proof of Good Health Form online within seven days after your election or a Proof of Good Health form will be mailed to you. If you do not complete the form online during this time, you must forward the completed form to MetLife for review within 30 days. Upon approval from MetLife, coverage will be added or increased. Coverage that requires Proof of Good Health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction.

New employees may elect any of the three levels of Spouse/Company-Recognized Domestic Partner Term Life Insurance with Proof of Good Health. If you do not enroll in Spouse/Company-Recognized Domestic Partner Term Life Insurance as a new employee, you will only be eligible to elect Option 1 at a later date with Proof of Good Health and then will only be eligible to increase coverage by one level per year thereafter, with Proof of Good Health.

You pay the entire cost for the Spouse/Company-Recognized Domestic Partner Term Life Insurance coverage you select. You elect coverage at the rate shown on your benefits enrollment screen in the American Airlines Benefits Service Center with after-tax contributions. Your Spouse/Company-Recognized Domestic Partner Term Life rate is based on your Spouse/Company-Recognized Domestic Partner's age, your pay and selected option. The cost of coverage that you pay will increase or decrease during the

year if the premium fluctuates due to changes in your Spouse/Company-Recognized Domestic Partner's age and/or your pay.

Child Term Life Insurance – All Employees

Eligible Employees may cover their Children under the age 26 under Child Term Life Insurance, unless the child has been approved as a Disabled Dependent..

Coverage is offered at $15,000 for each Child. Eligible Children are not required to be enrolled in other benefits (e.g., medical, dental, etc.) in order for you to elect Child Term Life Insurance. Child Term Life Insurance does not require Proof of Good Health.

Filing a Claim for Spouse/Company-Recognized Domestic Partner or Child Term Life Insurance

All life insurance benefits are provided under a group insurance policy issued by MetLife. MetLife also processes and pays all claims.

The following is a short summary of the procedures for filing a claim for Spouse/Company-Recognized Domestic Partner or Child Term Life Insurance benefits:

- Upon the death of your covered Spouse/Company-Recognized Domestic Partner or Child, you or your supervisor should inform the American Airlines Benefits Service Center of the death. You are the sole beneficiary for your Spouse/Company- Recognized Domestic Partner or Child's term life insurance.
- After the American Airlines Benefits Service Center is notified of the death, you will be sent a letter verifying the amount of life insurance payable. The letter will include a Beneficiary Life Insurance Claim Statement.
- Complete the Beneficiary Life Insurance Claim Statement and return it, along with a certified copy of the death certificate, to the American Airlines Benefits Service Center. Upon receipt of both items, the American Airlines Benefits Service Center will submit the claim to MetLife on your behalf.
- The life insurance claim will be paid in approximately four to six weeks after MetLife receives all necessary documentation. You may assign part of the benefits to pay funeral expenses (see "Assignment of Benefits" in the *Plan Administration* section).
- When a Spouse/Company-Recognized Domestic Partner or covered dependent dies, you may want to make changes to your benefits coverages. To process these changes, contact the American Airlines Benefits Service Center within 60 days from the date of your loss. For a list of allowable changes that may be appropriate at this time, see "Life Events" in the *Life Events: Making Changes During the Year* section. For your convenience, the letter you receive includes a Beneficiary Designation Form. This can be completed online through

the American Airlines Benefits Service Center. You can use this form to make any necessary changes to the beneficiary designations you have on file, if appropriate and as applicable.

Designating Beneficiaries

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

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

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

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

When a beneficiary is a minor (under the legal age defined by the beneficiary's state of residence) a guardian must be appointed in order for the Term Life Insurance benefits to be paid. MetLife requires a certified court document appointing the guardian of the minor's estate or property. If the beneficiary does not have a guardian, the Term Life Insurance benefits will be retained by MetLife and interest will be compounded daily until the minor Child reaches the legal age.

To avoid complications in paying beneficiaries, an organization or endowment should not be named unless it is a legal entity (has a legal existence, such as a corporation or trust that has been legally established). If you designate a trust, MetLife assumes that the designated trustee is acting in proper fiduciary capacity unless written notice to the contrary is received at the home office of MetLife. MetLife and the Company are not liable for any payment made to a trustee before receiving such written notice. If the full amount of your insurance is not payable to the trustee, or if a testamentary trustee is named, write to MetLife for assistance in proper documentation.

If your beneficiary is not living at the time of your death or if you have not designated a beneficiary, the benefits under your coverage are paid to the first class of surviving family members in the order outlined below:

- Spouse/Company-Recognized Domestic Partner
- Children or stepchildren

- Parents
- Brothers and sisters
- Estate

Coverage if You Become Disabled

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

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

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

In order for your Term Life Insurance coverage to continue at no cost to you, you must apply for a waiver of Voluntary Term Life Insurance contributions. To apply for a waiver of Voluntary Term Life Insurance contributions, you must file a claim with MetLife between the 9th and 12th month after the date your disability began. Claims filed after the 12th month will not be considered. Contact the American Airlines Benefits Service Center to request a claim form.

Ground Employees:

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

Pilots:

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

- If you became disabled on or after January 1, 1995, your life insurance coverage will be reduced to the retiree level when you begin collecting your pension benefit. If you are not eligible for a pension benefit or Retiree Life Insurance, your coverage stops at age 65.
- If you became disabled on or after January 1, 1995, your life insurance coverage will continue until you reach age 50. At age 50, your Voluntary Term Life Insurance coverage will terminate and your Basic Term Life Insurance will be reduced to the retiree level. The amount of your Pilot Additional Life Insurance will continue as long as you are permanently and totally disabled.

Flight Attendants:

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

All Eligible Employees: MetLife requires you to submit proof of your continuing disability at least once a year. Proof may include examination by doctors designated by the insurance company. If this proof is not submitted, coverage will terminate.

Special Provisions

Accelerated Benefit Option (ABO)

The ABO allows terminally ill people the opportunity to receive a portion of their life insurance during their lifetime. This money can be used to defray medical expenses or replace lost income during the last months of an illness and is not subject to income tax. The remaining portion of the Life Insurance benefit is payable to the named beneficiary when the covered person dies.

The ABO is available to employees who have Company-provided Basic and/or Voluntary Term Life Insurance. Employees who are approved as permanently and totally disabled are also eligible for an ABO. (Spouse/Company-Recognized Domestic Partner and Child Term Life Insurance are not eligible for ABO.)

To qualify for an ABO payout, you must have an injury or illness that is expected to result in death within six months (24 months for Texas residents), with no reasonable prospect for recovery. A Physician's certification is required, and all applications are subject to review and approval by MetLife's medical department. Based on this review, the claim is either paid or denied. If it is paid, you cannot later change the amount of your life insurance coverage.

ABO payout for approved claims is 50 percent of your total Term Life Insurance (Basic, Voluntary, and Pilot Additional, if applicable) coverage, up to a maximum of $250,000. Therefore, any life insurance coverage in excess of $500,000 is not eligible for the ABO.

Your life insurance premiums must be current at the time of the ABO application. If you are on sick leave and have allowed your coverage to default to the Company-provided amount, you are only eligible to receive ABO on that coverage amount. After an ABO payout, you are no longer permitted to change life insurance coverage levels.

Employees who have irrevocably assigned their life insurance benefits and employees who have applied for retirement benefits are not eligible for ABO benefits. See "Assignment of Benefits" for further information.

Taxation of Life Insurance

If your Basic Life plus Pilot Additional Life (if applicable) coverage is more than $50,000, you may be taxed on the value of your coverage over $50,000. This value is imputed to your income for tax purposes and referred to as "imputed income." (Only Basic Life and Pilot Additional Life coverage above $50K is subject to imputed income, since Voluntary Life coverage is after-tax.) IRS regulations require the Company to report employee federal wages and deduct Social Security taxes (FICA) on imputed income from your paycheck and report it on your Form W-2 each year.

Imputed income is based on your age and the monthly cost per $1,000 of life insurance over $50,000. To determine your monthly amount of imputed income, multiply the rate in the following IRS table by the amount of your insurance coverage over $50,000.

Age of Employee on December 31	Monthly Cost of $1,000 of Insurance
Under 25	$0.05
25-29	0.06
30-34	0.08
35-39	0.09
40-44	0.10
45-49	0.15
50-54	0.23
55-59	0.43
60-64	0.66
65-69	1.27
70+	2.06

The following two examples illustrate how imputed income works:

(1) Example 1

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

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

   $70,000 – $50,000 = $20,000

2. Divide that amount by $1,000: 20,000 / $1,000 = 20

3. Multiply the result by the IRS rate from the table above for an employee who is age 30:

   20 × $0.08 = $1.60

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

(2) Example 2

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

1. Figure the total amount of Term Life Insurance coverage: Basic Life: = $70,000

   Pilot Additional Life: = $105,000

TOTAL= $175,000

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

   $175,000 – $50,000 = $125,000

3. Divide that amount by $1,000:

   $125,000 / $1,000 = 125

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

   125 × $0.09 = $11.25

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

Conversion

Subject to policy provisions, you can convert all or any part of your Basic and/or Voluntary Term Life Insurance coverage to an individual life insurance policy (other than term life insurance) offered by MetLife without providing Proof of Good Health, if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for Term Life Insurance coverage,
- The Plan stops covering Term Life Insurance, and you have been covered under this insurance for at least five years, or
- Coverage for your particular job classification ends, and you have been covered under this insurance for at least five years.

If you are applying for an individual policy because your employment terminated, the amount of the policy may not be more than the amount of your Term Life Insurance on the day your coverage ended.

If you are applying for an individual policy because this coverage ended or changed, and you have been covered for at least five years, the amount of your policy will not be more than the lesser of:

- The amount of your coverage on the day it ended, less any amount of life insurance you may be eligible for under any group policy that takes effect within 31 days of the termination of this coverage, or
- $10,000.

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

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

Requesting Conversion

To convert to an individual policy, a Life Insurance Conversion Form and your first payment must be received by MetLife within 60 days of the date coverage terminates. Call MetLife at 1-877-275-6387 to discuss conversion and request a form. If you apply within this 60-day period, MetLife will not require you to provide Proof of Good Health.

If you die within 31 days of your coverage termination date, whether or not you have applied for the conversion policy or portability, MetLife will pay the appropriate beneficiary a death benefit equal to the amount of life insurance you had on the date coverage terminated.

To discuss conversion options and to request forms, contact MetLife at 1-877-275-6387.

Portability

Voluntary Term Life Insurance is portable. This means you may continue your Voluntary Term Life Insurance coverage under a separate group policy if you leave the Company or retire. The rates for this continuing coverage are not the same as those you pay as an active employee, but they are preferred group rates based on your age. MetLife will provide the rate schedule if you apply for portability. The minimum amount of coverage you may continue is $20,000 and the maximum amount is your current amount of Voluntary Term Life Insurance coverage. To apply for this continuing coverage, you must

submit an application form to MetLife within 60 days after you leave or retire from the Company.

To discuss portability options and to request forms, contact American Airlines Benefits Service Center.

Assignment of Benefits

As of January 1, 2015, no new assignments on your life insurance coverage will be accepted by the Company. Any existing life assignments as of December 31, 2014 will continue to be recognized by the Company. If you previously assigned your benefits, you are obligated to fulfill any conditions you have agreed to with your assignee.

MetLife's only obligation is to pay the Life Insurance Benefits due at your death.

Your beneficiary may continue to assign a portion of his or her benefit directly to the funeral home to cover the cost of the funeral. To assign benefits to a funeral home, the beneficiary signs an agreement with the funeral home. The funeral home sends a copy of the signed agreement and an itemized statement of funeral expenses to MetLife. When MetLife processes the claim, a separate check for this portion of the benefit will be paid directly to the funeral home.

Total Control Account

When a claim is processed, MetLife establishes a Total Control Account for each beneficiary whose share is $5,000 or more. (Smaller amounts are paid in a lump sum.) All insurance proceeds are deposited into this interest-bearing checking account that pays competitive money market interest rates and is guaranteed by MetLife.

MetLife sends a personalized checkbook to your beneficiary, who may withdraw some or all of the proceeds and interest whenever necessary. In addition, MetLife sends descriptions of alternative investment options to your beneficiary. The Total Control Account gives your beneficiary complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

For income tax purposes, proceeds deposited into the Total Control Account are treated the same as a lump sum settlement. Because the tax consequences of life insurance proceeds may vary, the Company strongly recommends that you or your beneficiary contact your tax advisor.

MetLife will only pay interest on a life insurance claim (to cover the time between death and date of payment) if the beneficiary lives in a state that requires interest payments. Because state insurance laws vary, calculation of interest differs from state to state.

Verbal Representation

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

Filing Claims

MetLife insures all Life Insurance benefits under a group insurance policy and processes all claims. The life insurance claim will be processed after MetLife receives all necessary documentation.

Please see the "Claims Procedures" chapter for a detailed description of the claims procedures that apply to your life insurance benefits.

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

Overview

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

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

Overview

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

The Accidental Death & Dismemberment Insurance ("AD&D") benefits of Employees of American Airlines, Inc. who were covered by collective bargaining agreements entered into between Legacy US Airways, Inc. and the IAM were converted from AD&D benefits under the American Airlines, Inc. Group Life and Disability Plan for Certain Legacy Employees, to AD&D benefits under this Plan.

Therefore, all references to "Ground Employees" shall be deemed to include Employees of American Airlines, Inc. who are covered by collective bargaining agreements entered into between the TWU/IAM Association covering Mechanics & Related, Material Logistics Specialists, Maintenance Training Specialists, Maintenance Control Technicians, and Fleet Service.
The Company provides the following Accident Insurance benefits to eligible Ground Employees:

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

Certain exclusions apply such as self-inflicted death. Please review the certificates for all exclusions

The insurance certificates are available on my.aa.com. As with all insured benefits, with respect to the accident insurance benefits for Ground Employees, the terms of the insurance certificates control when describing specific benefits that are covered or insurance-related terms.

Accident coverage is provided under group insurance policies issued by the Life Insurance Company of North America (LINA). New York Lifeprocesses and pays all claims for LINA. Contact the American Airlines Benefits Service Center for more information and to start a claim. .

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

Basic Accidental Death & Dismemberment Insurance (AD&D)

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

Voluntary Accidental Death & Dismemberment Insurance (AD&D)

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

- $10,000 increments up to $500,000 for employee coverage, and up to $350,000 for Spouse/Company-Recognized Domestic Partner coverage.
- $10,000 coverage for each dependent Child, regardless of the number of Children covered.

What is Covered under Basic and Voluntary AD&D

In the event of an Accidental Injury, AD&D insurance pays benefits to:

- You, in the case of certain Accidental Injuries to you or your covered dependent(s)
- You, in the event of your covered dependent's death
- Your named beneficiary, in the event of your death

A covered loss includes death, paralysis or loss of limb, sight, speech or hearing. The AD&D coverage pays a benefit if you have a loss within one year of an Accidental Injury. If you experience more than one loss from the same accident, the coverages pay the largest amount applicable to one loss.

The following table explains when an injury is covered as a loss:

If Injury Is to:	It Must Be:
Hand or foot	Severed through or above the wrist or ankle joint
Arm or leg	Severed through or above the elbow or knee joint
Eye	The entire, irrecoverable loss of sight
Thumb and index finger	Severed through or above the metacarpophalangeal joint (the point where the finger is connected to the hand)
Speech	An irrecoverable loss of speech that does not allow audible communication in any degree

Hearing	An irrecoverable loss of hearing in both ears that cannot be corrected with any hearing aid or device

The following table shows the portion of benefits that the AD&D coverage pays if you have an Accidental Injury which results in a loss:

If Injury Results in:	Benefit Is:
Death	Full benefit amount
Loss of two or more members (hand, foot, eye, leg or arm)	Full benefit amount
Loss of speech and hearing in both ears	Full benefit amount
Quadriplegia (total paralysis of both upper and both lower limbs)	Full benefit amount
Paraplegia (total paralysis of both legs)	Full benefit amount
Hemiplegia (total paralysis of the arm and leg on one side of the body)	Full benefit amount
Loss of one arm	3/4 benefit amount
Loss of one leg	3/4 benefit amount
Loss of one hand, foot or eye	1/2 benefit amount
Loss of speech	1/2 benefit amount
Loss of hearing in both ears	1/2 benefit amount
Loss of thumb and index finger on the same hand	1/4 benefit amount

If your Accidental Injury results in the loss of use of a limb (arm or leg) within one year from the date of an accident, you receive the following benefits:

Injury	Benefit
Loss of use of two limbs	***2/3 benefit amount***
Loss of use of one limb	***1/2 benefit amount***

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

Special Benefit Features Under Basic and Voluntary AD&D

- **Air bag benefit:** If you or your covered dependent dies in a motor vehicle accident and the safety airbag (as defined by the Benefit Option) is deployed as a result of such an accident, the participant will receive a benefit equivalent to 10 percent of the AD&D principal sum benefit, up to a maximum of $10,000. A seat belt must be worn in order for the Air Bag Benefit to be payable.
- **Childcare benefit:** If you or your Spouse/Company-Recognized Domestic Partner dies as the result of an accident and your Child is covered under the family AD&D, the coverage pays the surviving Spouse/Company-Recognized Domestic Partner an annual benefit of five percent of the total coverage amount (up to $7,500 per year) for the cost of surviving Child(ren)'s care in a licensed **Childcare facility**. This benefit is payable up to five years or until the Child enters first grade, whichever occurs first.
- **COBRA reimbursement:** If you die as a result of an accident and your Spouse/Company-Recognized Domestic Partner and Child are covered under the family AD&D, the coverage pays your dependents an additional annual benefit up to three percent of your AD&D coverage amount to assist them in paying for continuation of group

medical coverage, up to a maximum of $6,000 per year. This COBRA reimbursement benefit may be paid for up to three years or for the duration of your dependents' COBRA eligibility, whichever is longer. To be eligible for this benefit, your Spouse/Company-Recognized Domestic Partner and dependent Child(ren) must be covered under the family AD&D, as well as your Medical Benefit Option.

- **Coma benefit:** If you or a covered dependent becomes comatose as the result of an accident within 31 days of the accident, you receive 1 percent per month of the AD&D death benefit amount each month for up to 11 months. This benefit ends the earliest of:
    - The month the covered person dies,
    - The end of the 11th month for which the benefit is payable, or
    - The end of the month in which the covered person recovers.

This benefit is payable after a 31-day waiting period that begins on the day the covered person becomes comatose.

If the covered person remains comatose after 11 months, the coverage pays the amount of coverage for accidental death reduced by benefits already paid for injury or paralysis. If the covered person dies as the result of the accident while the coma benefit is payable, the coverage pays benefits for accidental death.

In addition to other AD&D exclusions (listed in the section "Basic and Voluntary AD&D Exclusions"), the coma benefit has one other exclusion. Benefits are not payable for a loss resulting from illness, disease, bodily infirmity, medical or surgical treatment or bacterial or viral infection, regardless of how it was contracted. However, a bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning is covered.

Coma benefits are paid to the legal guardian or person responsible for the care of the comatose patient. The Network/Claim Administrator determines who is most responsible if a legal guardian is not named.

Payment of the coma benefit to the legal guardian or person responsible for care does not change the designated beneficiary in the event of death.

- **Common disaster benefit:** If you elect family AD&D coverage and, as the result of a Common Accident, you or your Spouse/Company-Recognized Domestic Partner dies within one year of the covered accident, the Spouse/Company- Recognized Domestic Partner's loss of life benefits will be increased to 100 percent of your amount of coverage. However, the combined benefits of you and your Spouse/Company-Recognized Domestic Partner will not be more than $1 million.
- **Bereavement Counseling**: AD&D pays an additional benefit if you or an insured family member dies, becomes comatose or is paralyzed or suffers accidental dismemberment as a result of a covered

accident. AD&D will pay for up to five sessions of Medically Necessary Bereavement Counseling, at a maximum of $100 per session, for expenses incurred within one year of the date of the covered accident. Benefits are payable for the insured and any of the insured's immediate family members including mothers/fathers-in-law, and brothers/sisters-in-law.

- **Double benefit for dismemberment of Children**: If a covered Child experiences a loss as the result of an accident, the benefit amount is double (to a maximum benefit of $20,000). This provision does not apply if death occurs within 90 days of the accident.
- **Home/vehicle modification benefit**: If, as the result of an accident, the participant's covered injury(ies) require use accommodations to his/her home or motor vehicle, the participant will receive a benefit equivalent to 10 percent of his/her principal sum benefit, up to a maximum benefit of $10,000.
- **Escalator benefit**: Your AD&D benefits will automatically increase by three percent of your elected benefit amount each year, up to a maximum of 15 percent after five continuous years. This increased coverage is provided at no additional cost. If coverage ends for any reason, such as layoff, unpaid sick leave of absence or termination of contributions, any previous escalator benefit is lost. A new five-year escalator benefit period starts if you decrease your coverage or re-enroll.
- **Seat belt benefit**: If you or your covered dependent dies in an accident as the driver or passenger of any land vehicle (including Company-owned cars, pickups and commercial vehicles) and the covered person was properly wearing a seat belt at the time of the accident, the coverage pays an additional 20 percent of the benefit applicable to you or your dependent, to a maximum of $25,000. If the vehicle was not equipped with seat belts or the accident report shows seat belts were not in proper use, no seat belt benefit is payable.
- **Rehabilitation benefit:** If a participant suffers injury from an accident resulting in a loss for which benefits are payable under the AD&D Insurance benefit, this coverage will reimburse the participant for covered rehabilitative expenses that are due to the injury causing the loss. These covered rehabilitative expenses must be incurred within two years after the date of the accident causing the loss and will be payable up to a maximum of $50,000 for all injuries caused by the same accident.
- Covered rehabilitative expense means an expense that:
    - Is charged for a Medically Necessary rehabilitative training session of the participant, performed under the care, supervision or order of a Physician,

- Does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for hospital room and board charges, does not exceed the most common charge for hospital semi-private room and board in the hospital where the expense is incurred, and
- Does not include charges that would not have been made if no insurance existed.

Covered rehabilitative expense does not include any expenses for or resulting from any condition for which the participant is entitled to benefits under any Workers' Compensation Act or similar law.

- **Medically Necessary rehabilitative training service means any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that:**
  - Is essential for physical rehabilitative training due to the injury for which it is prescribed or performed,
  - Meets generally accepted standards of medical practice, and
  - Is ordered by a doctor.
- **Hospital means a facility that**:
  - Is operating according to law for the care and treatment of injured people,
  - Has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a pre-arranged basis,
  - Has 24-hour nursing service by registered Nurses, and
  - Is supervised by one or more Physicians.
- **A hospital does not include**:
  - A nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care,
  - A facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, or
  - Any military or veteran hospital or soldiers' home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.
- **Special education benefit**: If either you or your Spouse/Company-Recognized Domestic Partner dies as the result of an accident and your Children are all covered by the family AD&D, the coverage pays five percent of that parent's total coverage amount (up to $10,000 per

year) to each dependent Child for higher education. This benefit is payable for up to four consecutive years, as long as the Child is enrolled in School beyond 12th grade. If coverage is in force but there are no Children who qualify at the time of the accident, the coverage pays an additional $1,000 to the designated beneficiary.

- **Spouse/Company-Recognized Domestic Partner critical period:** If you or your covered Spouse/Company-Recognized Domestic Partner dies as a result of an accident, AD&D pays the surviving Spouse/Company-Recognized Domestic Partner an additional monthly benefit of a half of a percent (0.5%) of the deceased person's coverage amount. This benefit, provided to help the surviving Spouse/Company-Recognized Domestic Partner cope with the difficult period immediately following a death, is paid monthly for 12 months.
- **Spouse/Company-Recognized Domestic Partner retraining or refreshing skills benefit:** If you die accidentally and your Spouse/Company-Recognized Domestic Partner is also covered by the family AD&D, the coverage pays up to a maximum of $10,000 for your Spouse/Company-Recognized Domestic Partner to enroll as a student in an accredited School within 365 days of your death. This benefit is in addition to all other benefits.
- **Uniplegia benefit:** If a participant is involved in an accident resulting in the loss of use of only one arm or one leg, the participant will receive a benefit equivalent to 50 percent of his/her principal sum benefit.
- **Waiver of premium:** If you elect AD&D coverage for you and your dependents and you die as the result of an accident, any AD&D coverage you have elected for your Spouse/Company-Recognized Domestic Partner and Children continues without charge for 24 months.

Travel Assistance Services

If you have Basic or Voluntary AD&D coverage for yourself, you may also take advantage of travel assistance services when you and your covered family members travel internationally. Please note that New York Life Secure Travel is not an ERISA-covered benefit.

Through New York Life Secure Travel, you have access to more than 250,000 service professionals in over 200 countries. These agents are available 24 hours a day, seven days a week to provide you with the highest level of service whenever you need it.

New York Life Secure Travel offers the following services for international travel:

- Services before your departure, including:

- Immunization requirements
- Visa and passport requirements
- Foreign exchange rates
- Embassy/consular referral
- Travel/tourist advisories
- Temperature and weather conditions
- Cultural information

- Services available while traveling abroad (or within the US if 100 or more miles from home) include:
  - Medical referrals to local Physicians, Dentists and medical treatment centers in the event of an Emergency (accident or illness); you must follow your Medical Benefit Option rules to receive reimbursement for any Eligible Expenses
  - Assistance with paying for medical services (if payment is required at the time services are rendered)
  - Prescription assistance to refill a Prescription that has been lost, stolen or depleted
  - Assistance in replacing lost luggage, documents and personal items
  - Legal referrals to local attorneys, embassies and consulates; you will need to pay for any professional services rendered
  - Emergency message relay to notify friends, relatives or business associates if you have a serious accident or illness while traveling
  - Emergency medical evacuation for transportation to the nearest adequate hospital or treatment facility, if Medically Necessary
  - Repatriation of remains in the event of death overseas to cover the cost of returning remains to the place of residence and arranging necessary government authorizations to transfer remains
  - Return of dependent Children (who are under age 16) traveling with a covered member and who are left unattended when the covered member is hospitalized. CIGNA Secure Travel will arrange and pay for their transportation home. If someone is needed to accompany the Children, a qualified escort will be arranged and expenses paid.
  - If a covered member is traveling alone and must be hospitalized for more than 10 consecutive days,

arrangements will be made and paid to provide round-trip economy class transportation for an immediate family member or friend designated by the covered member from his or her home to the place where the covered member is hospitalized.

New York Life Secure Travel agents are available 24 hours per day and 7 days per week.

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

Basic and Voluntary AD&D Exclusions

AD&D coverage does not cover loss caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, self-inflicted death or an attempt to self-inflict death
- Declared or undeclared act of war within the U.S. or any nation of which you are a citizen
- An accident that occurs while you are serving full-time active duty for more than 30 days in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity; or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from the vehicle or device while:
    - The vehicle is being used for experimental purposes
    - You are operating, learning to operate or serving as a member of the crew of an aircraft other than an aircraft operated by or under contract with the Company
- Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed Physician (accidental ingestion of a poisonous substance is covered, as well as accidents caused by use of legal, Over-the-Counter drugs)
- Commission of a felony including, but not limited to: robbery, rape, arson, murder, kidnapping or burglary.

Filing a Claim for Basic or Voluntary AD&D

AD&D is provided under group insurance policies issued by the Life Insurance Company of North America (LINA). New York Life processes all claims for LINA. To file a claim for AD&D benefits:

- Contact the American Airlines Benefits Service Center to request a AD&D Claim Form within 30 days of the death or injury. Complete the form according to accompanying directions. All claims must be submitted on the applicable form.
- In the event of your death, your manager/supervisor will notify Survivor Support Services, who will coordinate filing for benefits, similar to the procedures outlined for life insurance claims in Filing Claims.
- Send the completed claim form to the American Airlines Benefits Service Center along with documentation of the claim, such as a police report of an accident and a certified copy of the death certificate. The American Airlines Benefits Service Center sends the claim to New York Life for processing.
- New York Life processes claims within 90 days from the day they are received. In some cases, however, more time may be needed. If this is the case with your claim, New York Life will notify you that an additional 90 days will be required. At any point during the claim review period, you may be asked to supply additional information and/or submit to a medical examination at LINA's expense.
- If your claim is approved, the insurance proceeds will be deposited into a New York Life resource manager account (similar to a money market checking account) that earns interest.
- If your claim is denied, you or your beneficiary will be notified in writing.

Notification explains the reasons for the denial and specifies the provisions of the LINA group policy that prevent approval of the claim. The notification may also describe what additional information, if any, could change the outcome of the decision.

- If your claim is denied or you have not received a response by the end of the second 90-day review period, you may request a review of your claim.
- No one may take legal action regarding the claim until 60 days after filing the claim. No legal action may be taken more than three years after filing the claim (with the exception of five years in Kansas and six years in South Carolina). You must exhaust your administrative appeals before filing any legal action regarding a claim denial.

Conversion Rights Under Basic and Voluntary AD&D

You can convert up to $250,000 in Accidental Death and Dismemberment (AD&D) Insurance coverage for you and your Spouse/Company-Recognized Domestic Partner and up to $10,000 in coverage for each eligible Child to individual policies offered by LINA within 31 days of termination of coverage if coverage terminates for one of the following reasons:

- Your employment ends,
- Your eligibility ends (however, a dependent who is no longer eligible for coverage may not convert to an individual policy while you remain eligible for coverage), or
- The coverage ends.

Contact LINA at 1-800-238-2125 for details on conversion.

Basic & Voluntary AD&D Insurance Policy

The terms and conditions of this AD&D coverage are set forth in the group insurance policies issued by LINA. These group policies are available for review from LINA. In the event of a conflict between the description in this SPD and the provisions of the insurance policies, the insurance policies will govern.

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

The Company provides Other Accident Insurance for certain situations described in this section. Other Accident Insurance programs include Special Risk Accident Insurance (SRAI), Special Purpose Accident Insurance (SPAI), and Management Personal Accident Insurance (MPAI) (for Management and Officer employees only).

These insurance coverages all have the following features:

- Premiums are paid by the Company.
- Coverage is provided without regard to your health history.
- The insurance provides 24-hour protection while you are traveling on Company business, from the time you leave until you return home or to your base, whichever occurs first.
- Benefits are payable in addition to any other insurance you may have.
- Covered losses include death or loss of limb, sight, speech or hearing. The insurance pays a benefit if you have a loss within one year of an Accidental Injury.

- No more than one Other Accident Insurance benefit will be paid with respect to injuries resulting from one accident. If you have more than one loss from the same accident, you are entitled to the largest benefit amount for a single loss.
- Benefits payable under these other accident coverages do not reduce any accident benefits you may receive under the AD&D Insurance Benefits coverage.

Special Risk Accident Insurance (SRAI) Benefit

The SRAI benefit provides insurance coverage for employees for accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world. You are covered while performing daily assignments at your home base and during business travel. Hostile acts of foreign governments are also covered for any occurrences outside the U.S.

SRAI pays a benefit of five times your annual base salary, up to a maximum of

$500,000. This coverage only applies to U.S. based employees on active payroll.

Special Purpose Accident Insurance (SPAI) Benefit

This insurance coverage pays up to $100,000 to each employee who is injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.

The SPAI benefit also covers non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft, and pays up to $100,000 for accidental death or dismemberment.

Management Personal Accident Insurance (MPAI) Benefits (For Management and Officer employees only)

MPAI provides insurance coverage for Management employees while traveling on Company business and for non-occupational accidents involving any land or water vehicle. Coverage is three times your salary, with a minimum of $35,000 and a maximum of $200,000.

Policy Aggregates under SRAI Benefit, SPAI Benefit, and MPAI Benefit

An accident may involve more than one employee. Total benefits to all covered employees involved in a single incident are limited to:

- $10,000,000 under the SRAI benefit.
- $2,000,000 per aircraft accident under the SPAI benefit.
- $5,000,000 per aircraft accident under the MPAI benefit. (For Management and Officer employees only)

If benefits for one incident would exceed the limit, benefits are distributed to beneficiaries in proportion to the amounts of insurance covering all employees who suffer losses in the same incident.

Exclusions under SRAI Benefit, SPAI Benefit, and MPAI Benefit

These accident insurance policies do not cover losses caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, self-inflicted death or an attempt to self-inflict death
- Declared or undeclared act of war (under the SRAI benefit, hostile acts of foreign governments are not covered within the U.S.)
- An accident that occurs while you are serving on full-time, active duty in the armed forces of any country or international authority.
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound.
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting, while:
    - The vehicle is used for test or experimental purposes.
    - You are operating, learning to operate or serving as a member of the crew except while riding solely as a passenger, mechanic, substitute flight attendant or acting as a crewmember on any aircraft owned by or under contract to American Airlines.
    - Being operated under the direction of any military authority other than transport-type aircraft operated by the Military Airlift Command (MAC) of the

U.S. or a similar air transport service of any other country.

    - Commuting to and from work (SRAI Benefit).

SRAI Benefit, SPAI Benefit, and MPAI Benefit Insurance Policy

The terms and conditions of the coverages are set forth in the group insurance policies issued by the Life Insurance Company of North America (LINA). The group policies are available for review from the Plan Administrator.

In the event of a conflict between the description in this SPD and the provisions of the insurance policies, the insurance policies will govern.

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

Overview

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

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

Overview

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

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

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

Certain exclusions apply such as self-inflicted death. Please review the certificates for all exclusions

The insurance certificates are available on my.aa.com. As with all insured benefits, with respect to the accident insurance benefits for Flight Employees, the terms of the insurance certificates control when describing specific benefits that are covered or insurance-related terms.

LINA's and New York Life's Roles

Accident coverage is provided under group insurance policies issued by the Life Insurance Company of North America (LINA). New York Life processes and pays all claims for LINA. Contact the American Airlines Benefits Service Center for more information and to start a claim.

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

Basic Accidental Death & Dismemberment Insurance (AD&D)

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

Voluntary Personal Accident Insurance (VPAI)

You may also elect to purchase Voluntary Personal Accident Insurance (VPAI) for yourself in $10,000 increments up to $500,000. You may also elect to purchase VPAI for yourself and your family. You pay premiums through before-tax payroll deductions. Other notable features include:

- Coverage is available without regard to previous health history.

- The Plan provides broad 24-hour protection, year-round, including coverage during travel.
- Benefits are payable in addition to any other insurance you may have.

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

Family Covered	Amount of Benefit
Spouse/Company-Recognized Domestic Partner **only**	70% of the employee's elected benefit amount
Spouse/Company-Recognized Domestic Partner **and Child(ren)**	Spouse/Company-Recognized Domestic Partner: 60% of the employee's elected benefit amount Each Dependent: 15% of the employee's elected benefit amount, not to exceed $75,000 for each covered Child
Children only	Each Dependent Child: 25% of the employee's elected benefit amount, not to exceed $125,000

What is covered under AD&D and VPAI

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

- You, in the case of certain accidental injuries/dismemberment to you or your covered dependent(s)
- You, in the event of your covered dependent's death
- Your named beneficiary, in the event of your death

A covered loss includes death, paralysis or loss of limb, sight, speech or hearing. The AD&D and VPAI coverages pay a benefit if you (or a covered dependent for VPAI) have a loss within one year of an Accidental Injury. If you experience more than one loss from the same accident, the coverages pay the largest amount applicable to one loss.

The following table explains when an injury is covered as a loss:

If Injury Is to:	It Must Be:
Hand or foot	Severed through or above the wrist or ankle joint
Arm or leg	Severed through or above the elbow or knee joint
Eye	The entire, irrecoverable loss of sight
Thumb and index finger	Severed through or above the metacarpophalangeal joint (the point where the finger is connected to the hand)
Speech	An irrecoverable loss of speech that does not allow audible communication in any degree

If Injury Is to:	It Must Be:
Hearing	An irrecoverable loss of hearing in both ears that cannot be corrected with any hearing aid or device

The following table shows the portion of benefits that the AD&D and VPAI coverages pay if you (or a covered dependent for VPAI) have an Accidental Injury which results in a loss:

If Injury Results in:	Benefit Is:
Death	Full benefit amount
Loss of two or more members (hand, foot, eye, leg or arm)	Full benefit amount
Loss of speech and hearing in both ears	Full benefit amount
Quadriplegia (total paralysis of both upper and both lower limbs)	Full benefit amount
Paraplegia (total paralysis of both legs)	Full benefit amount
Hemiplegia (total paralysis of the arm and leg on one side of the body)	Full benefit amount
Loss of one arm	3/4 benefit amount
Loss of one leg	3/4 benefit amount
Loss of one hand, foot or eye	1/2 benefit amount
Loss of speech	1/2 benefit amount
Loss of hearing in both ears	1/2 benefit amount
Loss of thumb and index finger on the same hand	1/4 benefit amount

If your Accidental Injury results in the loss of use of a limb (arm or leg) within one year from the date of an accident, you receive the following benefits:

Injury	Benefit
Loss of use of two limbs	***2/3 benefit amount***
Loss of use of one limb	***1/2 benefit amount***

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

Special VPAI Benefit Features

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

- **Air bag benefit:** If you or your covered dependent dies in a motor vehicle accident and the safety airbag (as defined by the Plan) is deployed as a result of such an accident, the participant will receive a benefit equivalent to 10 percent of the VPAI principal sum benefit, up to a maximum of $10,000. A seat belt must be worn in order for the Air Bag Benefit to be payable.
- **Child care benefit:** If you or your covered Spouse/Company-Recognized Domestic Partner dies as the result of an accident and

your Child is covered under the family VPAI, the coverage pays the surviving Spouse/Company-Recognized Domestic Partner an annual benefit of 5 percent of the total coverage amount (up to $7,500 per year) for the cost of surviving Children's care in a licensed child care facility. This benefit is payable up to five years or until the Child enters first grade, whichever occurs first.

- **COBRA reimbursement:** If you die as a result of an accident and your Spouse/Company-Recognized Domestic Partner and Child are covered under the family VPAI, the coverage pays your dependents an additional annual benefit up to 3 percent of your VPAI coverage amount to assist them in paying for continuation of group medical coverage, up to a maximum of $6,000 per year.

This COBRA reimbursement benefit may be paid for up to three years or for the duration of your dependents' COBRA eligibility, whichever is longer. To be eligible for this benefit, your Spouse/Company-Recognized Domestic Partner and dependent Child(ren) must be covered under the family VPAI, as well as your Medical Benefit Option.

- **Coma benefit:** If you or a covered dependent becomes comatose as the result of an accident within 31 days of the accident, you receive 1 percent per month of the VPAI death benefit amount each month for up to 11 months. This benefit ends the earliest of:
    - The month the covered person dies,
    - The end of the 11th month for which the benefit is payable, or
    - The end of the month in which the covered person recovers.

This benefit is payable after a 31-day waiting period that begins on the day the covered person becomes comatose.

If the covered person remains comatose after 11 months, the coverage pays the amount of coverage for accidental death reduced by benefits already paid for injury or paralysis. If the covered person dies as the result of the accident while the coma benefit is payable, the coverage pays benefits for accidental death.

In addition to other VPAI exclusions, the coma benefit has one other exclusion. Benefits are not payable for a loss resulting from illness, disease, bodily infirmity, medical or surgical treatment or bacterial or viral infection, regardless of how it was contracted. However, a bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning is covered.

Coma benefits are paid to the legal guardian or person responsible for the care of the comatose patient. The Network/Claim Administrator determines who is most responsible if a legal guardian is not named.

Payment of the coma benefit to the legal guardian or person responsible for care does not change the designated beneficiary in the event of death.

- **Common disaster benefit:** If you elect family VPAI coverage and, as the result of a Common Accident, you or your Spouse/Company-Recognized Domestic Partner dies within one year of the covered accident, the Spouse/Company- Recognized Domestic Partner's loss of life benefits will be increased to 100 percent of your amount of coverage. However, the combined benefits of you and your Spouse/Company-Recognized Domestic Partner will not be more than $1 million.
- **Bereavement Counseling:** VPAI pays an additional benefit if you or an insured family member dies, becomes comatose or is paralyzed or suffers accidental dismemberment as a result of a covered accident. VPAI will pay for up to five sessions of Medically Necessary Bereavement Counseling, at a maximum of $100 per session, for expenses incurred within one year of the date of the covered accident. Benefits are payable for the insured and any of the insured's immediate family members including mothers/fathers-in-law, and brothers/sisters-in-law.
- **Double benefit for dismemberment of Children:** If a covered Child experiences a loss as the result of an accident, the benefit amount is double (to a maximum benefit of $250,000). This provision does not apply if death occurs within 90 days of the accident.
- **Home/vehicle modification benefit:** If, as the result of an accident, the participant's covered injury(ies) require use accommodations to his/her home or motor vehicle, the participant will receive a benefit equivalent to 10 percent of his/her principal sum benefit, up to a maximum benefit of $10,000.
- **Escalator benefit:** Your VPAI benefits will automatically increase by three percent of your elected benefit amount each year, up to a maximum of 15 percent after five continuous years. This increased coverage is provided at no additional cost. If coverage ends for any reason, such as layoff, unpaid sick leave of absence or termination of contributions, any previous escalator benefit is lost. A new five-year escalator benefit period starts if you decrease your coverage or re-enroll. If you increase your level of coverage, you will retain the escalator benefit that has accrued on the previous amount and will begin a new five year escalator period for the additional amount of coverage.
- **Seat belt benefit:** If you or your covered dependent dies in an accident as the driver or passenger of any land vehicle (including Company-owned cars, pickups and commercial vehicles) and the covered person was properly wearing a seat belt at the time of the accident, the coverage pays an additional 20 percent of the benefit applicable to you or your dependent, to a maximum of $25,000. If the

vehicle was not equipped with seat belts or the accident report shows seat belts were not in proper use, no seat belt benefit is payable.

- **Rehabilitation benefit:** If a participant suffers injury from an accident resulting in a loss for which benefits are payable under the VPAI insurance benefit, this coverage will reimburse the participant for covered rehabilitative expenses that are due to the injury causing the loss. These covered rehabilitative expenses must be incurred within two years after the date of the accident causing the loss, and will be payable up to a maximum of $50,000 for all injuries caused by the same accident.
- **Covered rehabilitative expense means an expense that:**
    - Is charged for a Medically Necessary rehabilitative training session of the participant, performed under the care, supervision or order of a Physician,
    - Does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for hospital room and board charges, does not exceed the most common charge for hospital semi-private room and board in the hospital where the expense is incurred), and
    - Does not include charges that would not have been made if no insurance existed.

Covered rehabilitative expense does not include any expenses for or resulting from any condition for which the participant is entitled to benefits under any Workers' Compensation Act or similar law.

- **Medically Necessary rehabilitative training service means any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that:**
    - Is essential for physical rehabilitative training due to the injury for which it is prescribed or performed,
    - Meets generally accepted standards of medical practice, and
    - Is ordered by a doctor.
- **Hospital means a facility that:**
    - Is operating according to law for the care and treatment of injured people,
    - Has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a pre-arranged basis,
    - Has 24-hour nursing service by registered Nurses, and
    - Is supervised by one or more Physicians.

- **A hospital does not include:**
    - A nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care,
    - A facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, or
    - Any military or veteran hospital or soldiers' home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.
- **Special education benefit:** If either you or your Spouse/Company-Recognized Domestic Partner dies as the result of an accident and your Children are all covered by the family VPAI, the coverage pays 5 percent of that parent's total coverage amount (up to $10,000 per year) to each dependent Child for higher education. This benefit is payable for up to four consecutive years, as long as the Child is enrolled in School beyond 12th grade. If coverage is in force but there are no Children who qualify at the time of the accident, the coverage pays an additional $1,000 to the designated beneficiary.
- **Spouse/Company-Recognized Domestic Partner critical period:** If you or your covered Spouse/Company-Recognized Domestic Partner dies as a result of an accident, VPAI pays the surviving Spouse/Company-Recognized Domestic Partner an additional monthly benefit of a half of a percent (0.5%) of the deceased person's coverage amount. This benefit, provided to help the surviving Spouse/Company-Recognized Domestic Partner cope with the difficult period immediately following a death, is paid monthly for 12 months.
- **Spouse/Company-Recognized Domestic Partner retraining or refreshing skills benefit:** If you die accidentally and your Spouse/Company-Recognized Domestic Partner is also covered by the family VPAI, the coverage pays up to a maximum of $10,000 for your Spouse/Company-Recognized Domestic Partner to enroll as a student in an accredited School within 365 days of your death. This benefit is in addition to all other benefits.
- **Uniplegia benefit:** If a participant is involved in an accident resulting in the loss of use of only one arm or one leg, the participant will receive a benefit equivalent to 50 percent of his/her principal sum benefit.
- **Waiver of premium:** If you elect VPAI coverage for you and your dependents and you die as the result of an accident, any VPAI

coverage you have elected for your Spouse and Children continues without charge for 24 months.

Travel Assistance Services

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

Through New York Life Secure Travel, you have access to more than 250,000 service professionals in over 200 countries. These agents are available 24 hours a day, seven days a week to provide you with the highest level of service whenever you need it.

New York Life Secure Travel offers the following services for international travel:

- Services before your departure, including:
    - Immunization requirements
    - Visa and passport requirements
    - Foreign exchange rates
    - Embassy/consular referral
    - Travel/tourist advisories
    - Temperature and weather conditions
    - Cultural information
- Services available while traveling abroad (or within the U.S. if 100 or more miles from home) include:
    - Medical referrals to local Physicians, Dentists and medical treatment centers in the event of an Emergency (accident or illness); you must follow your Medical Benefit Option rules to receive reimbursement for any Eligible Expenses
    - Assistance with paying for medical services (if payment is required at the time services are rendered)
    - Prescription assistance to refill a Prescription that has been lost, stolen or depleted
    - Assistance in replacing lost luggage, documents and personal items
    - Legal referrals to local attorneys, embassies and consulates; you will need to pay for any professional services rendered
    - Emergency message relay to notify friends, relatives or business associates if you have a serious accident or illness while traveling

- Emergency medical evacuation for transportation to the nearest adequate hospital or treatment facility, if Medically Necessary
- Repatriation of remains in the event of death overseas to cover the cost of returning remains to the place of residence and arranging necessary government authorizations to transfer remains
- Return of dependent Children (who are under age 16) traveling with a covered member and who are left unattended when the covered member is hospitalized. CIGNA Secure Travel will arrange and pay for their transportation home. If someone is needed to accompany the Children, a qualified escort will be arranged and expenses paid.
- If a covered member is traveling alone and must be hospitalized for more than 10 consecutive days, arrangements will be made and paid to provide round-trip economy class transportation for an immediate family member or friend designated by the covered member from his or her home to the place where the covered member is hospitalized.

New York Life Secure Travel agents are available 24 hours per day and 7 days per week.

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

AD&D and VPAI Exclusions

AD&D and VPAI coverage does not cover loss caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, self-inflicted death or attempted self-inflicted death
- Declared or undeclared act of war within the U.S. or any nation of which you are a citizen

- An accident that occurs while you are serving full-time active duty for more than 30 days in the armed forces of any country or international authority

- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from the vehicle or device while:
    - The vehicle is being used for experimental purposes
    - You are operating, learning to operate or serving as a member of the crew of an aircraft other than an aircraft operated by or under contract with the Company
- Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed Physician (accidental ingestion of a poisonous substance is covered, as well as accidents caused by use of legal, Over-the-Counter drugs)
- Commission of a felony including, but not limited to: robbery, rape, arson, murder, kidnapping or burglary.

Filing a Claim for AD&D or VPAI Benefits

AD&D and VPAI are provided under group insurance policies issued by the Life Insurance Company of North America (LINA). New York Life processes all claims for LINA. To file a claim for VPAI and AD&D benefits:

- Contact the American Airlines Benefits Service Center to request an AD&D Claim Form within 30 days of the death or injury. Complete the form according to accompanying directions. All claims must be submitted on New York Life forms. If you have questions contact New York Life directly. New York Life contact information is located in the Contact Information section.
- In the event of your death, your manager/supervisor will notify Survivor Support Services, who will coordinate filing for benefits, similar to the procedures outlined for life insurance claims in Filing Claims.
- Send the completed claim form to the American Airlines Benefits Service Center along with documentation of the claim, such as a police report of an accident and a certified copy of the death certificate. The American Airlines Benefits Service Center sends the claim to New York Life for processing.
- New York life processes claims within 90 days from the day they are received. In some cases, however, more time may be needed. If this

is the case with your claim, New York Life will notify you that an additional 90 days will be required. At any point during the claim review period, you may be asked to supply additional information and/or submit to a medical examination at LINA's expense.

- If your claim is approved, the insurance proceeds will be deposited into a New York life resource manager account (similar to a money market checking account) that earns interest.
- If your claim is denied, you or your beneficiary will be notified in writing.

Notification explains the reasons for the denial and specifies the provisions of the LINA group policy that prevent approval of the claim. The notification may also describe what additional information, if any, could change the outcome of the decision.

- If your claim is denied or you have not received a response by the end of the second 90-day review period, you may request a review of your claim.
- No one may take legal action regarding the claim until 60 days after filing the claim. No legal action may be taken more than three years after filing the claim (with the exception of five years in Kansas and six years in South Carolina). You must exhaust your administrative appeals before filing any legal action regarding a claim denial.

AD&D and VPAI Conversion Rights

You can convert up to $250,000 in VPAI coverage for you and your family and up to

$10,000 in AD&D coverage for you to individual policies offered by LINA within 31 days of termination of coverage if coverage terminates for one of the following reasons:

- Your employment ends,
- Your eligibility ends (however, a dependent who is no longer eligible for coverage may not convert to an individual policy while you remain eligible for coverage), or
- The coverage ends.

Contact LINA at 1-800-238-2125 for details on conversion.

AD&D and VPAI Insurance Policy

The terms and conditions of these AD&D and VPAI coverages are set forth in the group insurance policies issued by LINA. These group policies are available for review from LINA. In the event of a conflict between the description in this SPD and the provisions of the insurance policies, the insurance policies will govern.

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

Terrorism and Hostile Act Accident Insurance (T&HAAI)

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

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

Special Purpose Accident Insurance (SPAI)

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

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

Policy Aggregates: T&HAAI and SPAI

An accident may involve more than one employee. Total benefits to all covered employees involved in a single incident are limited to:

- $10,000,000 under T&HAAI
- $2,000,000 per aircraft accident under SPAI

If benefits for one incident would exceed the limit, benefits are distributed to beneficiaries in proportion to the amounts of insurance covering all employees who suffer losses in the same incident.

T&HAAI and SPAI Exclusions

These accident insurance policies do not cover losses caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, self-inflicted death or an attempt to self-inflict death
- Declared or undeclared act of war

- An accident that occurs while you are serving on full-time, active duty in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting, while:
    - The vehicle is used for test or experimental purposes
    - You are operating, learning to operate or serving as a member of the crew except while riding solely as a passenger, mechanic, substitute flight attendant or acting as a crewmember on any aircraft owned by or under contract to American Airlines
    - Being operated under the direction of any military authority other than transport-type aircraft operated by the Military Airlift Command (MAC) of the United States of America or a similar air transport service of any other country

T&HAAI and SPAI Insurance Policy

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

Ground Employees – Short-Term Disability Benefits

Overview

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

Management & Support Staff Short-Term Disability (STD)

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

Overview

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

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

The following Ground Employees are not eligible to participate in the Short-Term Disability benefits under the Plan:

- Employees of American Airlines, Inc. who are covered by collective bargaining agreements entered into between Legacy US Airways, Inc. and the IAM.
- Employees of American Airlines, Inc. who are represented by the TWU (except FSEs, SimPs, and FCTIs).

MetLife's Role – OSTD/STD Pay

MetLife is the Network/Claim Administrator for ShortTerm and Optional Short Term Disability. Visit the MetLife website or contact MetLife at 1-888-533-6287 for more information.

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

Note: Additional details on this coverage are contained in supplemental insurance certificates on my.aa.com. These supplemental insurance certificates are incorporated and are a part of this SPD. As with all insured benefits, the terms of the insurance certificates control when describing specific benefits that are covered or insurance related terms.

Visit my.aa.com to view the insurance certificate for the Optional Short Term Disability (OSTD) Insurance Plan for certain PAFCA and FSE, SimPs, and FCTIs represented by the TWU and employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT.

How the OSTD Insurance Benefit Works

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

The Company offers a certain amount of paid sick time for salary continuance during disabilities. However, a gap may occur between the time accrued sick pay ends and Long Term Disability (LTD) benefits begin. (Note that Long Term Disability benefits are not part of this Plan.) In this case, the Company also offers OSTD Insurance benefits to provide income protection until LTD benefits begin.

OSTD Insurance benefits replace a portion of your salary when you are unable to work as a result of a non-work related disability. Before electing OSTD Insurance coverage, you should consider your accrued sick time because OSTD Insurance benefits are not payable until all of your accrued sick pay is used.

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

If you enroll, your selection remains in effect for two calendar years. If you choose not to enroll when you are first eligible and decide to enroll later, Proof of Good Health is required. Please note that enrollment may be denied based upon the presence of certain health conditions as determined by MetLife and the Plan.

Your OSTD Insurance will not become effective until you are actively at work and a payroll deduction has been taken.

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive OSTD Insurance benefits.

When You Qualify for OSTD Insurance Benefits

In order to qualify for OSTD Insurance, you must be considered “totally disabled.” You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

“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.

In addition, you will be required to receive Appropriate Care and Treatment during your disability. Appropriate Care and Treatment means medical care and treatment that is:

- Given by a Physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- Consistent with a Physician’s diagnosis of your disability; and

- Intended to maximize your medical and functional improvement.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

OSTD Insurance Benefit

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

- For regular, full-time employees, "adjusted monthly salary" is defined as your annual base salary or annualized hourly pay, plus skill and license premiums and market differentials. It does not include profit sharing, bonus, overtime or incentive pay.
- For converted and part-time employees, "adjusted monthly salary" is based on average weekly earnings for the last six months.

Your OSTD Insurance benefit will be adjusted to reflect income from other sources (see "Benefits from Other Sources," below) and any amount of your work earnings while participating in the Return-to-Work Program that causes your income from all sources to exceed 100 percent of your pre-disability earnings. In no event can the total amount you collect from all sources or income exceed 100 percent of your pre-disability earnings while you are disabled. Your pre-disability earnings are determined as of the date you become disabled. For part-time employees, pre-disability earnings are based on a 20-hour work week.

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

In some cases, OSTD Insurance benefits may be limited:

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico, you may be eligible for state disability benefits. Employees based in California, Hawaii and Rhode Island must apply directly to the state for benefits.
- An application for OSTD benefits includes an automatic and mandatory concurrent application and offset for New York state disability benefits.
- If you have accrued a significant number of unused sick days, you would not be able to collect OSTD Insurance until you have used all those days.

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

Benefits from Other Sources

Your OSTD Insurance benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- **No-Fault Auto Laws:** Periodic loss of income payments you receive under no- fault auto laws. Such payments will offset your OSTD Insurance benefit.
- **Third Party Recovery:** Recovery amounts that you receive from loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings may offset your OSTD Insurance benefit.
- Work Earnings, Rehabilitation Incentive, and Family Care Expenses will not be used to reduce your Weekly Benefit except as described in Work Incentive.
- Other Programs or Plans including:

  a. A compulsory benefit program of any government which provides income benefits, such as social security. 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.

  d. Benefits received under the Policyholder'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.

When OSTD Insurance Benefits Begin

Provided you qualify, OSTD Insurance benefits are payable on the eighth day of disability or when your accrued paid sick time is exhausted, whichever occurs later. If you are collecting vacation pay when OSTD Insurance benefits become payable, OSTD Insurance benefits will not begin until your vacation pay ends.

Successive Periods of Disability

There is no limit to the number of times you may receive OSTD Insurance benefits for different periods of disability. However, successive periods of disability separated by less than 60 days of full-time active work are considered a single period of disability. Such

disability will be considered to be a part of the original disability. MetLife will use the same pre-disability earnings and apply the same terms, provisions, and conditions that were used for the original disability. This benefits you because if you become disabled again due to the same or related sickness or Accidental Injury, you will not be required to meet a new elimination period. The only exception is if the later disability is unrelated to the previous disability and begins after you return to full-time active work for at least one full day.

Benefits Checklist

In order to receive OSTD Insurance benefits, you must provide MetLife with the following documentation:

- 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; and
- Any other material information related to your Disability which may be requested by MetLife

Filing a Claim for OSTD Insurance Benefits

If your disability continues for eight or more days, you should file your disability claim immediately. Do not wait until your sick pay is used up; file by the eighth day of your disability. The sooner you file, the sooner your claim can begin processing. However, the latest you can file your claim is six months after your disability began. If you are covered under a state-mandated STD plan and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim beyond the six-month deadline (or the state-mandated deadline, if sooner), your claim will not be accepted and you will not be eligible for benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance benefit, state disability plans (other than California, Rhode Island and Hawaii, which have their own forms that must be filed directly with the respective states) and LTD benefit. (Note that LTD benefits are not part of this Plan.) You or your supervisor should download the Disability Claim Form as soon as you become disabled.
- You, your supervisor and your attending Physician must each complete part of the form. The completed sections may be mailed together or separately to the Network/Claim Administrator at the address on the form.
    - Disability Claim Employer Statement: Your supervisor completes this page.
    - Disability Claim Employee Statement: You complete this

page. Be sure to sign the Reimbursement Agreement on the back of the form (see Benefits from Other Sources).

- Disability Claim Attending Physician Statement: Your Physician completes this page.

After the Network/Claim Administrator receives the form, along with the documentation referenced in the "Benefits Checklist" section, your claim will be processed. Sometimes the Network/Claim Administrator may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

Medical Examinations

MetLife has the right to have you examined at reasonable intervals by medical specialists of its choice and at MetLife's expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of your benefits.

MetLife is the Network/Claim Administrator for the OSTD Insurance benefit. The OSTD Insurance and state disability coverages are insured plans (including state plans in Hawaii, New Jersey, New York and Puerto Rico). The states of California and Rhode Island administer their own disability plans.

OSTD Insurance Return-to-Work Program

OSTD Insurance also offers a Return-to-Work Program that allows you to go back to work on a trial basis while recovering from a disability. If you participate in the Return- to-Work Program, you will collect:

- a 50 percent OSTD Insurance benefit that is adjusted for income from other sources,
- A 10 percent Return-to-Work Program incentive, and
- The amount you earn from participating in the voluntary Return-to-Work Program while you are disabled.

OSTD Family Care Incentive

If you work part-time or participate in the Return-to-Work Program while you are disabled, MetLife will reimburse you for up to $100 for weekly expenses you incur for each Child or family member incapable of independent living.

To receive the reimbursement, Child care must be provided by a licensed Child care Provider who may not be member of your immediate family or living in your residence. Child care must be provided for your or your Spouse's Child, legally adopted Child or a Child for whom you or your Spouse is legal guardian and who is:

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

This benefit also includes care for your family member who is living with you as part of your household and who is:

- Chiefly dependent on you for support; and
- Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to your family member may not be provided by a member of your immediate family.

When OSTD Insurance Benefits End

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

- The date the Network/Claim Administrator determines you are no longer disabled (e.g., you no longer meet the definition of total disability, you are no longer receiving Appropriate Care and Treatment, etc.); or
- The date you become gainfully employed in any type of job for any employer, except under the Return-to-Work Program; or
- The end of the maximum benefit period of 26 weeks; or
- The date you fail to provide MetLife with any of the information listed under Benefits Checklist; or
- The date you fail to attend a medical examination requested by MetLife as described in Medical Examination; or
- The date you die.

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

OSTD Insurance Exclusions and Limitations

The OSTD Insurance benefit has the following exclusions and limitations:

- **Preexisting conditions exclusion**: You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation of disability no longer applies, and you may receive benefits.
- If you are based in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island, then OSTD Insurance benefits are offset by the amount of the state benefit. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. If the state benefit is less than the OSTD Insurance benefit, an OSTD Insurance benefit is payable. If the state benefit is more than

the OSTD Insurance benefit, an OSTD Insurance benefit is not payable.

- Benefits are not payable if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered work-related for OSTD Insurance purposes if the claim is denied by Workers' Compensation.
- If you become disabled before the effective date, you are not covered under this insurance until you return to work and deductions are taken from your pay.
- Benefits are not payable if you are disabled as a result of committing or trying to commit a felony, assault or other serious crime.
- Benefits are not payable if you are disabled as a result of self-inflicted injuries or an attempt at self-inflicted death.
- Benefits are not payable if caused by a declared or undeclared act of war.
- Active participation in a riot.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling condition from a duly qualified Physician.
- Benefits may be reduced if you participate in the Return-to-Work Program.

Management & Support Staff Short Term Disability (STD)

How the STD Benefit Works

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

The Company offers a certain amount of paid sick time for salary continuance during disabilities. However, a gap may occur between the time accrued sick pay ends and LTD benefits begin. (Note that LTD benefits are not part of this Plan.) In this case, the Company also offers STD benefits to provide income protection until LTD benefits begin.

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

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive STD benefits.

When You Qualify for STD Benefits

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

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

“Regular care” means that you:

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

STD Benefits

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

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

STD benefits are payable for a maximum of 180 days. In some cases, STD benefits may be limited:

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico, you may be eligible for state disability benefits.
- An application for STD benefits includes an automatic and mandatory concurrent application and offset for New York state disability benefits.

Tax Consequences of STD Benefit

You may elect either of the following two options:

- STD Taxable – Your disability benefit payment will be 2/3 of your gross pay, which is subject to FICA and income tax.
- STD Non-Taxable – Your disability benefit payment will be 2/3 of your gross pay, but will not be subject to FICA and income tax. However, the Company’s portion of the premium will be added as imputed tax to your W-2 income.

Benefits from Other Sources

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

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

- The amount that you receive under any unemployment income act or law due to the end of employment with the Company.
- Benefits that you receive under the Company'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.

Benefits from Other Sources – Single Sum Payment
If you receive other income in the form of a single sum payment, you must, within 10 days after receipt of such payment, give written proof satisfactory to MetLife of:

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

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

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

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

When STD Benefits Begin

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

Successive Periods of Disability

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

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

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

- If your current disability is unrelated to your prior disability for which MetLife has made a payment, MetLife will treat your current disability as a new claim and you will have to complete another elimination period. Your disability will be subject to all of the plan provisions.

Filing a Claim for STD Benefits

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

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

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

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

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

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

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

STD Rehabilitation Incentives

The rehabilitation program, administered by MetLife, is a program designed to assist you to return to work. As your file is reviewed, medical and vocation information will be analyzed to determine if rehabilitation services might help you to return to work. Once the initial review is completed by MetLife, MetLife may elect to offer you and pay for a rehabilitation program. If the rehabilitation program is not developed by MetLife, you must receive written approval from MetLife for the program before it begins.

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

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

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

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

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

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

When STD Benefits End

Your STD benefit payments end automatically on the earliest of:

- the end of the maximum benefit period of 180 days;
- if MetLife determines you are able to work under a modified work arrangement and you choose not to do so;
- when you are able to work in your own occupation by using adaptive equipment or a worksite modification that MetLife considers appropriate for your situation and that is approved by an independent Doctor, but you choose not to;
- the date you are no longer disabled;
- the date you die;
- the date you choose not to participate in a Rehabilitation Program that MetLife considers appropriate for your situation and is approved by an independent Doctor;
- the date you fail to have a medical exam requested by MetLife;
- the date your work earnings exceed the amount allowable;
- the date you fail to provide required proof of continuing disability.

STD Exclusions and Limitations

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

- war, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
- your active participation in a riot;
- intentionally self-inflicted injury;
- attempt to commit or taking part in a felony;
- Occupational sickness or injury;
- A Pre-Existing Condition: You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation of disability no longer applies, and you may receive benefits; or
- Elective treatment or procedures, excluding organ donations, such as:
    - cosmetic surgery or treatment primarily to change appearance;
    - reversal of sterilization;
    - liposuction;

- visual correction surgery;
- in vitro fertilization; embryo transfer procedure; or artificial insemination (excluding disability resulting from pregnancy as a result of in vitro fertilization); and
- laser vision corrective surgery.

Flight Employees – Short-Term Disability Benefits

Overview

Pilot Short-Term Disability (STD)

Flight Attendant Optional Short-Term Disability (OSTD)

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

Overview

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

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

MetLife's Role –/STD Pay

MetLife is the Network/Claim Administrator for ShortTerm Disability. Visit the MetLife website or contact MetLife at 1-888-533-6287 for more information.

Pilot Short-Term Disability (STD)

How the Benefit Works

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

As an eligible employee, the Company provides a certain amount of paid sick time for salary continuance during disabilities. However, a gap may occur between the time accrued sick pay ends and other benefits begin. To help bridge the gap, the Company offers Short-Term Disability (STD) pay until other disability benefits begin.

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

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

When You Qualify for Pilot STD

To qualify for STD benefits, you must be considered "totally disabled." You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

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

When STD Benefits Begin

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

Successive Periods of Disability

There is no limit to the number of times you may receive these benefits for different periods of disability. However, successive periods of disability separated by less than one week of full-time active work are considered a single period of disability. The only exception is if the later disability is unrelated to the previous disability and begins after you return to full-time, active work for at least one full day.

Filing a Claim for STD Benefits

You must file a claim in order to receive STD Pay. If your disability continues for eight or more days, **you should file your claim by the eighth day of disability**. The sooner you file, the sooner your claim can begin processing.
You can file your claim up to one year after your disability began. If you are covered under a state-mandated STD plan, and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim after the one-year deadline has passed (or the state-mandated deadline, if sooner), your claim will not be accepted and you will not be eligible for benefits.

To file a claim for disability benefits:

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

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

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

filing information in the Pilot LTD Plan via my.aa.com. You must file a separate claim for Pilot LTD benefits.

When STD Benefits End

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

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

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

Exclusions and Limitations

STD pay has the following exclusions and limitations:

- **Preexisting conditions exclusion:** You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation of disability no longer applies, and you may receive benefits.
- Pay is not available if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered work-related if the claim is denied by Workers' Compensation.
- If you are based in California, Hawaii, New York, New Jersey, Rhode Island or Puerto Rico, STD pay does not apply. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. These state disability coverages are insured plans through MetLife.

Flight Attendant Optional Short Term Disability (OSTD)

The insurance certificate is available on my.aa.com. As with all insured benefits, with respect to the Flight Attendant OSTD benefit, the terms of the insurance certificate controls when describing specific benefits that are covered or insurance-related terms.

How the OSTD Insurance Benefit Works

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

The Company provides a certain amount of paid sick time for salary continuance during disabilities. However, a gap may occur between the time accrued sick pay ends and Long Term Disability (LTD) benefits begin. (Note that LTD benefits are not part of this Plan.) In this case, the Company also offers OSTD Insurance benefits to provide income protection until LTD benefits begin.

OSTD Insurance benefits replace a portion of your salary when you are unable to work as a result of a non-work related disability. Before electing OSTD Insurance coverage, you should consider your accrued sick time because OSTD Insurance benefits are not payable until all of your accrued sick pay is used. The cost of OSTD Insurance is collected through payroll deductions.

If you enroll, your selection remains in effect for two calendar years. If you choose not to enroll when you are first eligible and decide to enroll later, Proof of Good Health is required. Please note that enrollment may be denied based upon the presence of certain health conditions as determined by MetLife and the Plan. If your enrollment is denied, see the "Appealing an Enrollment or Eligibility Status Decision" section for information regarding filing an appeal.

Your OSTD Insurance will not become effective until you are actively at work and a payroll deduction has been taken.

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive OSTD Insurance benefits.

When You Qualify for OSTD Insurance Benefits

In order to qualify for OSTD Insurance, you must be considered "totally disabled." You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

"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.

In addition, you will be required to receive Appropriate Care and Treatment (during your disability). Appropriate Care and Treatment means medical care and treatment that is:

- Given by a Physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;

- Consistent with a Physician's diagnosis of your disability; and
- Intended to maximize your medical and functional improvement.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

OSTD Insurance Benefits

OSTD Insurance is insured through MetLife and is designed to supplement any other similar benefits to equal 50% of your adjusted monthly salary. For regular, full-time employees, "adjusted monthly salary" is defined as your annual base salary or annualized hourly pay, plus any skill or license premiums and market rate differentials, as determined by the Employer's established personnel practices.. It does not include profit sharing, bonus, overtime or incentive pay. The maximum covered salary is $200,000 annually.

Your OSTD Insurance benefit will be adjusted to reflect income from other sources (see "Benefits from Other Sources") and any amount of your work earnings while participating in the Return-to-Work Program that causes your income from all sources to exceed 100 percent of your pre-disability earnings. In no event can the total amount you collect from all sources or income exceed 100 percent of your pre-disability earnings while you are disabled. Your pre-disability earnings are determined as of the date you become disabled.

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

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico, you may be eligible for state disability benefits. Employees based in California, Hawaii and Rhode Island must apply directly to the state for benefits.
- An application for STD Insurance benefits includes an automatic and mandatory concurrent application and offset for New York state disability benefits.
- If you have accrued a significant number of unused sick days, you would not be able to collect OSTD Insurance until you have used all those days.
- The OSTD Insurance benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

Benefits from Other Sources

Your OSTD Insurance benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- **No-Fault Auto Laws**: Periodic loss of income payments you receive under no-fault auto laws. Such payments will offset your OSTD Insurance benefit.
- **Third Party Recovery**: Recovery amounts that you receive from loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings may offset your OSTD Insurance benefit.
- Work Earnings, Rehabilitation Incentive, and Family Care Expenses will not be used to reduce your Weekly Benefit except as described in Work Incentive.
- 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; and
    c. Any sick pay or other salary continuation, other than vacation pay, paid to you by the Employer will be counted.
    d. Benefits received under the Policyholder'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.

When OSTD Insurance Benefits Begin

Provided you qualify, OSTD Insurance benefits are payable on the eighth day of disability or when your accrued paid sick time is exhausted, whichever occurs later. If you are collecting vacation pay when OSTD Insurance benefits become payable, OSTD Insurance benefits will not begin until your vacation pay ends. Benefits are payable for a maximum of 26 weeks.

Successive Periods of Disability

There is no limit to the number of times you may receive these benefits for different periods of disability. However, successive periods of disability separated by less than 60 days of full-time active work are considered a single period of disability. Such disability will be considered to be a part of the original disability. MetLife will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used for the original disability. This benefits you because if you become disabled again due to the same or related sickness or Accidental Injury, you will not be required to meet a new elimination period. The only exception is if the later disability is unrelated to the previous disability and begins after you return to full-time active work for at least one full day.

Benefits Checklist

In order to receive OSTD Insurance Benefits, you must provide MetLife with the following documentation:

- 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; and
- Any other material Information related to your Disability which may be requested by MetLife

Filing a Claim for OSTD Insurance Benefits

If your disability continues for eight or more days, you should file your disability claim immediately. **Do not wait until your sick pay is used up**; **file by the eighth day of your disability**. The sooner you file, the sooner your claim can begin processing.

However, the latest you can file your claim is six months after your disability began. If you are covered under a state-mandated STD plan and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim beyond the six-month deadline (or the state-mandated deadline, if sooner), your claim will not be accepted and you will not be eligible for benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance benefit, state disability plans (other than California, Rhode Island and Hawaii, which have their own forms that must be filed directly with the respective states) and LTD benefit. (Note that LTD benefits are not part of this Plan.) You or your supervisor should request the Disability Claim Form as soon as you become disabled.
- You, your supervisor and your attending Physician must each complete part of the form. The completed sections may be mailed together or separately to the Network/Claim Administrator at the address on the form.
    - Disability Claim Employer Statement: Your supervisor completes this page.
    - Disability Claim Employee Statement: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see Benefits from Other Sources).
    - Disability Claim Attending Physician Statement: Your Physician completes this page.

After the Network/Claim Administrator receives the form, along with the documentation referenced in the "Benefits Checklist" section, your claim will be processed. Sometimes the Network/Claim Administrator may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

Medical Examinations

MetLife has the right to have you examined at reasonable intervals by medical specialists of its choice and at MetLife's expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of your benefits.

MetLife is the Network/Claim Administrator for the Optional Short-Term Disability Insurance benefit. The OSTD Insurance and state disability coverages are insured plans (including state plans in Hawaii, New Jersey, New York and Puerto Rico). The states of California and Rhode Island administer their own disability plans.

OSTD Insurance Return-to-Work Program

OSTD Insurance also offers a Return-to-Work Program that allows you to go back to work on a trial basis while recovering from a disability. If you participate in the Return-to-Work Program, you will collect:

- a 50 percent OSTD Insurance benefit that is adjusted for income from other sources,
- a 10 percent Return-to-Work Program incentive, and
- The amount you earn from participating in the voluntary Return-to-Work Program while you are disabled.

OSTD Insurance Family Care Incentive

If you work part-time or participate in the Return-to-Work Program while you are disabled, MetLife will reimburse you for up to $100 for weekly expenses you incur for each Child or family member incapable of independent living.

To receive the reimbursement, child care must be provided by a licensed child care provider who may not be member of your immediate family or living in your residence.

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

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

This benefit also includes care for your family member who is living with you as part of your household and who is

- Chiefly dependent on you for support; and

- Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to your family member may not be provided by a member of your immediate family.

When OSTD Insurance Benefits End

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

- The date the Network/Claim Administrator determines you are no longer disabled (e.g., you no longer meet the definition of total disability, you are no longer receiving Appropriate Care and Treatment, etc.); or
- The date you become gainfully employed in any type of job for any employer, except under the Return-to-Work Program; or
- The end of the maximum benefit period of 26 weeks; or
- The date you fail to provide MetLife with any of the information listed under the Benefits Checklist; or
- The date you fail to attend a medical examination requested by MetLife as described in Medical Examination; or
- The date you die.

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

Exclusions and Limitations

The OSTD Insurance benefit has the following exclusions and limitations:

- **Preexisting conditions exclusion:** You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation of disability no longer applies, and you may receive benefits.
- If you are based in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island, then OSTD Insurance benefits are offset. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. If the state benefit is less than the OSTD Insurance benefit, an OSTD Insurance benefit is payable. If the state benefit is more than the OSTD Insurance benefit, an OSTD Insurance benefit is not payable.
- Benefits are not payable if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered

work-related for OSTD Insurance purposes if the claim is denied by Workers' Compensation.

- If you become disabled before the effective date, you are not covered under this insurance until you return to work and deductions are taken from your pay.
- Benefits are not payable if you are disabled as a result of committing or trying to commit a felony, assault or other serious crime.
- Benefits are not payable if you are disabled as a result of self-inflicted injuries or due to an attempt to self-inflict death.
- Benefits are not payable if caused by a declared or undeclared act of war.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling condition from a duly qualified Physician.
- Active participation in a riot.
- Benefits may be reduced if you participate in the Return-to-Work program.

Long-Term Care Insurance

Contact MetLife for a copy of the insurance certificate. As with all insured benefits, with respect to the long-term care insurance benefit, the terms of the insurance certificate controls when describing specific benefits that are covered or insurance-related terms.

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

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

Additional Rules That Apply to the Plan

Overview

Qualified Medical Child Support Orders (QMCSO)

Coordination of Benefits

Subrogation and Reimbursement

Notice of Privacy Rights

Plan Service Providers

Rescission in Event of Fraud

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

Overview

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

Qualified Medical Child Support Orders (QMCSO) Procedures

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

This notice applies to the health care components of the following plans: American Airlines, Inc. Health & Welfare Plan for Active Employees, the Supplemental Medical Plan for Employees of Participating American Airlines Group Subsidiaries, the American Airlines, Inc. Health and Life Plan for Retirees, the TWA Retiree Health and Life Benefit Plan, the American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees, the American Airlines Inc. Flexible Benefit Plan for Certain Legacy Employees, and any other group health plan for which American Airlines, Inc. ("American") or its delegate serves as Plan Administrator (collectively, the "Plan").

Use of Terms

- The term "Plan" as used in these procedures refers to the options and benefits described above, except to the extent that a plan is separately identified.
- The term "Participant," as used in these procedures, refers to an employee who is eligible for a Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.
- The term "Alternate Recipient," as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.
- The term "Order," as used in these procedures, refers to a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security

Act (as added by section 13822 of OBRA ’93) with respect to a group health plan.

- The term “QMCSO” or “NMSN,” as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these Procedures, or a notice from a state agency ordering the coverage of an Alternate Recipient under health benefits with respect to a Participant under a plan and that meets the requirements to be an NMSM decreed to be a QMCSO.
- The term “Plan Administrator,” as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at:

American Airlines QMCSO PO BOX 1542

Lincolnshire, IL 60069-1542

Fax#: 847-442-0899

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

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

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

- Must be a “medical child support order”, which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health

benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) (OBRA '03)) with respect to a group health plan.

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

American Airlines, Inc. does not provide interim coverage to any employee's dependent during the pendency of a QMCSO or NMSN review. A dependent's entitlement to benefits under the Plan prior to the approval of a QMCSO or an NMSN is determined by the dependent's eligibility and enrollment in the Plan in accordance with the terms of the Plan. Without a QMCSO or NMSN, the Company cannot be held liable if an employee's

dependent is either (i) not enrolled in coverage in the Plan, or (ii) is eliminated from coverage in the Plan. In addition, neither American Airlines, Inc. nor the Plan has any obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) an employee's dependent except upon application by the employee in accordance with the terms of the Plan, or in accordance with a QMCSO or NMSN. If the requesting party needs assistance in preparing or submitting a QMCSO or NMSN, he or she may contact the Plan Administrator or go to the Department of Labor website for more information on QMCSOs and NMSNs and for sample NMSN forms or to obtain a sample National Medical Support Notice.

Review of a Medical Child Support Order or Notice

Not later than 20 business days after receipt by the Plan Administrator of a medical child support order, the Plan Administrator shall review the Order to determine if it meets the criteria to make it a QMCSO or NMSN. Under OBRA '93, a state-ordered medical child support order is not necessarily a Qualified Medical Child Support Order. Thus, before the Plan honors the Order, the Order must meet the requirements for a QMCSO or NMSN specified above.

Procedures upon Final Determination

The Participant, Alternate Recipient and any party specified in the medical child support order shall be notified of the acceptance of the medical child support order or national medical support notice as being qualified. Once the Order is determined to be a QMCSO or NMSN, the Plan Administrator will follow the terms of the Order and shall authorize enrollment of the Alternate Recipient as well as have any payments for such coverage deducted from the payroll of the Participant. In addition, a copy of the appropriate Summary Plan Description describing applicable Medical Benefit Options and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipient, at the issuing agency's address. If the Participant is not enrolled, the Plan Administrator shall enroll the Participant, as well as the child in the coverage.

Notification will occur within 40 business days of receipt of the Order or notice.

If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Participant, the Alternate Recipient, the state agency issuing the notice or any designated representative in writing of such fact within 40 business days of receipt of the Order or notice. The notification will state the reasons the Order or notice is not a QMCSO or NMSN and that the Plan Administrator shall treat the Participant's benefits as not being subject to the Order. Any subsequent determination that an Order is a QMCSO will be administered prospectively only.

Appeal Process

If the Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he or she must file an Application for Appeal within 60 days of receiving notification of denial of the medical child support order's or medical support notice's qualification. Appeals will be reviewed by the Employee Benefits Committee (EBC) or its

authorized delegate in accordance with ERISA and the terms and provisions of the Plan and notify the Participant or Alternate Recipient within 60 days of receipt of the appeal of their decision. A copy of the Plan's appeal procedures, as set forth in the Summary Plan Description, shall be provided upon request.

Coordination of Benefits

This section explains how the Plan coordinates coverage between the Plan and any other benefits/plans that provide coverage for you or your Eligible Dependents.

If you or any other covered dependents have primary coverage (see "Which Plan Is Primary" in this section) under any other group medical or group dental benefits/plans, your Company-sponsored Medical, Dental and Vision Benefit Options 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 Options were your only coverage.

For example, if your dependent is covered by another benefit/plan and the HIGH COST COVERAGE Medical Benefit Option is his or her secondary coverage, the HIGH COST COVERAGE Medical Benefit Option pays only up to the maximum benefit amount payable under the HIGH COST COVERAGE Medical Benefit Option, and only after the primary benefit/plan has paid.

The maximum benefit payable depends on whether 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 under this Plan, 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 benefit program coverage.

If you or your dependent is hospitalized when your benefit program coverage changes from one Medical Benefit Option to another, your prior coverage is responsible for payment of Eligible Expenses until you or your dependent is released from the hospital.

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 Co-Pays 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 Benefit Options 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:
    - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise.
- For a stepchild or Special Dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the other plan has a gender rule, that plan determines which plan is primary.

Coordination with Medicare

If you (or one of your dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare benefits for Prescription drug benefits), the Plan 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; or

- You become eligible for Medicare due to becoming eligible for Social Security Disability and your coverage under this Plan is due to the current employment status of the employee. (For this purpose, you will only be considered to have current employment status during the first six months in which you receive Company paid disability benefits that are subject to FICA tax. Generally, Medicare does not begin to pay benefits until after this period ends.)

If you (or one of your dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare benefits for Prescription drug benefits), the 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 age 65 or over and the 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 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 Plan, the Plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the Plan considers eligible, the Plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any.

When Medicare is the primary payer, no benefits will be payable under the Plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

Subrogation and Reimbursement

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

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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Notice of Privacy Rights

This notice describes how your protected health information or PHI may be used or disclosed under the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). It applies to the health care components of the following plans: American Airlines, Inc. Health & Welfare Plan for Active Employees, the Supplemental Medical Plan for Employees of Participating

American Airlines Group Subsidiaries, the American Airlines, Inc. Health and Life Plan for Retirees, the TWA Retiree Health and Life Benefit Plan, the American Airlines, Inc. PPO Plan,, , the American Airlines, Inc. DFW ConnectedCare Plan, and any other group health plan for which American Airlines, Inc. ("American") or its delegate serves as Plan Administrator (collectively, the "Plan").

Uses and Disclosures of Your Information

The following uses and disclosures of your PHI may be made by the Plan:

For Treatment, Payment, and Health Care Operations. The Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan, including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and claims management purposes. Note that the Genetic Information Nondiscrimination Act ("GINA") prohibits using PHI that is genetic information for underwriting purposes.

To the Plan Sponsor. The Plan may disclose your PHI to the Plan Sponsor so that the Plan Sponsor can perform administrative functions on behalf of the Plan, such as facilitating claims or appeals.

When Required or Permitted by Law. The Plan may also disclose or use your PHI where required or permitted by law. Federal law, under HIPAA, generally permits health plans to use or disclose PHI for the following purposes:

- To family members, other relatives and your close personal friends that you have identified and who are directly involved with your care or payment for that care.
- To notify a family member or other individual involved in your care of your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.
- When required by law.
- For purposes of public health activities.
- To report abuse, neglect or domestic violence to public authorities.
- To a public health oversight agency for oversight activities.
- Pursuant to judicial or administrative proceedings.
- For certain law enforcement purposes.
- For a coroner, medical examiner, or funeral director to obtain information about a deceased person.
- For government-approved research activities.

- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- To comply with Workers' Compensation laws.
- For organ, eye, or tissue donation purposes.
- For certain government functions, such as related to military service or national security.

Pursuant to Your Authorization. Any other use or disclosure of your PHI will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes.

Stricter State Privacy Laws. Under the HIPAA privacy and security rules, the Plan is required to comply with State laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter).

Rights You May Exercise

You have several rights with respect to your PHI, which are described below. Please call the privacy contact listed below if you have questions about your rights.

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.

To Access. You have the right to request access to your PHI and to inspect and copy your PHI in the designated record set under the policies and procedures established by the Plan or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies. You or your personal representative will be required to make a written request to request access to the PHI in your designated record set.

To Amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those you have authorized or for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request.

To Obtain a Paper Copy of This Notice. An individual who receives or has consented to receive an electronic copy of this notice has the right to obtain a paper copy of this notice from the Plan upon request.

To Request Confidential Communication. You have the right to request confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

Our Duties With Respect to Your Individually Identifiable Health Information

The Plan is required by law to maintain the privacy of your PHI and to provide you with a notice of its legal duties and privacy practices with respect to your PHI. The Plan is required to abide by the terms of the notice that is currently in effect. The Plan is required to notify you if there is a breach of your unsecured PHI. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. If there is a material change to any provisions of this notice, the Plan will distribute a revised notice.

Organized Health Care Arrangement

The Plan is part of an organized health care arrangement with the plans listed on the first page of this notice. The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.

Questions?

If you have questions or would like more information about the Plan's privacy policies, you may contact the American Airlines Benefits Service Center at 888-860-6178

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You cannot be retaliated against for filing such a complaint.

Plan Service Providers

American Airlines, Inc. and/or the Plan generally may share, without your consent, your contact information and other information the Plan has about you with Plan service providers so that these services providers can perform services under the Plan.

Accordingly, a service provider might contact you about the service provider's services or offerings connected with the Plan, invite you to participate in surveys concerning the service provider's performance, or for other purposes allowed by the Plan. Before sharing your information with a service provider, consistent with HIPAA and other privacy laws, American Airlines, Inc. and/or the Plan would obtain the service provider's written agreement to safeguard your information and use it only for the purposes for which it was disclosed to the service provider.

Rescission in Event of Fraud

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

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-543-7669 (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 1-866-444-3272.

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 January 1, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – 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: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program https://dhcs.ca.gov/hipp Phone: 916-445-9322 Email: hipp@dhcs.ca.gov	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
IOWA – Medicaid	**MONTANA – Medicaid**

Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: https://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/ HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP Program: 1-800-852-3345, ext. 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid**
Enrollment Website: http://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/client s/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/info-details/masshealh-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hip p.htm Phone: 573-751-2005	Website: https://www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

OREGON – Medicaid	VERMONT – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.greenmountaincare.org Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462	Medicaid Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 or 401-462-0311 (Direct Rite Share Line)	Website: https://www.hca.gov.wa.gov Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: https://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 1, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

http://www.dol.gov/agencies/ebsa

1-866-444-3272

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov**

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

COBRA

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Eligibility
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Overview

If your health coverage under the Plan would otherwise end because of certain Qualifying Events (described below), you may elect to continue your health benefits as part of your continuation of coverage options available through Alight Solutions, the COBRA administrator. Alight Solutions will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your medical coverage through COBRA, claims incurred after the date of your termination are not payable.

The STANDARD Medical Benefit Option, HIGH COST COVERAGE Medical Benefit Option, CORE Medical Benefit Option, OUT-OF-AREA Medical Benefit Option, Dental Benefit Option, Vision Benefit Option, HMOs, the Health Care Flexible Spending Account and the Limited Purpose Flexible Spending Account provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain Qualifying Events (described below). If you and/or your dependents have coverage at the time of the Qualifying Event, you may be eligible to elect continuation of coverage under the following:

- Medical
- Dental
- Vision
- Health Care Flexible Spending Account or Limited Purpose Flexible Spending Account, for the remainder of the calendar year in which you became eligible for continuation of coverage. (Although you would not be able to make contributions on a pre-tax basis, by electing continuation of coverage for this account, you would still have the opportunity to file claims for reimbursement based on your account balance for the year.) In addition, the Plan allows you to carryover up to $550 of any amount remaining in your HCFSA or LPFSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the COBRA continuation period (i.e. 18, 29, or 36 months, as applicable). Any unused amount of more than $550 remaining in your HCFSA or LPFSA at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.

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

Eligibility

Eligibility for continuation of coverage depends on the circumstances that result in the loss of existing coverage for you and your Eligible Dependents. The sections below

explain who is eligible to elect continuation of coverage and the circumstances that result in eligibility for this coverage continuation.

Continuation of Coverage for You and Your Dependents (Qualifying Events)

You may elect continuation of coverage for yourself and your Eligible Dependents for a maximum period of 18 months, if your coverage would otherwise end because of the following Qualifying Events:

- layoff or termination of your employment for any reason (except in the event of termination for gross misconduct).

Notwithstanding the above, the 18-month period may be extended to a maximum of 36 months if the following conditions are satisfied:

- The extended COBRA period is specified in the terms of a written agreement between the Company and the Eligible Employee.
- The Eligible Employee is charged the full COBRA premium.

If the Company offers this extended continuation coverage, all rules governing COBRA continuation coverage described in this Section apply to such coverage.

If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you (or any Eligible Dependent) are disabled at any time during the first 60 days of continuation of coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself and your dependents. To qualify for this additional coverage, the Qualified Beneficiary must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (Alight Solutions) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.

Continuation of Coverage for Your Dependents Only (Qualifying Events)

Your covered dependents may continue coverage for a maximum period of 36 months if coverage would otherwise end because of the following Qualifying Events:

- Your divorce or legal separation
- Becoming enrolled in Medicare benefits
- Loss of eligibility because the dependent no longer meets the Plan's definition of a dependent (for example, if a Child reaches the Plan's limiting age). The dependent loses coverage on the last day of the month in which they attain age 26.
- Your death

If you experience more than one of these Qualifying Events, your maximum continuation of coverage is the number of months allowed by the Qualifying Event that provides the longest period of continuation.

How to Elect Continuation of Coverage

Solicitation of Coverage Following Layoff or Termination

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

Solicitation of Coverage Following a Qualifying Event

In the event of a Qualifying Event (as shown above as for your dependents only), you must notify the American Airlines Benefits Service Center by registering a Qualifying Event within 60 days of the event. You can register most Life Events via the American Airlines Benefit Service Center. For more information, see "Life Events" in the Making Changes During the Year section.

Enrolling for Coverage

You (or your dependents) must provide written notification of your desire to elect to purchase continuation of coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage, or else you lose your right to elect to continue coverage. See "Contact Information" in the Reference Information section for Alight Solutions address.

You and your dependents may each independently elect continuation of coverage. Once you elect continuation of coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election.

If you waive continuation of coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify the American Airlines Benefits Service Center before your 60-day election period expires.

Note: If you are 65 or older and Medicare-eligible, Medicare will become the primary payer, even if you have not enrolled in Medicare. COBRA is secondary to Medicare and only covers what Medicare does not. You can enroll in Medicare when your active coverage ends, even outside of the annual enrollment period. If you do not have Medicare coverage, or have only Medicare Part A, when your group health plan coverage ends, you can still enroll in Medicare Part B during a "Medicare Special Enrollment Period" without having to pay a Medicare Part B premium penalty. To avoid paying this premium penalty, you need to enroll in Medicare Part B either at the same time you enroll in Medicare Part A or during a Medicare Special Enrollment Period after your group health plan coverage ends. You avoid the premium penalty by documenting your employment based group health plan coverage by completing a form supplied by the Social Security

Administration. This form, CMS L564, will need to be submitted to the American Airlines Benefits Service Center for completion.

If you are eligible for Medicare and decide to elect COBRA coverage anyway, and you wait until the COBRA coverage ends before enrolling in Medicare Part B, you will have to pay a Medicare Part B premium penalty.

Processing Life Events after Continuation of Coverage Is in Effect

If you elect continuation of coverage for yourself and later marry, give birth, or adopt a Child while covered by continuation of coverage, you may elect coverage for your newly acquired dependents after the Life Event. To add your dependents, contact the American Airlines Benefits Service Center within 60 days of the marriage, birth, or adoption.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29 or 36 months, depending on the Qualifying Event). This new dependent will not have the right to continue coverage on his or her own if there is a divorce or another event that causes loss of coverage. You may add a newborn Child or a Child newly placed for adoption to your COBRA continuation of coverage. You should notify the American Airlines Benefits Service Center of the newborn Child or Child newly placed for adoption within 60 days of the Child's birth or placement for adoption.

All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to continuation of coverage.

Paying for COBRA Coverage

To maintain COBRA continuation of coverage, you must pay the full cost of continuation of coverage on time, including any additional expenses permitted by law. Your first payment is due within 45 days after you elect continuation of coverage. Premiums for subsequent months of coverage are due on the first day of each month for that month's coverage. If you elect continuation of coverage, you will receive invoices from Alight Solutions indicating when each payment is due. Contributions are due even if you have not received your invoice in the mail. Failure to pay the required contribution on or before the due date, or by the end of the grace period, will result in termination of COBRA coverage, without the possibility of reinstatement.

Refund of Premium Payments

If you elect continuation of coverage and later discover that you do not meet the eligibility requirements for coverage - for example, if you enroll in Medicare benefits, you must contact the American Airlines Benefits Service Center immediately, but no later than three months after you make your first COBRA premium payment in order to be eligible for a refund. Payments will not be refunded after this three-month period, regardless of the reason.

If claims have been paid during this three-month period, the Plan will request reimbursement from you. If the amount of your premium payments for continuation of

coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the Plan receives reimbursement for your claim, the Plan will refund your premiums.

This time limit for refunds also applies if the Company discovers that continuation of coverage has been provided to you or your dependent in error.

When Continuation of Coverage Begins

If you or your dependents elect continuation of coverage within 60 days of receiving your election forms, the coverage becomes effective on the date your other coverage would otherwise end. Thus, the first premium for continuation of coverage includes payment for this retroactive coverage period.

When Continuation of Coverage Ends

Continuation of coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29 or 36 months) expires. (See "Processing Life Events After Continuation of Coverage Is in Effect" in this section.)
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement.
- The Plan Participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a Pre-Existing Condition Limitation that affects the Plan Participant. In that event, the Participant is eligible for continuation of coverage up to the maximum time period.
- The Plan Participant continuing coverage becomes enrolled in Medicare
- The Company no longer provides the coverage for any of its employees or their dependents

See "Dependent Eligibility Criteria" in the *General Eligibility* section.

Keep Us Informed of Address Changes

In order to protect you and your family's rights, your address should be kept up to date.

- Employees must update their personal information through Employee Central via Jetnet.
- If you are separated from the Company, you must contact the Team

Member Service Center at 1-800-447-2000

- Dependents may be updated online by visiting the American Airlines Benefits Service Center website or by dialing 1-888-860-6178.

Impact of Failing to Elect Continuation of Coverage on Future Coverage

In considering whether to elect continuation of coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse or Company-Recognized Domestic Partner's employer) within 30 days after your Plan coverage ends because of the Qualifying Event listed above. You may also have the right to enroll in coverage through a state-based or federally-facilitated healthcare exchange under the Patient Protection and Affordable Care Act (PPACA). You will also have the same special enrollment rights at the end of continuation of coverage if you get continuation of coverage for the maximum time available to you.

Additional Questions

If you have any additional questions on continuation of coverage under COBRA, you should contact the American Airlines Benefits Service Center.

Claims Procedures

Time Frame for Initial Claim Determination
Appealing a Denial
When You are Deemed to Have Exhausted the Internal Claim and Appeal Process
The External Review Process
Deadline to Bring Legal Action

Time Frame for Initial Claim Determination

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

Medical, Dental, and Vision Claims

For claims for medical, dental, and vision, benefits, the processing rules vary by the type of claim. For **Urgent Care claims** and **pre-service claims** (claims in which the service has not yet been rendered and/or that require approval of the benefit or precertification before receiving medical care), the Network/Claim Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- As soon as possible after receipt of a claim initiated for **Urgent Care**, but no later than 72 hours after receipt of a claim initiated for Urgent Care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification); and
- Fifteen days after receipt of a **pre-service claim**.

For **post-service claims** (claims that are submitted for payment after you receive medical care), the Network/Claim Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For **Urgent Care claims**, if you fail to provide the Network/Claim Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Network/Claim Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The Network/Claim Administrator's receipt of the requested information
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time

For **pre- and post-service claims**, a 15-day extension may be allowed to make a determination, provided that the Network/Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Network/Claim Administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for **pre- and post-service claims** due to your or your authorized representative's failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the Network/Claim Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan's procedures for filing a **pre-service claim**, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving **Urgent Care**) following the failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that:

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

Urgent Care Claims

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

- Could seriously jeopardize the patient's life, health or ability to regain maximum function; or
- In the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the Urgent Care definition has been satisfied. However, if a Physician with knowledge of the patient's medical condition determines that the claim involves Urgent Care, it must be considered an Urgent Care claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an Urgent Care claim and decided according to the Urgent Care claim time frames described earlier. If an ongoing course

of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent circumstance, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

Health Care Flexible Spending Account (HCFSA), Dependent Care Flexible Spending Account (DCFSA), and Limited Purpose Flexible Spending Account Claims (LPFSA)

For claims under the Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account, the Network/Claim Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. A 15-day extension may be allowed to make a determination, provided that the Network/Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Network/Claim Administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

- If You Receive an Adverse Benefit Determination on a Medical, Dental, Vision, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, or Limited Purpose Flexible Spending Account Claim the Network/Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth: The specific reason(s) for the adverse benefit determination,
- References to the specific Plan provisions on which the benefit determination is based,
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary,
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request,

- If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits,
- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim,
- For Medical claims, the Network/Claim Administrator is required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale,
- Date of service, the health care Provider, the claim amount (for Medical claims),
- The denial code and corresponding meaning (for Medical claims),
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for internal appeal or external review, and will not trigger the start of an internal appeal or external review) (for Medical claims),
- A description of the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for Medical claims),
- A description of the external review process, if applicable (for Medical claims),
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for Medical claims).

Disability Claims

This section applies to Short-Term Disability (STD) Pay and Optional Short Term Disability (OSTD) Insurance.

All Disability claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the Network/Claim Administrator. After the Network/Claim Administrator has reviewed the claim for Disability benefits and

obtained any other information that it deems necessary or relevant, the Network/Claim Administrator shall notify you within a reasonable period of time not to exceed 45 days after receipt of the acceptance or denial of the claim. The 45-day period during which a claim for Disability benefits is reviewed may be extended by the Network/Claim Administrator for up to 30 days, provided the Network/Claim Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 45-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 30-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 30-day period provided the Network/Claim Administrator notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made.

If your claim for Disability benefits is denied, in whole or in part, the Network/Claim Administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The notice shall contain:

- Specific reasons for the denial,
- Specific references to the Plan provisions on which the denial is based,
- A description of any information or material necessary to perfect the claim,
- An explanation of why this material is necessary,
- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review,
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding you presented by you to the Plan made by the Social Security Administration,
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol does not exist,
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination,

applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request,

- 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 for benefits.

All Other Claims

This section applies to the following benefits:

- Employee Term Life Insurance;
- Spouse/Company-Recognized Domestic Partner Term Life Insurance;
- Child Term Life Insurance;
- Accidental Death & Dismemberment Insurance (Employee, Spouse/Company- Recognized Domestic Partner, Child)
- Special Purpose Accident Insurance
- Special Risk and Accident Insurance
- Management Personal Accident Insurance (For Management and Officer employees)
- Voluntary Personal Accident Insurance (for Flight Attendants and Pilots)
- Terrorism and Hostile Act Accident Insurance

All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the Network/Claim Administrator. After the Network/Claim Administrator has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the Network/Claim Administrator shall notify you within a reasonable period of time not to exceed 90 days after receipt of the acceptance or denial of the claim. The 90-day period during which a claim for benefits is reviewed may be extended by the case manager or Network/Claim Administrator for up to 90 days, provided the Network/Claim Administrator both determine that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 90-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 90-day period provided the Network/Claim Administrator notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for benefits is denied, in whole or in part, the Network/Claim Administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The notice shall contain:

- Specific reasons for the denial,

- Specific references to the Plan provisions on which the denial is based,
- A description of any information or material necessary to perfect the claim,
- An explanation of why this material is necessary, and
- An explanation of the Plan's appeal and review procedure, including a statement of the participant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review.

Effect of Failure to Submit Required Claim Information

If the Network/Claim Administrator determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the Network/Claim Administrator request for information or upon a demonstration to the satisfaction of the Network/Claim Administrator that under the circumstances the Network/Claim Administrator request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the Network/Claim Administrator, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the Network/Claim Administrator deems relevant.

Appealing a Denial

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

Important Information about Health Care Provider's Appeals

Health care Providers, whether in-Network or out-of-Network, may not pursue appeals on your behalf, unless you designate your Provider as your authorized representative. The Plan prohibits the assignment of any benefit or any legal claim or cause of action (whether known or unknown). (See "Anti-Assignment of Benefits" in the Plan Administration chapter.)

Appealing an Enrollment or Eligibility Status Decision

American Airlines, Inc. or its delegate will determine Enrollment and Eligibility appeals (also referred to as "Administrative appeals") under the following process:

- **First Level Appeal:** If your request for eligibility or enrollment in a benefit under the Plan has been denied, you may submit a First Level Appeal to Alight Solutions. You have 180 days from the date of the denial within which the file a First Level Appeal. A First Level Appeal form, which must accompany your request for a First Level Appeal can be found at *https://my.aa.com/forms-notices*. Alight Solutions will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing within 30 days of receipt of your First Level Appeal.
- **Second Level Appeal:** Upon your receipt of the First Level Appeal decision notice upholding the prior denial, you may submit a Second Level Appeal to the Employee Benefits Committee (EBC). You have 180 days from the date of the First Level Appeal decision within which to file a Second Level Appeal. A Second Level Appeal form, which must accompany your request for a Second Level Appeal can be found at https://my.aa.com/forms-notices. The EBC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing within 60 days of receipt of your Second Level Appeal.

American Airlines, Inc. reserves the right to change its process for determining enrollment and eligibility appeals at any time and without prior notice.

Appealing an Adverse Benefit Determination

American Airlines, Inc., as Plan Sponsor and Plan Administrator of the Plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the Network/Claim Administrator or benefit vendor that rendered the adverse benefit determination. Second Level Appeals are also conducted by the Network/Claim Administrator, except for Pilot STD, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account. Second level appeals for those benefits are conducted by the EBC or its delegate at American Airlines, Inc. (Appeals may be filed on adverse benefit determinations such as claim denial or reduction in benefits, partial payment or partial denial of benefits, rescission of coverage, application of a benefit penalty, or other such adverse benefit determinations).

This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document. The one exception to this mandatory two-tiered process is an appeal for an Urgent Care claim – for Urgent Care claim appeals, only Second Level Appeals are required – no First Level Appeals are necessary. Employees must use both levels of appeal (or the Second Level Appeal for Urgent Care claims) and must exhaust all administrative remedies to resolve any claim issues.

With respect to adverse benefit determinations made on fully insured benefits, the appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The insurers and HMOs make the final appeal determinations for their respective insured coverages/benefits. Each insurer or HMO has its own appeal process,

and you should contact the respective insurer or HMO for information on how to file an appeal (see "HMO Contact Information" in the Health Maintenance Organizations (HMOs) section.) For purposes of this paragraph, "full-insured benefits" include the following:

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

First Level Appeal

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Network/Claim Administrator. You or your authorized representative have 180 days following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the Network/Claim Administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination. For Urgent Care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

Information about filing a First Level Appeal can be found https://my.aa.com/appeals

The Network/Claim Administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For pre-service claims – within 15 days of receipt of your First Level Appeal
- For post-service claims – within 30 days of receipt of your First Level Appeal
- For Urgent Care claims – within 72 hours of receipt of your First Level Appeal
- For Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account claims – within 30 days of receipt of your First Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If the Network/Claim Administrator requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First

Level Appeal (the Network/Claim Administrator will notify you if this additional time period is needed to complete a full and fair review of your case). For disability claims, this process may also be referred to as a "Second Level Review."

- For all other claims for all benefits other than Medical, Dental, Vision, Long-Term Care, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Limited Purpose Flexible Spending Account, or Disability, within 60 days of receipt of your First Level Appeal, if the Network/Claim Administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your First Level Appeal (the Network/Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Second Level Appeal

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal. Second Level Appeals are also conducted by the Network/Claims Administrator, except for Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account. Second level appeals for those benefits are conducted by the EBC or its delegate at American Airlines, Inc. Notwithstanding anything to the contrary in this section, for Pilot STD, Second Level Appeals are conducted by the the Network/Claim Administrator, not the EBC.

You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the Network/Claim Administrator or the EBC (for Pilot STD, Enrollment/Eligibility Status Decisions (also referred to as Administrative Appeals), Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account), please complete an application for Second Level Appeal, and include with the application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. Information about filing a second level appeal can be found at https://my.aa.com/appeals.

The Network/Claim Administrator (or the EBC for Pilot STD, Enrollment/Eligibility Status Decisions, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account) will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within 15 days of receipt of your Second Level Appeal

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

Upon its receipt, your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the Network/Claim Administrator or the EBC (for Pilot STD, Enrollment/Eligibility Status Decisions/Administrative Appeals, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account).

Note for the Pilot STD, Enrollment/Eligibility Status Decisions/Administrative Appeals, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account: Appointed officers of American Airlines, Inc. are on the EBC. In some cases, the EBC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the Network/Claim Administrator, if appropriate, will be reviewed by the EBC or its designee(s).

Rights on Appeal

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

- Submit written comments, documents, records and other information relating to the claim for benefits

- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
    - Was relied upon in making the benefit determination
    - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
    - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
    - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony
- Receive from the Plan Administrator or Network/Claim Administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond to the new rationale
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the Plan Administrator or Network/Claim Administrator has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is Experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination,

regardless of whether the advice was relied upon in making the decision

- In the case of a claim for Urgent Care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
    - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

For appeals of Disability claims and for appeals of Medical claims, you also have the following rights:

- Before the Plan issues an adverse benefit determination on review, the Plan shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible to give you a reasonable opportunity to respond prior to the date on which the notice of adverse benefit determination on review is required to be provided.
- Before the Plan issues an adverse benefit determination on review based on a new or additional rationale, the Plan shall provide you, free of charge, with the rationale. The rationale will be provided as soon as possible to give you a reasonable opportunity to respond prior to the date on which the notice of adverse benefit determination on review is required to be provided.

Notice of Determination

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

- The specific reason(s) for the adverse benefit determination,
- References to the specific Plan provisions on which the benefit determination is based,
- A description of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request (for appeals for all benefits except for those benefits listed under "All Other Claims" and except for Disability claims),

- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that such rules, guidelines, protocols, or similar criteria of the Plan do not exist (for Disability claims),
- If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request (for appeals for all benefits except for those benefits listed under “All Other Claims”). Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits,
- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits,
- A description of any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures,
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by you to the Plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding you presented by you to the Plan made by the Social Security Administration (for Disability claims),
- Date of service, the health care Provider, the claim amount (for Medical claims),
- The denial code and correspondent meaning (for Medical claims),
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for external review, and will not trigger the start of external review) (for Medical claims),

- A description of the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for Medical claims),
- A description of the external review process, if applicable (for Medical claims), and
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for Medical claims).

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

If the Plan Administrator or Network/Claim Administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review (for Medical claims), you may pursue a civil action under ERISA §502(a), or you may pursue civil action under state law if the adverse benefit determination involved a fully-insured benefit. However, keep in mind that the claim and appeal process won't be deemed exhausted based on de minimis violations of law (as long as the Plan Administrator or Network/Claim Administrator that the violation was for good cause, was committed in a good faith exchange of information between you, or was due to matters beyond the Plan Administrator's or Network/Claim Administrator's control).

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

If an external reviewer (for Medical claims) or court rejects your request for immediate review because it finds that the Plan Administrator or Network/Claim Administrator met the standards for exception (de minimis violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or Network/Claim Administrator will notify you of your opportunity to file the internal appeal of your claim. The 12-month claim filing limit will begin to run upon your receipt of the Plan Administrator's or Network/Claim Administrator's notice.

If your claim is filed under one of the Plan's fully-insured benefits (an HMO, for example), contact the insurer for information on the State process for immediate review.

The External Review Process

After you have exhausted (or have been deemed to have exhausted) your internal appeal rights under the benefit plan(s), you have the right to request an external review of your adverse benefit determination. This external review process is defined by federal law—

and Medical Benefit Options will comply with the requirements of this external review process.

The external review process is applicable to adverse benefit determinations made under group health plans, in which the adverse benefit determination involved a medical judgment—such as:

- adverse determinations based on lack of Medical Necessity
- adverse determinations based on the assertion that the service or supply at issue was determined to be Experimental, Investigational, or Unproven in nature
- adverse determinations based on the assertion that the service or supply was cosmetic in nature
- adverse determinations based on appropriateness or type of care, appropriateness of place of care, manner of care, level of care, or whether Provider Network status could have affected availability or efficacy of treatment
- adverse determinations based on the determination of whether care constituted “emergency care”, “Urgent Care”
- adverse determination based on a plan exclusion or limitation of coverage for a particular treatment in the presence of certain medical conditions
- adverse determination based on the determination of whether care was “preventive” in nature and the care was not referenced by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, or the Centers for Disease Control
- adverse determination that brings into question if the benefit plan is complying with the non-quantitative treatment limitations in the Mental Health Parity and Addiction Equity Act (such as methods and limitations on medical management)

Your external review will be conducted by an independent review organization not affiliated with the Plan. Your appeal denial notice will include more information about your right to file a request for an external review on contact information. You must file your request for an external review within four months of receiving your final internal appeal determination.

An external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

Deadline to Bring Legal Action

You must use and exhaust the Plan's administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Plan Administration

Administrative Information
Other Legal Information

Administrative Information

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

Plan Sponsor

American Airlines, Inc., or its authorized delegate Mailing address:

Mail Drop 8A203

P.O. Box 619616

DFW Airport, TX 75261-9616

Street address (do not mail to this address):

1 Skyview Drive

Fort Worth, Texas 76155

Plan Administrator

American Airlines, Inc., or its authorized delegate Mailing address:

Mail Drop 8A203

P.O. Box 619616

DFW Airport, TX 75261-9616

General Phone: 1-800-447-2000

Street address (do not mail to this address):

1 Skyview Drive

Fort Worth, Texas 76155

American Airlines, Inc. has delegated certain administrative functions to Alight Solutions, including answering questions about eligibility on behalf of American Airlines, Inc. They can be reached at: 1-888-860-6178.

American Airlines, Inc. has also delegated certain administrative functions to Accolade Health. Accolade is available to provide information regarding eligibility, enrollment, benefit coverage, health benefit options, solutions, and costs, available providers and their network status, status of deductible or out-of-pocket maximum, claims decisions, status of claims, and instructions for filing claims and appeals. Accolade can be reached at 833-346-3929.

The Plan Administrator (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the Plan described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply

omissions. All decisions and interpretations of the Plan Administrator (or its delegate(s)) made pursuant to the Plan described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The Plan Administrator may delegate this discretionary authority to selected service Providers. In certain circumstances, for all purposes of overall costs savings or efficiency, the Plan Administrator (or its delegate(s)) may, in their sole discretion, offer benefits for services that would not otherwise be covered. The fact that the Plan Administrator (or its delegate(s)) do this in any particular case shall not in any way be deemed to require the Plan Administrator (or its delegate(s)) to do so in similar cases.

The Plan Administrator for Second Level Claim Appeals for Administrative/Eligibility/Enrollment, HCFSA, DCFSA, and LPFSA

Employee Benefits Committee (EBC) American Airlines, Inc.

Mail Drop 8A201

P.O. Box 619616

DFW Airport, TX 75261-9616

Agent for Service of Legal Process

Senior Vice President, Chief People Officer

American Airlines, Inc.

Mailing address:

Mail Drop 8A204

P.O. Box 619616

DFW Airport, TX 75261-9616

Express Delivery address:

1 Skyview Drive

Mail Drop 8A204

Fort Worth, TX 76155

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Plan Type

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

Plan Funding

Please see the chapter "Benefits under the Plan and Contact Information" for information regarding how benefits under the Plan are funded.

Collective Bargaining Agreement

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

Other Legal Information

Plan Amendment and Termination

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

No Liability for Benefits

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

No Commitment to Employment

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

No Precedent

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

Severability

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

Anti-Assignment of Benefits

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

For information about whether you can assign Life Insurance benefits, see "Assignment of Benefits" under "Special Provisions" in the Life Insurance section.

Confidentiality of Claims

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

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

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see "Notice of Privacy Rights**".**

Payment of Benefits

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

- Your guardian
- Your estate
- Any institution or person (as payment for expenses in connection with the claim)

- Any one or more persons among the following relatives: your parents, Children, brothers or sisters.

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

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

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

Right to Recovery

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

The Network/Claim Administrator may also seek recovery from one or more of the following:

- Any Plan participant to or for whom benefits were paid
- Any institution, Physician, or other service Provider
- Any other organization.

Your Rights Under ERISA

Your Rights Under ERISA

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

Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We encourage you to come to us if you have any questions or problems. In addition, as already noted, the Plan Documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

For general information contact:

American Airlines Benefits

Service Center

PO Box 661052

Dallas, TX 75266-1052

1-888-860-6178

For information about your claims, contact the appropriate Network/Claim Administrator or Plan Administrator at the addresses and phone numbers located in the "Contact Information" in the Reference Information section.

Benefits under the Plan and Contact Information

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

Benefit Option	Health Assistant, Network/Claim Administrator, and Plan Funding
Health Assistant	
	Accolade 1-833-346-3929
Medical and Mental Health/Chemical Dependency Coverage	
CORE Medical Benefit Option STANDARD Medical Benefit Option HIGH COST COVERAGE Medical Benefit Option OUT-OF-AREA Medical Benefit Option	**Network/Claim Administrators:** **BlueCross and BlueShield of Texas** P.O. Box 660044 Dallas, TX 75266-0044 Website: www.bcbstx.com/americanairlines **UMR** American Airlines, Inc. Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551 Website: americanairlines.welcometouhc.com Please contact the above Network/Claim Administrators for CheckFirst (Predetermination of Benefits) and QuickReview (Pre-authorization for Hospitalization). **Plan Funding:** Self-funded through the general assets of the Company and employee contributions
Telehealth	For more information about Telehealth services and technological requirements, visit Doctor on Demand via Website: doctorondemand.com Phone: 1-800-997-6196.
Health Maintenance Organizations (HMOs)	**Community Care Managed Healthcare Plans of Oklahoma** Phone: 1-800-777-4890 **Website:** http://aa.ccok.com Group Number: C01338 **Kaiser Permanente Hawaii** Phone: 1-800-966-5955 Website: http://my.kp.org/americanairlines Group Number:10121

Benefit Option	Health Assistant, Network/Claim Administrator, and Plan Funding
	Kaiser Northern California Phone: 1-800-464-4000 Website: http:/my.kp.org/americanairlines Group Number: 8653 **Kaiser Southern California** Phone: 1-800-464-4000 Website: http://my.kp.org/americanairlines Group Number: 102105 **Kaiser Mid-Atlantic States (Maryland and Washington, D.C.)** Phone: 1-800-777-7902 Website: http://www.my.kp.org/americanairlines Group Number: 3381 **Humana Health Plans of Puerto Rico** Phone: 1-800-314-3121 Website: http://www.humana.com/ Group Number: 113262 **TRIPLE-S Inc. (Puerto Rico only)** Phone: 1-787-774-6060 Website: http://www.ssspr.com/ Group Number: SP0003447 Fully insured, funded through the general assets of the Company and employee contributions
Prescription Drugs (Except HMOs)	
Mail Service Drug Option (Mail Order Pharmacy Service)	**CVS Caremark** P.O. Box 3938 Spokane, WA 99220-3938 Phone: 1-844-758-0767 Website:caremark.com

Benefit Option	Health Assistant, Network/Claim Administrator, and Plan Funding
Prescriptions - Prior Authorization	**CVS Caremark** P.O. Box 3938 Spokane, WA 99220-3938 Phone: 1-844-758-0767 Website: caremark.com
Filing Retail Prescription Claims	**CVS Caremark** P.O. Box 3938 Spokane, WA 99220-3938 Phone: 1-844-758-0767 Website: caremark.com Self-funded through the general assets of the Company and employee contributions
Employee Assistance Program	
American Airlines, Inc. On-Site Employee Assistance Program	**EAP at American Airlines** Phone: 1-833-721-2322
Employee Assistance Program (EAP)	**Aetna** Phone: 1-833-721-2322 Website: www.resourcesforliving.com Password: American Self-funded through the general assets of the Company
Dental Coverage	
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/ Self-funded through the general assets of the Company and employee contributions

Benefit Option	Health Assistant, Network/Claim Administrator, and Plan Funding
Vision Insurance	
Vision Insurance	**EyeMed Vision Care** 4000 Luxottica Place Mason, OH 45040 Phone: 1-844-714-5678 Website: https://www.eyemedvisioncare.com/american First American Administrators, Inc. will decide claims and first levels appeals. Fully insured, and paid entirely by employee contributions
Life Insurance	
Life Insurance: Employee Basic Term Life Voluntary Life Spouse Term Life Child Term Life	**MetLife** American Airlines Customer Unit P.O. Box 3016 Utica, NY 13504-3016 Phone: 1-800-638-6420 The following benefits are fully insured and premiums are paid through the general assets of the Company: ○ Employee Basic Term Life Insurance The following benefits are fully insured and paid entirely by employee contributions: • Voluntary Life Insurance • Spouse Term Life Insurance • Child Term Life Insurance
Accident Insurance	
Accidental Death & Dismemberment (AD&D) Insurance: Basic Voluntary Other Accident Insurance: Special Purpose Accident Insurance Special Risk Accident Insurance Management Personal Accident Insurance Terrorism and Hostile Act Insurance	American Airlines, Inc. Benefits Service Center P.O. Box 661052 Dallas, TX 75266-1052 Phone: 1-847-554-1884 The following benefits are fully insured and premiums are paid through the general assets of the Company: • Basic AD&D Insurance • Special Purpose Accident Insurance • Special Risk Accident Insurance • Management Personal Accident Insurance • Terrorism and Hostile Act Insurance The following benefits are fully insured and paid entirely by employee contributions: Voluntary AD&D (Ground Employees only) ○ Voluntary Personal Accident Insurance (Flight Employees only)

Benefit Option	Health Assistant, Network/Claim Administrator, and Plan Funding
Disability Coverage for Ground Employees: Employees represented by the Communications Workers of America, AFL-CIO, CLC, and Officers, Management/Specialists and Support Staff	
• Short-Term Disability (Management and Support Staff only) • Optional Short Term Disability (OSTD) Insurance (Employees represented by the Communications Workers of America, AFL-CIO, CLC only)	**MetLife Disability** American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590 Phone: 1-888-533-6287 Fax: 1-800-230-9531 Website (claims tracking and coverage information): https://mybenefits.metlife.com/ The following benefits are self-funded through the general assets of the Company and are not subject to ERISA: ○ Short-Term Disability (Management/Specialists and Support Staff only) The following benefits are fully insured and paid entirely by employee contributions: ○ Optional Short-Term Disability Insurance (Employees represented by the Communications Workers of America, AFL- CIO, CLC only)
Disability Coverage for Ground Employees: PAFCA and FSE, SimPs, and FCTIs represented by the TWU	
Optional Short Term Disability (OSTD) Insurance	**MetLife Disability** American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590 Phone: 1-888-533-6287 Fax: 1-800-230-9531 Website (claims tracking and coverage information): https://mybenefits.metlife.com/ Fully insured and paid entirely by employee contributions.
Disability for Flight Attendants	
Optional Short Term Disability (OSTD) Insurance	**MetLife Disability** American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590 Phone: 1-888-533-6287 Fax: 1-800-230-9531 Website (claims tracking and coverage information): https://mybenefits.metlife.com/ This benefit is fully insured and paid entirely by employee contributions.

Benefit Option	Health Assistant, Network/Claim Administrator, and Plan Funding
Disability for Pilots	
Short-Term Disability (STD)	**MetLife Disability** American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590 Phone: 1-888-533-6287 Fax: 1-800-230-9531 Website (claims tracking and coverage information): https://mybenefits.metlife.com/ This benefit is self-funded through the general assets of the Company and is not subject to ERISA.
Flexible Spending Accounts (FSAs), Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA)	
• HSA (applies to CORE Medical Benefit Option Only) • HRA (applies to STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options Only) • Health Care FSA (for STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options, PPO and OUT-OF-AREA Option under the PPO Plan Only) • Limited Purpose Health Care FSA (applies to CORE Medical Benefit Option Only) • Dependent Care FSA	**Alight Solutions** Smart-Choice Accounts P.O. Box 785040 Orlando, FL 32878-5040 Fax: 1-888-211-9900 Please note that the HSA is not Company-sponsored. Reimbursements are paid from the Company's general assets. ○ HRA These benefits are self-funded and paid entirely by employee contributions. ○ Health Care FSA ○ Limited Purpose Health Care FSA ○ Dependent Care FSA
Long-Term Care Insurance	

Long-Term Care Insurance	**MetLife Long-Term Care** 57 Greens Farms Road Westport, CT 06880 Phone: 1-800-438-6388 Website (claims tracking and coverage information): https://mybenefits.metlife.com/ Fully insured (Policy 96659) and paid entirely by employee contributions
Other Options (Not Company-Sponsored) The following program options are offered to eligible employees (and Eligible Dependents). American Airlines, Inc. does not sponsor these programs.	
Added Benefits Program	**Added Benefits** Phone: 1-855-550-0706 Website: www.AAaddedbenefits.com Covered services include: ○ MetLife 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

More Information About:	Contact
General questions Dependent eligibility Information updates	**American- Airlines, Inc. Benefits Service Center** P.O. Box 661052 Dallas, TX 75266-1052 Phone: 1-888-860-6178
Online Help from a Benefits Service Center Representative	American Airlines, Inc. Benefits Service Center Access Chat via my.aa.com or newjetnet.aa.com Click on Team Member Services, then Health & Benefits, click Benefits Service Center, click on "chat" at the bottom of the screen.
Forms, Guides and Contact Information	my.aa.com (Benefits Information page)

More Information About:	Contact
Qualified Medical Child Support Orders (QMCSO)	**American Airlines QMCSO** P.O. Box 1542 Lincolnshire, IL 60069-1542 Fax: 1-847-442-0899 (Include a cover sheet with the employer name and employee name)
Provider Directories	**If your Network/Claims Administrator is:** BlueCross BlueShield of Texas http://www.bcbstx.com/americanairlines United Healthcare http://americanairlines.welcometouhc.com/
Continuation of Coverage (COBRA) Direct billing while on Leave of Absence	**COBRA Administrator:** Alight Solutions P.O. Box 1345 Carol Stream, IL 60132-1345 Phone: 1-888-860-6178 Fax: 1-847-554-1884
Appeals (for Medical, Prescription Drug, Dental, Vision, Life, Accident, Enrollment/Eligibility Status Decisions, and Disability) (except for Second Level Appeals for HCFSA, DCFSA, and LPFSA)	**BlueCross and BlueShield of Texas** Attn: Appeals Department PO Box 660044 Dallas, TX 75266-0044 Phone: 1-833-346-3929 Fax: 801-994-1083 Email: Send a secure email using the Message Center by logging into Blue Access for Members℠ (BAM) at bcbstx.com **UMR** For Pre-Service Claim Issues Only: Attn: Pre-Service Claims Appeal Unit P.O. Box 400046 San Antonio, TX 78229 Phone: 1-833-346-3929 **UMR** For Post-Service Claim Issues Only: Attn: Post-Service Claims Appeal Unit P.O. Box 30546 Salt Lake City, UT 84130-0546 Phone: 1-833-346-3929 **CVS Caremark** For Clinical Appeals Only: Attn: ESI Clinical Appeals

More Information About:	Contact
	Department P.O. Box 66588 St. Louis, MO 63166-6588 Phone: 800.282.2881 Fax: 877.852.4070 For Administrative Appeals Only: Attn: ESI Administrative Appeals Department P.O. Box 66587 St. Louis, MO 63166-6587 Phone: 800-282-2881 Fax: 877-328-9660 **MetLife** Dental Attn: Appeals Department MetLife Group Claims Review P.O. Box 14589, Lexington, KY 40512 Phone: 866-838-1072 STD & PTD for Life Insurance American Airlines Appeals Unit P.O. Box 14590 Lexington, KY 40511-4590 1-888-533-6287

More Information About:	Contact
	EyeMed FAA/EyeMed Vision Care, LLC Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040 Fax: 1-513-492-3259 **American- Airlines, Inc. Benefits Service Center Enrollment or Eligibility Status Decisions, Benefit Changes Secondary to Life Events, Benefit Contributions (including payment of contributions while on leave of absence), Benefit Changes Outside the Annual Enrollment Period, Elections or Claim Denials involving Flexible Spending Accounts, etc.** **Attn: Claims and Appeals Management** **American Airlines** **P.O. Box 7105** **Rantoul, IL 61866**

More Information About:	Contact
	Phone: 1-888-860-6178
Second Level Appeals (HCFSA, DCFSA, and LPFSA)	Employee Benefits Committee (EBC) American Airlines, Inc. Mail Drop 8A201 P.O. Box 619616 DFW Airport, TX 75261-9616

Glossary of Terms

Accidental Injury: An injury caused by an outside and unforeseen traumatic force, independent of all other causes.

Alternative and/or Complementary Medicine: Diverse medical health care systems, practices and products that are not considered to be part of Conventional Medicine. Alternative and/or Complementary Medicine have not been proven safe and effective through formal scientific studies and scientific clinical trials conducted by the National Institutes of Health (National Center for Complementary and Alternative Medicine) or that are not recognized in Reliable Evidence as safe and effective treatments for the illness or injury for which they are intended to be used. Alternative and/or Complementary Medicine lack proof of safety and efficacy through formal, scientific studies or scientific clinical trials conducted by the National Institute of Health or similar organizations recognized by the National Institute of Health. Some examples of Alternative and/or Complementary Medicine are:

- Mind-body interventions (meditation, mental healing, creative outlet therapy, etc.)
- Biological therapies (herbal therapy, naturopathic or homeopathic treatment, etc.)
- Manipulative or body-based treatment (body-work, massage, rolfing, etc.)
- Energy therapies (qi-gong, magnetic therapies, etc.)

These examples are not all inclusive, as new forms of Alternative and/or Complementary Medicine exist and continue to develop. Other terms for Complementary and/or Alternative Medicine include (but are not limited to) unconventional, non-conventional, Unproven and irregular medicine or health care.

Alternative Mental Health Care Centers: These centers include Residential Treatment Centers and Psychiatric Day Treatment Facilities (see definitions in this section).

American Airlines Benefits Service Center or Benefits Service Center (Alight Solutions): The online enrollment tool, available via my.aa.com.

American Airlines Medical Plan: Any of the following health and welfare plans sponsored by American Airlines:

- The American Airlines, Inc. Health & Welfare Plan for Active Employees
- The American Airlines, Inc. DFW ConnectedCare Plan
- The American Airlines, Inc. Plus Plan for Active Employees
- The American Airlines, Inc. PPO Plan

Ancillary Charges: Charges for hospital services, other than professional services and room and board charges, to diagnose or treat a patient. Examples include fees for X-rays, lab tests, medicines, operating rooms and medical supplies.

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

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

Appropriate Care and Treatment: Medical care and treatment that is:

- Given by a Physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- Consistent with a Physician's diagnosis of your disability; and
- Intended to maximize your medical and functional improvement.

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

- (1) Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  (a) The National Institutes of Health.

  (b) The Centers for Disease Control and Prevention.

  (c) The Agency for Health Care Research and Quality.

  (d) The Centers for Medicare & Medicaid Services.

  (e) Cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

  (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

  (g) Any of the following if certain conditions are met:

  - The Department of Veterans Affairs.

- The Department of Defense.
- The Department of Energy.

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

- (2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- (3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Benefit Options: The employee welfare benefits offered as part of this Plan, identified in the chapter "Benefits under the Plan and Contact Information."

Bereavement Counseling: Counseling provided by a licensed counselor (usually a certified social worker, advanced clinical practitioner or clinical psychologist) of a hospice facility to assist the family of a dying or deceased Plan participant with grieving and the psychological and interpersonal aspects of adjusting to the participant's death.

Chemical Dependency Treatment Center: An institution that provides a program for the treatment of alcohol or other drug dependency by means of a written treatment plan that is approved and monitored by a Physician. This institution must be:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral
- Accredited by the Joint Commission on Accreditation of Health Care Organizations
- Licensed, certified or approved as an alcoholism or other drug dependency treatment program or center by any state agency that has the legal authority to do so

Child: Your

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Spouse, Common Law Spouse, or Company-Recognized Domestic Partner as defined by the Plan
- Stepchild
- Special Dependent, if you meet all of the requirements listed in the section "Dependent Eligibility Requirements – Generally (All Benefits)" in the chapter "Eligibility and Enrollment"

Chiropractic Care: Medically Necessary diagnosis, treatment or care for an injury or illness when provided by a licensed chiropractor practicing within the scope of his or her license.

Co-Insurance: A percentage of Eligible Expenses. You pay a percentage of the cost of Eligible Expenses and the Medical Benefit Option pays the remaining percentage, after you meet your deductible.

Collective Bargaining Agreement(s): The labor agreements entered into between American Airlines, Inc. and its union-represented employees, listed as follows:

- Joint Collective Bargaining Agreement (JCBA) Between American Airlines, Inc. and the Airline Pilots in the Service of American Airlines, Inc. and US Airways, Inc. as Represented by the Allied Pilots Association
- Agreement between American Airlines, Inc. and the Flight Attendants in the Service of American Airlines, Inc. as Represented by the Association of Professional Flight Attendants
- Letter of Agreement between American Airlines, Inc. and the Flight Attendants in the Service of American Airlines, Inc. as Represented by the Association of Professional Flight Attendants
- Agreement between American Airlines, Inc. and the Flight Dispatchers and Dispatcher's Assistants in the Service of American Airlines, Inc. as Represented by Professional Airline Flight Control Association (PAFCA).
- Agreement between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Fleet Service Employees
- Agreement between American Airlines and Transport Workers Union of America, AFL-CIO Covering Flight Crew Training Instructors and Simulator Pilot Instructors in the Service of American Airlines, Inc. and US Airways, Inc.
- Agreement between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Aviation Maintenance Technicians and Plant Maintenance Employees of American Airlines, Inc.
- Agreement between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Material Logistics Specialists and Crew Chief Material Logistics Specialists Employees of American Airlines, Inc.
- Agreement between American Airlines, Inc. and the Transport Workers Union of America, AFL-CIO Covering Maintenance Control Technician Employees of American Airlines, Inc.

- Agreement between American Airlines, Inc. and Transport Workers Union of American, AFL-CIO and International Association of Machinists and Aerospace Workers, AFL-CIO Covering Flight Simulator Engineers
- Passenger Service Agreement between American Airlines, Inc. and the Communications Workers of America- International Brotherhood of Teamsters (CWA-IBT) Association

Common Accident: With respect to Accidental Death and Dismemberment (AD&D) Insurance, this refers to the same accident or separate accidents that occur within one 24-hour period.

Company: American Airlines, Inc. and any successor thereto.

Company-Recognized Domestic Partner: Two people in a spouse-like relationship who meet all of the criteria listed in the section "Determining a Spouse (SP), Company-Recognized Domestic Partner (DP) or Common Law Spouse Eligibility (CLSP).

Convalescent or Skilled Nursing Facility: A licensed institution that:

- Mainly provides Inpatient care and treatment for persons who are recuperating from illness or injury
- Provides care supervised by a Physician
- Provides 24-hour nursing care by Nurses who are supervised by a full-time registered Nurse
- Keeps a daily clinical record of each patient
- Is not a place primarily for the aged or persons who are chemically dependent
- Is not an institution for rest, education or Custodial Care

Conventional Medicine: Medical health care systems, practices and products that are proven and commonly accepted and used throughout the general medical community of medical doctors, doctors of osteopathy and allied health professionals such as physical therapists, registered Nurses and psychologists. Conventional Medicine has been determined safe and effective, and has been accepted by the National Institutes of Health, United States Food and Drug Administration, Centers for Disease Control or other federally recognized or regulated health care agencies, and has been documented by Reliable Evidence as both safe and effective for the diagnosis and/or treatment of the specific medical condition. Other terms for Conventional Medicine include (but are not limited to) allopathy, western, mainstream, orthodox and regular medicine.

Co-Pays or Co-Payments: The specific dollar amount you must pay for certain covered services when you use In-Network Providers.

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

Deductible: The amount of Eligible Expenses a person or family must pay before a Benefit Option under the Plan will begin reimbursing Eligible Expenses.

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

Detoxification: 24-hour medically directed evaluation, care and treatment of drug-and alcohol addicted patients in an Inpatient setting. This care is evaluated for coverage under the Medical Benefit Options. The services are delivered under a defined set of Physician- approved policies and procedures or clinical protocols.

Disabled Dependent Child: A Child who meets all of the criteria listed in the section "Coverage for a Disabled Dependent Child – Medical, Dental, and Vision Coverage."

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

Educational Services: A service is considered to be an Educational Service if:

- It is a service for learning and educational disorders (which include, but are not limited to, services for reading disorders, alexia, developmental dyslexia, dyscalculia, spelling disorders and other learning difficulties).
- It is an early intensive behavioral intervention for autism and pervasive developmental disorders (which include, but are not limited to, development delay services and Applied Behavior Analysis (ABA)).
- It involves testing or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded).

Eligible Dependent: Dependent eligibility requirements differ depending on the benefit coverage you elect. See the section "Dependent Eligibility" in the chapter "Eligibility and Enrollment" for information on dependent eligibility requirements by Benefit Option.

Eligible Medical Expenses or Eligible Expenses: The Plan covers the portion of regular, Medically Necessary services, supplies, care and treatment of non-occupational injuries or illnesses up to the Fee Limits, when ordered by a licensed Physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage. See MOC definition below for more information.

Emergency Medical Condition: A medical condition involving acute symptoms (including severe pain) that are severe enough so a prudent layperson, with average knowledge of health and medicine, could reasonably expect that lack of immediate medical attention will result in:

- Placing the person's health (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- Serious impairment to bodily functions; or
- Serious dysfunction of any body organ or part

Experimental or Investigational Service or Supply: A service, drug, device, treatment, procedure or supply is Experimental or Investigational if it meets any of the following conditions:

- It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.
- Reliable Evidence shows that the drug, device, procedure or medical treatment is the subject of ongoing phase I, II or III clinical trials or under study (or that the consensus of opinion among experts is that further studies or clinical trials are necessary) to determine its maximum tolerated dose, toxicity, safety or efficacy, both in diagnosis and treatment of a condition and as compared with the standard means of treatment or diagnosis.
- The drug or device, treatment or procedure has FDA approval, but is not being used for an indication or at a dosage that is accepted and approved by the FDA or the consensus of opinion among medical experts.
- Reliable Evidence shows that the medical service or supply is commonly and customarily recognized throughout the Physician's profession as accepted medical protocol, but is not being utilized in accordance or in compliance with such accepted medical protocol and generally recognized standards of care.
- The drug, device, treatment or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure that is used with a patient informed consent document that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function.
- A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- The treatment or procedure is less effective than conventional treatment methods.

- The language appearing in the consent form or in the treating hospital's protocol for treatment indicates that the hospital or the Physician regards the treatment or procedure as experimental.

Explanation of Benefits (EOB): A statement provided by the Network/Claims Administrator that shows how a service was covered by the Plan, how much is being reimbursed and what portion, if any, is not covered.

Flight Employees: Pilots and Flight Attendants employed by the Company.
Flexible Spending Accounts (FSAs): The Health Care Flexible Spending Account (HCFSA), Limited Purpose Flexible Spending Account (LPFSA), and Dependent Care Flexible Spending Account (DCFSA).

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

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

Gender Reassignment Benefit (GRB): Provides coverage for gender reassignment for the treatment of gender dysphoria. For more information, see the section "Covered Expenses" in the chapter "Medical Benefits."

Ground Employees: The below group of American Airlines, Inc. employees:

- Agents/Representatives/Planners (ARP) employees of the Company who are represented by the Communications Workers of America and the International Brotherhood of Teamsters ("CWA-IBT")
- Officers, Management, Support Staff (OMSS) employed by the Company;
- Employees who are represented by the Transport Workers Union ("TWU");
- Employees who are represented by the Professional Airline Flight Control Association ("PAFCA");
- Employees of American Airlines, Inc. who are covered by collective bargaining agreements entered into between the TWU/IAM Association covering Mechanics & Related, Material Logistics Specialists, Maintenance Training Specialists, Maintenance Control Technicians, and Fleet Service.
- . **Hire Date:** The first date that you were on the U.S. payroll of American Airlines, Inc. as a Regular Employee.

Home Health Care: Services that are Medically Necessary for the care and treatment of a covered illness or injury furnished to a person at his or her residence.

Hospice Care: A coordinated plan of care that treats the terminally ill patient and family as a family unit. It provides care to meet the special needs of the family unit during the final stages of a terminal illness. Care is provided by a team of trained medical personnel, homemakers and counselors. The hospice must meet the licensing requirements of the state or locality in which it operates.

In-Network: Refers to benefits and services you receive from Providers that contract with the Network/Claim Administrators. Generally, your benefits under the Plan are higher (and your Out-of-Pocket expenses lower) when you use In-Network services.

Individual Annual Deductible: An annual Deductible is the amount of Eligible Expenses you must pay each year before your Medical Benefit Option will start reimbursing you. After you satisfy the Deductible, your selected Medical Benefit Option pays the appropriate percentage of eligible covered medical services.

Infertility Treatment: Includes medical services, supplies and procedures for or resulting in impregnation and testing of fertility or for hormonal imbalances that cause male or female infertility (regardless of the primary reason for the hormone therapy). Infertility Treatment or testing and treatment promoting fertility includes, but is not limited to: all forms of in-vitro fertilizations, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversals of tubal ligations or vasectomies, drug therapy, including drug treatment for ovarian dysfunction and infertility drugs, such as Clomid, Pergonal, Lupron or Repronex.

Inpatient or Hospitalization: Medical treatment or services provided at a hospital when a patient is admitted and confined, for which a room and board charge is incurred.

Life Event: Certain circumstances or changes that occur during your life that allows you or your dependents to make specific changes in coverage options outside the Annual Enrollment Period. The Internal Revenue Service dictates what constitutes Life Events.

Life-Threatening Condition: Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Loss or Impairment of Speech or Hearing: Loss or damage of verbalization or hearing, or communicative disorders generally treated by a speech pathologist, audiologist, or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and that fall within the scope of his or her license or certification.

Mammogram or Mammography: The X-ray examination of the breast using equipment dedicated specifically for Mammography, including the X-ray tube filter compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views of each breast. This also includes Mammography by means of digital or computer-aided (CAD) systems, and 3-D Mammography.

Married Employees: Employees of the Company who are married (legal or common law) to other employees of the Company.

Maximum Out-of-Network Charge (MOC): The MOC is the amount that your Network/Claim administrator will use in determining how much the Plan will pay toward Out-of-Network services. The MOC applies to the CORE, STANDARD, HIGH COST COVERAGE, and OUT-OF-AREA Medical Benefit Options. However, the Maximum Out-of-Network charge for treatment of an Emergency Medical Condition or for services rendered by certain out-of-network providers practicing at in-network facilities is based on an amount determined in accordance with ERISA § 716.

The MOC for individual providers of all other services is either a rate negotiated by the Network/Claim Administrator or 140% of the rate that the federal Medicare program would pay for the service. The MOC for Out-of-Network facilities will be limited to 140% of the amount the federal Medicare program would have paid for the same service, or an amount based on 60% of the reasonable and customary charge as determined by your Network/Claim Administrator using its internal claims databases. Your Network/Claim Administrator will determine the MOC based on this formula.

Medical Benefit Option: The medical coverage offered by the Company to eligible employees to provide benefits for eligible employees and covered dependents in the event of an illness or injury. The Company offers the following Medical Benefit Options:

- CORE
- STANDARD
- HIGH COST COVERAGEOUT-OF-AREA
- HMO

Medical Necessity or Medically Necessary: A medical or dental service or supply required for the diagnosis or treatment of a non-occupational, Accidental Injury, illness or pregnancy. The Benefit Option determines Medical Necessity based on and consistent with standards approved by the Network/Claims Administrator's medical personnel. To be Medically Necessary, a service, supply, or inpatient confinement must meet all of the following criteria:

- Ordered by a Physician (although a Physician's order alone does not make a service Medically Necessary)
- Appropriate (commonly and customarily recognized throughout the Physician's profession) and required for the treatment and diagnosis of the illness, injury or pregnancy
- Unavailable in a less intensive or more appropriate place of service, diagnosis, or treatment that could have been 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 Network/Claims Administrator determines them to be:

- Appropriate for the treatment of the illness or injury
- Not for the patient's scholastic education, vocation or training
- Not custodial in nature
- A determination that a service or supply is not Medically Necessary may apply to all or part of the service or supply

Mental Health Disorder: A mental or emotional disease or disorder.
Multiple Surgical Procedures: One or more surgical procedures performed at the same time as the Primary Surgical Procedure, which are Medically Necessary but were not the primary reason for surgery.

Network: A group of Physicians, hospitals, pharmacies and other medical service Providers who have agreed, via contract with the Network/Claims Administrators to provide their services at negotiated rates.

Network/Claim Administrators: The third-party organizations with which the Company maintains contracts to process benefit claims, determine Medical Necessity, and manage a Network of Providers and care facilities.

Nurse: This term includes all of the following professional designations:

- Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)

Nursing services are covered only when Medically Necessary and the Nurse is licensed by the State Board of Nursing, and if the Nurse is not living with you or related to you or your Spouse/Company-Recognized Domestic Partner.

Original Medicare: The term used by the Centers for Medicare and Medicaid Services (CMS) to describe the coverage available under Medicare Parts A, B, and D.

Out-of-Network: Refers to benefits and services received from Providers that are not part of the Network/Claim Administrators' networks. Generally, your benefits under the Plan are lower (and your Out-of-Pocket expenses higher) when you use Out-of-Network services.

Out-of-Pocket/Out-of-Pocket Maximum: Out-of-Pocket is the portion of covered expenses that you have to pay during the Plan Year. Out-of-Pocket Maximum is the most you will pay for covered expenses during the Plan Year.

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

Over-the-Counter (OTC): Drugs, products and supplies that do not require a Prescription by federal law.

Physician: A licensed or certified practitioner of the healing arts acting within the scope of his or her license or certification. The term includes but is not limited to the following licensed individuals:

- Audiologist
- Certified social worker or advanced clinical practitioner
- Chiropractor
- Clinical psychologist
- Doctor of Dental Medicine (DMD)
- Doctor of Dental Surgery (DDS)
- Doctor of Osteopathy (DO)
- Doctor of Medicine (MD)
- Nurse anesthetist
- Nurse practitioner
- Physical or occupational therapist
- Physician Assistant (PA)
- Speech pathologist or speech language pathologist or therapist

The term does not include:

- You
- Your Spouse/Company-Recognized Domestic Partner
- A parent, Child, sister or brother of you or your Spouse/Company-Recognized Domestic Partner

Plan Administrator: American Airlines, Inc., or its authorized delegate, is the Plan Administrator. The Plan Administrator maintains sole responsibility for the Plan and the benefits it provides. The Plan Administrator has the sole discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, including entitlement to benefits. The Plan Administrator also has the sole discretion to determine all matters relating to interpretation and operation of the Plan and may contract with third parties to provide some or all of these services to participants.

Plan Document: A formal written document or documents that establish the terms of employer sponsored group coverage. The American Airlines, Inc. Health and Welfare

Plan Wrap Document for Active Employees serves as the Plan Document for the Plan, together with the documents that it incorporates by reference.

Plan Sponsor: American Airlines, Inc. is the Plan Sponsor.
PPACA: The Patient Protection and Affordable Care Act.

PPO Plan: The American Airlines, Inc. PPO Plan.

Pre-Existing Condition or Pre-Existing Condition Limitation: (applies to Optional Short-Term Disability Insurance in the American Airlines, Inc. Health & Welfare Plan for Active Employees). A Pre-Existing Condition includes any physical or mental condition that was diagnosed or treated before the participant's original coverage effective date (the date first enrolled in coverage) in a plan and that will not be covered under that plan for a specified period after enrollment.

Preferred Provider Organization (PPO) (applies to the Medical Benefit Options and Dental Benefit Options): A group of Physicians, hospitals and other health care Providers who have agreed to provide medical services at negotiated rates.
Prescriptions: Drugs and medicines that must, by federal law, be requested by a Physician's written order and dispensed only by a licensed pharmacist. Prescription drugs also include injectable and self-administered specialty drugs.

Primary Care Physician (PCP): An In-Network Physician who specializes in family practice, general practice, internal medicine, pediatrics, or OB/GYN and who may coordinate all of the In-Network medical care for a participant in the Medical Benefit Options.

Primary Surgical Procedure: The principal surgery prescribed based on the primary diagnosis.
Prior Authorization for Prescriptions: Authorization by the Prescription drug program administrator that a Prescription drug for the treatment of a specific condition or diagnosis meets all of the Medical Necessity criteria.

Proof of Good Health or Statement of Health (also referred to as Evidence of Insurability or EOI): Some Benefit Options require you to provide Proof of Good Health when you enroll for coverage at a later date (if you do not enroll when you are first Eligible), or when you increase levels of coverage. Proof of Good Health is a form you must complete and return to the appropriate Plan Administrator when you enroll in the Optional Short-Term Disability Insurance or increase levels of Voluntary Life Insurance for you or your Spouse/Company-Recognized Domestic Partner (beyond certain levels). Life Insurance coverage amounts will not increase (beyond certain levels), nor will you be enrolled in the Optional Short-Term Disability Insurance, until the Plan Administrator approves your Proof of Good Health Form and you pay the initial/additional contribution for coverage.

If a death or accident occurs before your enrollment for coverage or increase in coverage is processed, the amount of Life Insurance, Accidental Death & Dismemberment (AD&D) Insurance, or Voluntary Personal Accident Insurance (VPAI) coverage that will be payable is your current amount of coverage or default coverage (if you have not enrolled following

your initial period of eligibility). You may obtain a Proof of Good Health Form from the Plan Administrator for each Benefit Option.

Please note that your Proof of Good Health form will be reviewed, and enrollment may be denied based upon the presence of certain health conditions as determined by MetLife and the Plan.

Provider: The licensed individual or institution that provides medical services or supplies. Providers include Physicians, hospitals, pharmacies, surgical facilities, Dentists and other covered medical or Dental service and supply Providers.

Psychiatric Day Treatment Facility: A mental health institution that provides treatment for individuals suffering from acute Mental Health Disorders. The institution must:

- Be clinically supervised by a Physician who is certified in psychiatry by the American Board of Psychiatry and Neurology
- Be accredited by the Program of Psychiatric Facilities of the Joint Commission on the Accreditation of Health Care Organizations
- Have a structured program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the program's treatment format.

Qualifying Event: A change in your status that causes you to lose eligibility for Medical, Dental, Vision and Health Care Flexible Spending Account coverages and would qualify you to be eligible for COBRA Continuation of Coverage. Qualifying Events are defined by COBRA. For examples, see "Continuation of Coverage" in the Additional Health Benefit Rules section.

Qualified Medical Child Support Order (QMCSO): An order, decree or judgment from a court or administrative body, which directs the Plan to provide coverage to the Child of a participant under the Plan.

Regular Employee: An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, or a Flexible Work Arrangement, depending on the business needs of the organization or the terms of the applicable labor agreement. A Regular Employee is eligible for the benefits and privileges that apply to his or her workgroup or as outlined in his or her applicable labor agreement.

Reliable Evidence: Reliable Evidence includes:

- Published reports and articles in the authoritative peer reviewed medical and scientific literature including: American Medical Association (AMA) Drug Evaluation, American Hospital Formulary Service Drug Information, U.S.
- Pharmacopoeia Dispensing Information and National Institutes of Health, and U.S. Food and Drug Administration
- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment or procedure

- Written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure

Reliable Evidence does not include articles published only on the Internet.

Residential Treatment Center: A facility that offers 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The center must be licensed or certified by the state as a psychiatric and/or substance abuse Residential Treatment Center, or accredited by one of the following entities: the Commission on Accreditation of Rehabilitation Facilities ("CARF"), the Joint Commission on the Accreditation of Health Care Organizations, or the Council on Accreditation ("COA").

Restorative and Rehabilitative Care: Care that is expected to result in an improvement in the patient's condition and restore reasonable function. This is focused on a function that you had at one time and then lost, due to illness or injury. After improvement ceases, care is considered to be maintenance and is no longer covered.

Retiree Benefit Guide: Retiree Benefit Guide and Summary Plan Description for American Airlines, Inc. Group Life and Health Plan for Retirees and American Airlines, Inc. Supplemental Medical Plan.

Return-to-Work Program: A voluntary program offered under certain of the Plan's Disability Benefit Options that allows you, as a disabled employee collecting disability benefits, to work in an occupation or job for wage or profit for a trial period without losing your disability benefits.

School: A school or educational institution, including a vocational or technical school, if the student is enrolled:

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

Social Security Disability Benefits (SSDB): Disability benefits paid by the Social Security Administration to individuals and their families who qualify.

Sound Natural Teeth: Teeth that satisfy all of the following criteria:

- Both deciduous teeth and permanent teeth that developed in your own mouth.
- Teeth free of active or chronic clinical decay or disease.
- Teeth that have at least 50 percent bone support, and have at least 50 percent tooth structure in the crown portion of the teeth.
- Teeth which are functional in the dental arch.
- Teeth that have any type of restorations (including but not limited to, fillings, crowns, inlays, onlays, bridges, veneers) are not sound natural teeth.

Specialist: A Specialist is any Provider or entity, other than a Primary Care Physician.

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

Spending Accounts: Refers to the Health Care Flexible Spending Account (HCFSA), Limited Purpose Flexible Spending Account (LPFSA), Dependent Care Flexible Spending Account (DCFSA), Health Savings Account (HSA), and Health Reimbursement Account (HRA).

Spouse: Refers to both a "Spouse" and a "Common Law Spouse," as those terms are defined in the section "Determining a Spouse (SP), Company-Recognized Domestic Partner (DP) or Common Law Spouse Eligibility (CLSP)."

Summary Plan Description (SPD): A document provided to participants outlining terms of employer sponsored group coverage. This document serves as the Summary Plan Description for the Plan, along with any other benefits summary published by the Company that contains a description of this Plan. In our efforts to provide you with multimedia access to benefits information, American Airlines, Inc. has created online versions of the Summary Plan Descriptions for our benefit plans. If there is any discrepancy between the online version and the official hard copy of this document, then the official hard copy, plus official notices of Plan changes/updates will govern.

Telehealth: Live face–to-face video consultations for medical visits offered by Doctor on Demand for participants enrolled in one of the self-funded Medical Benefit Options.

Timely Pay or Timely Payment: Timely Payment means payment of the full amount of contribution or premium due by the payment due date or before the end of the 30-day grace period for payment (as reflected on the invoice or payment coupon). Payments rejected due to insufficient funds (e.g., "bounced" checks) are also considered not Timely Paid. This term applies to Benefit Options for which you are required to pay ongoing contributions or premiums in order to maintain coverage under the Benefit Options.

Urgent Care or Immediate Care: Care required because of an illness or injury that is serious and requires prompt medical attention, but is not life threatening. The Network/Claim Administrators determine whether care is Urgent Care or Immediate Care.

Unproven Service, Supply or Treatment: Any medical or Dental service, supply or treatment that has not been proven both safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications, or has not been proven both safe and effective by Reliable Evidence.

Usual and Prevailing Fee Limits (U&P): The maximum amount that the Plan will consider as an Eligible Expense for Dental services and supplies. For purposes of the Plan, "usual and prevailing" shall be equivalent with the terms "usual and customary", "reasonable and customary", and "usual, reasonable and customary". The primary factors considered when determining if a charge is within the Usual and Prevailing Fee Limits:

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

Usual and Prevailing Fee Limits can also be impacted by the number of services or procedures you receive during one dental treatment. Under the Plan, when reviewing a claim for usual and prevailing fee determination, the Network/Claims Administrator looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by Providers (often referred to as "coding fragmentation" or "unbundling") usually results in higher Physician's charges that if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

Vision: The vision benefit offered under the Plan.

Workers' Compensation: Insurance that provides cash benefits and/or medical care for employees who are injured or become ill as a direct result of their employment.