American Airlines, Inc.
DFW ConnectedCare Plan

Summary Plan Description

Effective January 1, 2024

Introduction

The Company partners with Baylor Scott & White Quality Alliance ("BSWQA") – an integrated health care network that is part of Baylor Scott & White Health – to offer the American Airlines, Inc. DFW ConnectedCare Plan ("Plan"), a medical plan option only available in the Dallas-Fort Worth area.

The Plan exclusively uses the BSWQA network of more than 5,000 primary and specialty care providers, 50 hospitals, and more than 95 facilities, laboratory and imaging service providers—all conveniently located throughout the DFW area. In addition, BSWQA partners with select providers and facilities that include Methodist Health System, Cook Children's Healthcare System and Children's Health.

Your coordinated care is delivered exclusively by this network in the DFW area. Your primary care physician (PCP) and all of your other BSWQA health care providers and facilities work together to understand your health care needs. With this unique understanding of you, your ConnectedCare team is empowered to deliver coordinated care and robust in-network resources ensuring you get the right care at the right time. The Plan's terms for paying providers for their services include financial incentives (such as bonuses or withheld payments) that are designed to reward high-quality and cost-effective treatments in connection with certain services. Check to see if your preferred provider(s) are in-network by visiting dfwconnectedcare.com.

DFW ConnectedCare Center:

Your Health Care Coordinator will be your primary contact and help you find a provider, schedule an appointment, answer benefits coverage questions and help you connect to the right place at the right time. They are backed by a team of experts as noted below

- **Registered Nurse (RN) Care Manager:** Guides and supports you to manage your chronic illness and answers questions about your health care.
- **Social Worker:** Helps you with problems that may keep you from meeting your health goals and provide counseling for behavioral, health, and social issues.
- **Community Health Worker:** He/she can connect you with community resources and offer support.
- **Pharmacist/Pharmacy Tech:** Teaches you about your medications and checks to make sure you are taking medications safely.
- **Claims Specialist:** Assist with claims or explanation of benefits questions.

Outreach:

Someone from the DFW ConnectedCare Center may reach out to you. For example, your Health Care Coordinator may reach out to offer help before and after a hospital stay or ask how they can help with your health care needs. You may receive an occasional check-in call or more regularly, depending on your health needs and what you're comfortable with. All communications are handled in strict confidence. If you were previously engaged with Accolade to manage your health, your new Care Management Team will support you.

Contacting DFW ConnectedCare Center:

The DFW ConnectedCare Center should be your first point of contact if you are unsure of where to go or who to contact with a benefits plan or health related question.

The DFW ConnectedCare Center can be reached 7am-9pm CT, seven days a week, Sunday – Monday, at 1-800-784-5473.

- If your need is urgent and outside of normal business hours, you can connect with the team via the 24/7 nurse line using the same number 1-800-784-5473. 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.

Before choosing the Plan, consider these details:

- **Dallas-Fort Worth area:** Covered care is offered only by the BSWQA network, which is primarily located in the DFW area. If you have covered dependents at college or living outside the DFW metroplex, this Plan probably isn't right for you.

- **Traveling:** The Plan does not cover the services of doctors, hospitals or providers who are not in the Plan's network except in cases of urgent or emergency care (as defined by the Plan). Note, however, that Plan participants are eligible to receive telemedicine and eVisits as well as services from certain retail clinics. Team members are also able to access American's onsite clinics.

- **Network:** There is no coverage outside the BSWQA network unless you use an emergency room for an Emergency Medical Condition (as defined by the Plan) or are traveling outside of the area and need urgent or emergency care. If you are traveling outside of the DFW area, within the United States, you will have access to urgent and emergent care facilities in the Aetna Signature network. If you or one of your dependents is under the care of a provider outside the BSWQA network and no other provider can lead that care, this option may not be for you. To find providers in the BSWQA network, visit dfwconnectedcare.com.

An important difference between this Plan and most of the other medical plan options that the Company offers is that **you must always use the specific doctors, hospitals and other providers that are in the Plan's network**. If you receive services from a provider outside the Plan's network, your expenses **will not be covered**, except in cases of an Emergency Medical Condition (as defined by the Plan).

To help you make the most of those benefits, this Summary Plan Description ("SPD") describes its provisions, effective January 1, 2024. The terms and conditions of the Plan are set forth in this SPD and the formal Plan Document. The SPD is incorporated by reference into the formal Plan Document, and together these documents 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.

Please note that this SPD only describes the medical and prescription drug benefits available under this Plan. You may also be eligible for other health and welfare benefits offered by the Company, including dental, vision, spending accounts, wellness programs, life insurance, AD&D insurance, and disability benefits. For a description of other health and welfare benefits offered by the Company, please see the SPDs available on my.aa.com.

Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and this Summary Plan Description, the Plan Document controls. If the Plan Document is silent, then the Summary Plan Description controls.

The Company, or its authorized delegate, reserves the right to modify, amend or terminate the Plan, any program described in this SPD, or any part thereof, at its sole discretion. 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.

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Eligibility and Enrollment

Employee Eligibility

Eligible Employees

Generally, all active, full-time or part-time employees on the U.S. payroll of American Airlines, Inc. with a permanent residence or alternate/benefits address in a designated region as described in the following chart are eligible for the Plan, except for any individual or employee specifically listed as ineligible in the "Ineligible Employees" section below.

Plan	Available to Employees With a Permanent Residence or Alternate/Benefits Address in a zip code in one of the following eligible counties (and not in an excluded zip code):
The American Airlines, Inc. DFW ConnectedCare Plan	<u>Eligible Counties</u> • Collin, Dallas, Denton, Ellis, Johnson, Parker, Rockwall, and Tarrant <u>Excluded Zip Codes</u> • 75143 Kemp • 76008 Aledo • 76020 Azle • 76023 Boyd • 76033 Cleburne • 76035 Cresson • 76049 Granbury • 76061 Lillian • 76066 Milsap • 76067 Mineral Wells • 76070 Nemo • 76082 Springtown • 76085 Weatherford • 76086 Weatherford • 76087 Weatherford • 76088 Weatherford • 76439 Dennis • 76462 Lipan • 76485 Peaster • 76487 Poolville • 76490 Whitt

You are eligible for benefits under the Plan if your permanent residence or alternate/benefits address is in a designated region described in the chart above. Your permanent residence is your home address (*i.e.*, the address you use for tax purposes). Your alternate/benefits address is a P.O. Box or street address other than your home address.

You are eligible for benefits by county as follows:

- You have an alternate/benefits address on record and the zip code in the county of your alternate/benefits address on record matches a county in the chart above and is not in one of the excluded zip codes; or

- You have a permanent residence on record and the zip code in the county of your permanent residence on record matches a county in the chart above and is not in one of the excluded zip codes.

If you or one of your dependents is under the care of a provider outside the Plan's network and no other provider can lead that care, this option may not be for you.

Ineligible Employees

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

- Any active, full-time or part-time employee on the U.S. payroll of American Airlines, Inc. who does <u>not</u> have a permanent or alternate/benefits address on record in a zip code in one of the eligible counties described in the chart above, under "Eligible Employees," or who does have a permanent or alternate/benefits address on record in a zip code in one of the eligible counties described in the chart above, under "Eligible Employees," but such zip code is in an "excluded zip code."

- **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 Department of Labor ("DOL").

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

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 United States and is related to the employee in one of the following ways:

- Spouse and Common Law Spouse.
- Child until the end of the month he/she turns 26 (as defined below in the Determining a Child's Eligibility section).
- Disabled Dependent Child age 26 or over, as defined below under "Coverage for a Disabled Dependent Child."
- 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.

Coverage for a Disabled Dependent Child

A "Disabled Dependent Child" age 26 or older is eligible for continuation of coverage if all 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 within 31 days prior to the date coverage would otherwise end, or if the child is not in coverage within 60 days of your qualifying Life Event (such as marriage or loss of coverage).
- The American Airlines Benefits Service Center will forward your request to your Network 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 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.

Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Spouse or Common Law Spouse as defined by the Plan
- Stepchild
- Special Dependent, if you meet all of the following requirements:
    - You 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 findings. If your request is approved, the notification letter will include an approval

date. If you submit your request within 60 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by 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.

- 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 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).

Dependents of Deceased Employees

If you have elected coverage under the Plan for your Spouse and Children and you die as an active employee, your dependents' coverage will continue for 90 days at no contribution cost.

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

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

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

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

- **Spouse (SP).** Your Spouse means an individual who is lawfully married to the employee 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 United States and the individual is recognized as lawfully married by that state,

possession, or territory of the United States; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the United States 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.

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 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.

Notice will be provided via email and/or paper correspondence mailed to your address on file. Failure to respond to these requests within the requested timeframe of 31 days 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).

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 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 as employees under more than one medical benefit sponsored by American Airlines, Inc. Therefore, Married Employees have the option of being covered either: (1) as an employee and a dependent Spouse under the Plan; or (2) separately as individual employees each without a dependent Spouse under their own Plan benefits.

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

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

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 due to the timeframe of the leave of absence are Life Events (see the Life Events section). When Company-provided benefits terminate for a Married Employee's Spouse on a leave of absence, the Married Employee on leave may elect COBRA continuation coverage or be covered as the Dependent of his or her actively working Married Employee, but not both.

If the 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:

- 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 timeframe allowed based upon company policy or Joint Collective Bargaining Agreement during a leave of absence for family, sick, injury-on-duty or maternity leaves.

Eligible Dependent Children:

- Children cannot be covered under both parents' Plan benefits.
- If one Spouse is covered under the Plan, the Children are covered under the parent who participates in the Plan.

Contributions: If Married Employees choose to be covered under one employee, the contributions for the employee covering both will reflect either "Employee plus Spouse" or "Employee plus Family," if the employee also elects to cover dependent Children.

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

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).

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.

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." "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 if the reason you are not actively-at work is due to a health condition; in that event, your coverage under the Plan 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).

When Coverage Begins as a Current Employee

When you enroll during the Annual Enrollment Period, your selected 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.

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 available benefits 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 coverage under the Plan for yourself and your Eligible Dependents for a period of time during a leave, subject to the specific rules in the Company policies governing leaves of absence, which are available 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, 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. You may also be able to elect COBRA continuation coverage, as described later in this document.

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 have 60 days to 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 unpaid 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 your benefits by processing a life event within 60 days of your return to work.

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 Benefit 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

If you declined coverage for you or your dependents under the Plan 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 Plan, 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 Plan if one of the following events occurs:

- You have a new dependent as a result of your marriage, common law marriage, 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, 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 is not enrolled in the Plan 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 in the Plan 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).

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.

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, phone call, and/or a mailing to your address on file. **If you miss the 31-day deadline, your Life Event change will not be processed.** You will have to wait until the next Annual Enrollment Period or 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 process your Life Event within 60 days of the event, your changes are retroactive to the date the Life Event occurred.
- 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 the Following Life Event…	Then, You May be Able to…
You become eligible for Company-provided benefits for the first time	Enroll online through the American Airlines Benefits Service Center.
Your Spouse, or Eligible Dependent Child dies	• You lose a Spouse or Eligible Dependent Child: Stop coverage for your lost Spouse/ /Eligible Dependent Child (dependent coverage may be subject to QMCSO). Start coverage for yourself or your Eligible Dependent Child if the loss of your Spouse results in loss of eligibility under your Spouse's plan • You gain a Spouse/Eligible Dependent Child: Start coverage for yourself, your Spouse, and/or your Eligible Dependent Child. Stop coverage for yourself and/or your Eligible Dependent Child if you gain coverage under new Spouse's plan. You may change Plan benefits. • Change in your, your Spouse's or your Eligible Dependent Child's employment: If you/your Spouse/ or your Eligible Dependent Child gain eligibility under the other employer's plan, you can drop yourself, your Spouse/, and/or your Eligible Dependent Child. If you/your Spouse or your
You or your Spouse gives birth to or adopts a Child or has a Child placed with you for adoption or you gain an Eligible Dependent(s) • To add a natural child to your coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth 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 60 days to arrive and prevent you from starting coverage effective on the baby's birth date.** • To add an adopted child to your benefit coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective the date the child is placed with	

you for adoption and is not retroactive to the child's date of birth.	Eligible Dependent Child lose eligibility or employer contribution under the other employer's plan, you can add yourself, your Spouse, and/or your Eligible Dependent Child.
You get legally married (including common law marriage), divorced, legally separated, or have your married annulled OR You declare a or that relationship ends	
You change your employment with an employer other than the Company OR Change in Spouse's Eligible Dependent Child's employment or other health coverage OR Your Spouse's Eligible Dependent Child's employer no longer contributes toward health coverage OR Your Spouse's Eligible Dependent Child's employer no longer covers employees in your Spouse's/Eligible Dependent Child's position	

If You Experience the Following Life Event…	Then, You May be Able to…
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 enrolls in his/her Spouse's employer group health plan	• Stop coverage for your Spouse/Eligible Dependent • Child (dependent coverage may be subject to QMCSO). **Additionally:** • Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible Dependent's address.
Your benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant") OR Your contribution amount is significantly increased or decreased by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")	**Make changes to Plan benefits:** • 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	• Start coverage for yourself • Start coverage for your Eligible Dependent Child named in the QMCSO
You, or your Eligible Dependents enroll in Medicare or Medicaid or CHIP coverage	• Stop coverage for you or the affected Eligible Dependent.
You, or your Eligible Dependents lose Medicare, Medicaid or CHIP coverage	• Start coverage for yourself and the affected Eligible Dependent.
You, or your Eligible Dependents become eligible for Medicaid or CHIP coverage	• Start coverage for yourself and the affected Spouse or Eligible Dependent Child.
You, your Spouse or your Eligible Dependent Child become eligible for/lose eligibility for and become enrolled/dis-enrolled in government-sponsored Tricare coverage	• Start coverage for yourself if you lose eligibility • Stop coverage for yourself if you gain eligibility • Start coverage for your Spouse if he/she loses eligibility

If You Experience the Following Life Event…	Then, You May be Able to…
	• Stop coverage for your Spouse if he/she gains eligibility • Start coverage for your Eligible Dependent Child if he/she loses eligibility • Start coverage for your Eligible Dependent Child if he/she gains eligibility
You 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. • Stop coverage • Stop Spouse coverage • Stop Eligible Dependent Child coverage
You return from an unpaid leave of absence	If you did not continue payment of your benefits during your leave and wish to reactivate your benefits upon your return to work, you may do so. Go to the American Airlines Benefits Service Center, register your "Return to Work" Life Event and make selections or changes to your benefits. Start/Resume coverage for yourself • Start coverage for your Spouse • Start coverage for your Eligible Dependent Child
You or your Eligible Dependent are newly eligible for COBRA	• Change Plan benefits
You die	**Continuation of Coverage:** Your Eligible Dependents should 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.

If You Experience the Following Life Event…	Then, You May be Able to…
You end your employment with the Company or you are eligible to retire	**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	• Changes are allowed only to the extent that the change in workgroup affects benefit eligibility • Start/Stop coverage for yourself, your Spouse and/or your Eligible Dependent Child (dependent coverage may be subject to QMCSO).
You, your Spouse, and/or your Eligible Dependent Child declined the Company's medical coverage because you or they had coverage elsewhere (external to the Company), and any of the following events occur: • Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) • Employer contributions for the other coverage stopped • Other coverage was COBRA and the maximum COBRA coverage period ended • Exhaustion of the other coverage's lifetime maximum benefit • Other employer-sponsored coverage is no longer offered • Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your Eligible Dependents no longer reside, live, or work in its service area	• Start coverage for yourself o Note that you must enroll in the coverage in order to elect coverage for your and/or Eligible Dependent Child. • Start coverage for your affected Spouse • Start coverage for your affected Eligible Dependent Child
You, your Spouse, 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: • Stop coverage for yourself, Spouse, and Eligible Dependent Child
You, your Spouse, 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:

If You Experience the Following Life Event…	Then, You May be Able to…
	• Start coverage for yourself, Spouse, and Eligible Dependent Child
Your permanent residence or alternate/benefits address changes making you no longer eligible for the plan.	• Stop coverage for yourself, Spouse, and Eligible Dependent Child
Your permanent residence or alternate/benefits address changes making you eligible for the plan.	• Add coverage for yourself, Spouse, and Eligible Dependent Child

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 file a Life Event or contact American Airlines Benefits Service Center to remove the ineligible Dependent(s) from your coverage—even if you have missed the 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 receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified American Airlines Benefits Service Center of their ineligibility. In addition, the coverage for your dependent(s) will be retroactively terminated and any claims paid under the Plan will be reversed.

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

If 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 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 the Plan 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 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 coverage for your Spouse and Children and you die as an active employee, your dependents' coverage will continue for 90 days at no contribution cost. Your covered dependents are also eligible to continue 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 the Plan.

Medical Benefits

The Plan is a plan with a comprehensive network of providers who are committed to improving the quality, appropriateness and efficiency of healthcare services that are delivered. To accomplish this, the Plan offers coverage through the Clinical Integration Program, which provides medical services to you and your Eligible Dependents in the geographic area in which the Plan is offered. If you receive services from a provider outside the Plan's network, your expenses will not be covered, except in cases of an Emergency Medical Condition or urgent care while traveling (as defined by the Plan).

The Company offers you the opportunity to enroll in medical coverage under the Plan for you and your Eligible Dependent(s). Eligible employees who choose to participate in the Plan do so in lieu of any other medical benefit option offered by the Company. An employee may not be enrolled in this Plan and another medical benefit option offered by the Company at the same time.

You may choose from the following coverage levels:

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

Your dependents must be enrolled in the same medical benefit option that you are enrolled in. If you waive coverage under this Plan, your dependents cannot be enrolled in coverage under this Plan. See the Eligibility section for additional rules.

Network Administrator

Baylor Scott & White Quality Alliance (hereinafter referred to as the "Network Administrator") is the entity that the Plan contracts with to manage a Network of health care Providers and care facilities. The Network Administrator has, in turn, delegated certain administrative responsibilities to a Claims Administrator, as described in this SPD.

Network Administrator Responsibilities

Your Network 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 Administrator also negotiates fees and contracts with care Providers and the Claims Administrator processes claims.

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.

Relocation and my Network Administrator

If you relocate to an area outside of the geographical region that the Plan covers, you will no longer be eligible for benefits under the Plan. In that event, you will have 60 days to elect another medical benefit option offered by the Company.

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 a Network 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 a 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 a 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 a 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 a Network Provider of air ambulance services. If you receive these services, the out-of-network providers cannot balance bill you.

Cost-Sharing

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

Important Facts For You To Know About The Schedule of Benefits Chart...	
Co-Insurance	This is the percentage of covered expenses that you're required to pay. When you see a percentage referenced in the Schedule of Medical Benefits chart, it is the Co-Insurance that is your financial responsibility. All Co-Insurance goes toward your Out-of-Pocket Maximum
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 Schedule of Medical Benefits chart it is the Co-Pay that is your financial responsibility. All Co-Pays go toward your Out-of-Pocket Maximum.

Medical Necessity	ALL of the medical services and supplies described in the Schedule of Medical Benefits 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. **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.

Schedule of Medical Benefits

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.

Schedule of Medical Benefits	
Annual (Calendar Year) Deductibles and Out-of-Pocket Limits	
Individual Coverage Annual Deductible	$0
Family Coverage Annual Deductible	$0
Individual Coverage Annual Out-of-Pocket Maximum	$3,500
Family Coverage Annual Out-of-Pocket Maximum	$7,000
Individual medical maximum benefit	Unlimited
Preventive Care	
ACA preventive care	No cost to you

COVID-19 Preventive Services *See "Additional Covered Expenses" section for details and limitations.*	No cost to you
Medical Care	
Physician's office visit (including X-ray, lab work, injections and in office surgery)	$15 per visit
Telehealth office visit Provided by Doctor on Demand or the Network Administrator	$10 per visit
Specialist's office visit ((including X-ray, lab work, injections, and in office surgery)) (Specialists include chiropractors)	$50 per visit
Retail/ Convenience Clinic visit (i.e., clinics inside of retail pharmacies.) Including lab, x-ray and other charges	$20 per visit

Urgent Care Clinic, lab, x-ray, and other charges made by the Urgent Care clinic	$75 per visit OR $15 per visit at select BS&W locations
Chemotherapy/Radiation/Infusions	20% Co-insurance
Speech, physical, occupational, restorative and rehabilitative therapy and acupuncture Prior authorization is required after 12 visits or 30 days from initial visit in duration, whichever is less. Educational Services are not covered	$50 Co-Pay, up to $500 maximum per episode
COVID-19 Tests and Related Services. *See "Additional Covered Expenses" section for details and limitations.*	PCP: $15 Co-Pay Specialist: $50 Co-Pay Urgent Care Clinic: $75 per visit OR $15 per visit at select BS&W locations

Outpatient Services (not in a Physician office setting or a hospital)	
Diagnostic X-ray and lab (for non-urgent, non-immediate and non-emergent care)	Basic Radiology (e.g. X-ray): $50 Co-Pay
	Advanced Radiology (e.g. MRI, CAT, CT, and PET scans): $100 Co-Pay
	Lab: $50 Co-Pay
Outpatient surgery	Facility (including hospitals): $300 Co-Pay Surgery in office by PCP: $15 Co-Pay per provider Surgery in office by Specialist: $50 Co-Pay per provider
Hospital Services	
Inpatient room and board	$500 per day, up to $1,500 maximum per stay
Surgery	$50 Co-Pay
Diagnostic X-ray and lab (while not inpatient) (for non-urgent, non-immediate and non-emergent care)	Basic Radiology (e.g. X-ray): $50 Co-Pay Advanced Radiology (e.g. MRI, CAT, CT, and PET scans): $400 Co-Pay Lab: $50 Co-Pay
Emergency ambulance	No cost to you
Emergency Room If you're admitted to the Hospital on an inpatient basis directly from the Emergency Room, the Emergency Room Co-Pay is waived.	$300 Co-Pay for an Emergency Medical Condition; $300 + 40% for non-emergency

Out-of-Hospital Care	
Convalescent and Skilled Nursing Facilities following hospitalization Within 15 days of hospitalization. Maximum of 60 days per episode, as long as the individual is enrolled in an American Airlines Medical Plan.	$50 Co-Pay per day, up to $500 maximum per stay
Home Health Care Maximum of 40 services per year.	$50 Co-Pay per day, up to $500 maximum per episode
Hospice Care	$50 Co-Pay per day, up to $500 maximum per episode
Other Services	
Supplies, equipment and Durable Medical Equipment (DME) Your cost is the Co-Insurance shown, regardless of where the device is purchased, and is *in addition to* any Physician's visit costs you're required to pay.	20% Co-Insurance
Mental Health and Chemical Dependency Benefits	
Inpatient mental and chemical dependency health care	$500 per day, up to $1,500 maximum per stay
Alternative Mental Health Care Center – intensive Outpatient and partial hospitalization	$100 per day, up to $300 maximum per episode
Outpatient mental health care	$50 Co-Pay for office visits; $50 Co-Pay for all other Outpatient services
Marriage/ Couple/ Family Therapy	$50 Co-Pay

Additional Covered Expenses

Generally, this Plan covers the same items and services that are covered under the Company's other medical plan options. Specifically, charges for medical procedures, services, equipment and supplies will be "covered expenses" that the Plan will pay for if the following three conditions are satisfied:

- 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 the DFW ConnectedCare Center. 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.

- **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.)

- **Ambulance:** Professional ambulance services and air ambulance to and from:
    - The nearest hospital qualified to provide necessary treatment in the event of an Emergency Medical Condition
    - The nearest hospital or convalescent Inpatient care
    - An In-Network hospital, if you are covered under any Medical Benefit Option and your Network Administrator authorizes the transfer

- **Bariatric Surgery:** The Plan covers Bariatric 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.

- **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 Network Administrator and as required by law. These costs will be subject to the Plan's otherwise applicable Co-pay/Co-insurance and other 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.

- **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:** Maximum benefit is 60 days per episode, as long as the individual is enrolled in an American Airlines Medical Plan.

- **Cosmetic surgery:** Expenses for cosmetic surgery are covered only if they are incurred under one of the following conditions:

  (1) As a result of a non-work related injury.
  (2) For replacement of diseased tissue surgically removed.
  (3) 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) is covered by the Plan at 100% for in-network providers only. A qualifying preventive service means an item, service, or immunization that is intended to prevent or mitigate COVID-19 and has a rating of A or B in the recommendation of the USPSTF or is recommended by the Advisory Committee on Immunization Practice of the CDC.

- **COVID-19 Tests and Related Items and Services Ordered by an Attending Provider:**
  (1) COVID-19 Test(s): The Plan covers a COVID-19 test only when ordered and performed by your primary care provider or other medical professional, subject to any applicable copays. Such test will be subject to any applicable copays and co-insurance percentage.
  (2) COVID-19 Tests conducted to screen for general workplace health and safety, for public surveillance for COVID-19, 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 the purposes of travel, are not covered.
  (3) Related Items and Services: The part of any office visit (including telehealth visits), urgent care or emergency room visit related to the administration of a covered COVID-19 test are covered, subject to any applicable copays and co-insurance percentage.
  (4) Payment will be made to each provider in accordance with the applicable negotiated rate.

- **COVID-19 At Home Tests Not Ordered By An Attending Provider**

  - Effective May 11, 2023, the Plan does not cover COVID-19 At Home Tests.

- **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:**
  (1) 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,
  (2) 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.
  (3) 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.
  (4) Fractures and/or dislocations of the jaw, or
  (5) 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)
  (6) 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.

(7) 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:
  (1) Is under the age of five; or
  (2) 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;

- **Durable Medical Equipment (DME):** Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan 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.

- **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.

- **Family/Marriage/Couples Therapy:**
  (1) 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.
  (2) Only the employee needs to be a Plan participant in order for the service to be covered.

- **Gender Reassignment/Sex Changes:**
  (1) The Gender Reassignment Benefit (GRB) provides coverage for gender reassignment for the treatment of gender dysphoria.
  (2) Specialized facilities/providers outside the DFW area are available for the GRB.
  (3) The surgical benefit is available to employees and their Eligible Dependents age 18 and over enrolled in the Plan.
  (4) 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.
  (5) An employee who receives the benefit under the GRB for active employees cannot receive any additional benefits under the GRB for retirees.
  (6) $30,000 lifetime maximum benefit (for the entire time you are covered under an American Airlines Medical Plan).
  (7) **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.
  (8) **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 an American Airlines Medical Plan. Subsequent surgical revisions, modifications or reversals are excluded from coverage. Coverage is limited to treatment performed by In-Network Providers.
  (9) **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.
  (10) **Travel Reimbursement.**
    - 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 and lodging expenses will be reimbursed up to a maximum of $10,000. 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 a pre-authorized surgery only.

Itemized receipts will be required by your Network/Claims Administrator. Contact your Network/Claim Administrator for instructions on receiving reimbursement for your expenses.

- Only travel expenses that are medical expenses within the meaning of Code section 213(d) and excludable from wages are reimbursable under this benefit, specifically:
  - **Transportation:** Transportation, up to the amount of actual expenses, or alternatively, for car expenses, at the IRS standard mileage rate. This includes the cost of taxis, buses, trains, airplanes, rental cars, and ambulances hired to go to and from the point of medical treatment
  - **Lodging:** Hotel rooms limited to $50 per night for one person and $100 per night for two people;
  - **Meals:** Meals provided in the hospital
  - **Companion Travel:** The above-listed travel costs of a companion traveling with the person receiving medical care, if the presence of such companion is necessary to enable the person to receive medical care.

(11) **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.

- **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 osseo integrated hearing systems are also covered.

- **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)**
  (1) This benefit is subject to a $50,000 maximum per person for the entire time the person is covered under an American Airlines Medical Plan.
  (2) 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), 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 $50,000 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.

    (3) 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.

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

- **Mental health and chemical dependency care:** The Plan covers the following mental health and chemical dependency care:
    (1) **Inpatient mental health care**: When you use Providers under the Plan 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).

(2) **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.

- **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 Plan does not cover expenses for a family member to accompany the patient being treated.
- **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).

- **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 60 day deadline you will not be able to add your baby to your coverage until the next Annual Enrollment Period unless you experience another qualifying Life Event, even if you already have other Children enrolled in coverage. The filing or payment of a maternity claim does not automatically enroll the baby.

- **Oral surgery:** Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process, only if it is Medically Necessary to perform oral surgery in a hospital setting rather than in a Dentist's office. The Plan will pay room and board, anesthesia and miscellaneous Hospital charges. Oral surgeons' and Dentists fees are not covered under the Plan. Prior authorization is required.

- **Penile prosthesis:** Surgical implantation of a penile prosthesis will be covered if the following conditions are met. All penile prosthesis requires 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

- **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.

- **Pregnancy:** Charges in connection with pregnancy for employees, Spouses, Common Law Spouses, 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 provided by either a Physician or midwife. Labor, delivery, and post-natal expenses are covered by the applicable Co-pay amount.
  - Prescription prenatal vitamin supplements are covered by Medical Benefit Options.
  - Doulas (certified by Doulas of North America (“DONA”) International or the National Black Doula Association), who provide support through pregnancy and birth, are covered at 100% up to $2,000 per pregnancy. Expenses are paid on a reimbursement basis (i.e., participants must pay their doula directly and submit a claim for reimbursement that includes a copy of doula certification, and a receipt for the cost of doula services).
  - One breast pump per year, including hands-free a breast pump, is covered at 100%.
  - Delivery may be in an In-Network 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.
  - 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.

- **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 preventive care covered at no cost to you visit Search Results | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) 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, 2024, the Plan is not required to cover it until January 1, 2026.
        - Please call your Claims 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 your Claims Administrator 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, 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. Prior authorization is required.

- **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:** Proton beam therapy for Definitive Therapy is covered for the treatment of prostate cancer.
    - This benefit is subject to an overall maximum of $50,000 per episode (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. Prior authorization is required.

- **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.

- **Sleep Studies:**
    - For employees: The Plan will cover sleep studies that are either homebased 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.
    - Inpatient sleep studies require prior authorization.

- **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.

- **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.

- **Telehealth**: The Plan will offer live face to face video consultations for medical benefits for participants. These medical benefits are offered by Doctor on Demand, a telehealth service offering video medical visits through a secure mobile application, and by the Network Administrator.

- **Temporomandibular joint dysfunction (TMJD):** Eligible expenses under the Plan 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.
    - 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 a transplant facility. Your Claims Administrator can help you locate a transplant facility. These facilities specialize in transplant surgery and may have the most experience, the leading techniques and a highly qualified staff.

    - 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.

    - **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 Plan, as determined in the sole discretion of the Network Administrator and its delegate, the Claims Administrator:
• Artery or vein • Artificial Cervical Disk Implantation (see 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 the DFW ConnectedCare Center 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 roundtrip is covered for any illness or injury and will be covered only if medical attention is required en-route.
    - For information on ambulance services, see “Ambulance” in this section.

- **Tubal ligation and vasectomy:** These procedures are covered; Reversal of these procedures is covered under the infertility benefit only. See “Infertility Treatment services (other than testing and diagnosis),” above.

- **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 Co-Pays, Co-Insurance and Out-of-Pocket limits under the Plan. 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.

Care Coordination

The Plan requires Network Providers to participate in the Clinical Integration Program, which assists Network Providers in coordinating care, educating you and your Eligible Dependents about your health status, and motivating you and your Eligible Dependents to take steps to improve your health or avoid injury. The Plan implements programs designed to proactively engage you and your Eligible Dependents to manage chronic disease.

Prior Authorization

The Plan may condition, withhold, or deny payment for services in the event that the Claims Administrator determines that the service was not medically necessary, as defined under the Claims Administrator's policy governing Medical Necessity.

In-Network Providers are responsible to receive approval for any proposed services before rendering services. In the event that an In-Network Provider fails to comply with the Plan's prior authorization requirements, or provides services for which the Claims Administrator denies prior authorization and any subsequent pre-service appeal, neither the Plan nor the patient will be liable to In-Network Providers for reimbursement of such services. In-Network Providers may rely on any prior authorization or pre-certification of services provided by the Claims Administrator as evidence that the service(s) preauthorized is (are) a covered service and is (are) medically necessary, as long as you and/or your Eligible Dependents are eligible to receive the service at the time rendered.

The following services require prior authorization:

- Durable Medical Equipment (DME) with a purchase price greater than $1,000 or $1,000 cumulative rental
- Clinical Trials
- Non-Emergency air ambulance
- Dialysis
- Genetic testing
- Sleep apnea evaluation (inpatient or home)
- IV Infusions
- Advanced radiology (includes MRI/CAT/CT/PET, etc.)

- Outpatient surgery not done in a Physician office setting
- Chemotherapy
- Inpatient stays including surgery (*i.e.* rehabilitation, hospital stays, pain management, cardiac rehabilitation, hospice, acute care and hyperbaric treatments, and sleep studies)
- Assistant surgeon
- Long term acute care
- Home infusion therapy
- Speech therapy (12 visits or 30 days in durations then prior authorization required; whichever is less)
- Physical therapy (12 visits or 30 days in durations then prior authorization required; whichever is less)
- Occupational therapy (12 visits or 30 days in durations then prior authorization required; whichever is less)
- Chiropractic care (12 visits or 30 days in durations then prior authorization required; whichever is less)
- Acupuncture (12 visits or 30 days in durations then prior authorization required; whichever is less)
- Dental procedures
- Repetitive transcranial magnetic stimulation
- Maternity stays (over 48 hours or 96 hours for C-section)
- Infertility treatment or treatment promoting fertility
- Proton Beam Therapy
- Gender Reassignment Benefit (GRB)
- Transplants
- Bariatric surgery
- Skilled nursing
- Private duty nursing
- Home health
- Out of network hospitalization for non-Emergency care or greater than 7 days for emergency care
- Emergency care over 48 hours
- Specialty medications over $1,000 billed under the medical benefit
- Mental health/chemical dependency
    - Inpatient admissions
    - Residential treatment center (RTC) admissions
    - Partial hospitalization programs (PHPs)
    - Intensive outpatient programs (IOPs)
    - Psychological testing
    - Neuropsychological testing
    - Psychiatric home care services
    - Outpatient detoxification

- Applied behavior analysis (ABA)
- Outpatient electroconvulsive therapy

Emergency Services

Emergency services for an Emergency Medical Condition will be reimbursed by the Claims Administrator on behalf of the Plan in accordance with the requirements of this SPD. See the Glossary for the definition of an "Emergency Medical Condition."

Well-being Program

If you are enrolled in the Plan and participated in the well-being program in the past, you may have earned dollars that were credited to your Health Reimbursement Arrangement (HRA) for completing certain activities. See the Summary Plan Description for the American

Excluded Expenses

This section contains a list of alphabetical items that are excluded from coverage under the Plan.

- **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 (i) Medically Necessary and required as a result of Accidental Injury or surgical removal of diseased tissue; or (ii) covered under Gender Reassignment Benefits, described above.

- **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.

- **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 of the BSWQA Network or the United States:** Any non-emergency or non-Urgent Care such as routine Physician care, preventive care, or care, treatment, or procedures that you arrange before you arrive with providers outside of the BSWQA Network or in a foreign country, is not covered.

- **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

- **Occupational Services:** 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.

- **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 Plan, 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 your Claims Administrator to learn what preventive care is not covered.

- **Proton Beam Therapy:** Proton beam therapy is excluded if you do not receive pre-certification approval from the Claims 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.”

- **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 episode.

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

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

Prescription Drug Program

How the Prescription Drug Benefit Works

Prescription drug coverage is based upon a formulary. The amount of Co-Payment you pay under the Plan 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 vendor for the Plan. 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 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.

There is no deductible for Prescription drug coverage.

Please note that if you select a brand name drug when a generic is available, you will pay the generic Co-Payment plus the cost difference between generic and brand name prices.

Infertility medications: Medications used to treat infertility or to promote fertility are covered by the Plan, subject to an overall maximum of $25,000 per person, for the entire time such person is covered under an American Airlines Medical Plan.

Prescription drugs: The plan covers 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: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
  - ❖ Unless otherwise noted, 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, 2024, the Plan is not required to cover the medication until January 1, 2026.
  - ❖ Please call your Claims Administrator 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 Maintenance Choice 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 used to treat infertility or promote fertility are covered, subject to a $25,000 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 Plan may be reimbursed under the Health Care Flexible Spending Accounts (see "Covered Expenses" in the *Health Care Flexible Spending Account* section of the American Airlines, Inc. Health and Welfare Plan for Active Employees.
- Specialty medications greater than $1,000 require prior authorization.

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 may 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-Payment. 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.

The Co-Payment 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-Payments requirements for retail drug coverage under the Plan.

Features	In-Network
RETAIL Pharmacy (typically a 30-day supply)	**Generic:** $20 Co-Pay **Preferred Brand:** $50 Co-Pay **Non-Preferred Brand:** $100 Co-Pay
	There is no Deductible

	Note: You pay the lesser of the Co-Pay or full cost for all prescriptions.

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
  - CVS Caremark will notify your Network/Claim Administrator of all amounts applied to the Out-of-Pocket Maximum.
  - CVS Caremark reports the claim for your Network/Claim Administrator. Any eligible amounts will be applied to your Out-of-Pocket Maximum.
  - If you do not present your CVS Caremark prescription ID card when filling your prescriptions any out-of-pocket expenses may not 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.
  - 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 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 of the American Airlines, Inc. Health and Welfare Plan for Active Employees SPD. If you have funds credited to your Health Reimbursement Account (HRA), you can use those funds to pay eligible retail drug Out-of-Pocket expenses once your HCFSA funds have been exhausted.

Retail Refill Allowance – Long-Term Medications

You and your covered dependents will pay the lesser of 175 percent of the drug Copayment or 100 percent of the 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). Short-term medications should continue to be purchased at a retail pharmacy and you will pay your retail pharmacy Co-Payment.

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 https://www.caremark.com or call 1-844-758-0767.

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 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 clinical programs and the specific drugs subject to these programs can be obtained from CVS Caremark.

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.

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

CVS Caremark will send you and your Physician a letter about the authorization review.

If authorization is approved, the system automatically allows refills for up to one year. Prior Authorizations must be renewed periodically. When the renewal date approaches, you should contact CVS Caremark for renewal instructions.

If the pharmacy does not fill a Prescription because there is no Prior Authorization on file, the pharmacy's denial will not be treated as a claim for benefits. You must submit the request for Prior Authorization to CVS 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.). For assistance with specialty medications, you or your physician may call CVS Specialty Pharmacy at 800-237-2767.

Self-administered specialty medications are not reimbursable through your medical benefit and must be filled through CVS Specialty Pharmacy. Specialty medications requiring administration under the direct supervision of a physician or nurse that are administered in a physician's office or via home infusion can be filled through CVS Specialty Pharmacy or through your medical benefit.

CVS Specialty Pharmacy can ship the Prescription to your home, office, or a CVS retail pharmacy 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 the CVS Specialty pharmacy, your medication will not be covered.

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

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

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

Specialty medications require Prior Authorization to ensure appropriate diagnoses, dosages, and required laboratory tests are performed.

Members enrolled in the PrudentRx Solution will have a $0 out-of-pocket responsibility for PrudentRx eligible specialty medications. If the specialty medication is not on the PrudentRx drug list, the applicable Co-Insurance associated with the Prescription Drug benefit will apply to the Specialty Pharmacy Prescriptions.

Specialty Pharmacy Copay Assistance Program

The DFW ConnectedCare Plan includes a specialty pharmacy copay assistance program* 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. Members participating in the Prudent Rx Solution, which includes enrollment in an available manufacturer copay assistance program, will have a $0 out-of-pocket responsibility for Prescriptions covered under the Prudent Rx Solution. Payments made by a manufacturer's copay assistance program will not count toward the plan deductible or out-

of-pocket maximum, unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an “essential health benefit” under the Affordable Care Act will not count toward your out-of-pocket maximum, unless otherwise required by law.

*“Copay assistance” may also be referred to as financial assistance, manufacturer coupons, discount programs, and/or coupon programs.

Maintenance Choice Program

You and your covered dependents are eligible for the Maintenance Choice Program. You may use this option to purchase a 90-day supply of the Prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You can order medications on a 90-day supply basis through the Maintenance Choice Program at a local Baylor Scott & White pharmacy, CVS or Safeway-owned pharmacy, such as Tom Thumb, Randall’s, or Vons, at a Kroger Pharmacy or Costco Pharmacy, or through the CVS Mail Order Pharmacy. You can locate participating pharmacies by logging into Caremark.com and using the pharmacy locator tool. 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.

In addition, 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 The DFW ConnectedCare Center every 12 months to re-enroll in the program and 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). You pay a Co-Payment (with no annual

Deductible) for each Prescription or refill. Please see the chart below for Co-Payment requirements.

For Mail Order Prescriptions, you *must* purchase through the CVS Mail Order Pharmacy; 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 through Mail Order Prescription Drug benefit, when filled at a local Baylor Scott & White, CVS or Safeway-owned pharmacy, Kroger or Costco 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 If you purchase contraceptives for reasons other than the prevention of pregnancy, the appropriate Co-Payment will apply.

Features	**In-Network**	**Out-of- Network**
MAIL ORDER AND MAINTENANCE CHOICE PHARMACIES[1] (typically a 90-day supply)	**Generic:** $40 Co-Pay **Preferred Brand:** • $100 Co-Pay **Non-Preferred Brand** • $200 Co-Pay **Note:** You pay the lesser of the Co-Pay or full cost for all prescriptions.	Not covered

[1] *Applies to Specialty Drugs*

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 25 pills for a 3-month supply.

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.

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, unless otherwise required by law, 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-Payment

Your mail order Prescription Drug Co-Payment is the Out-of-Pocket amount you must pay when you fill your Prescription Drugs. It is not eligible for reimbursement under the Plan. However, if you elected to participate in the Health Care Flexible Spending Account (HCFSA), your Co-Payment may be eligible for reimbursement. See the Health Care Flexible Spending Account section of the American Airlines, Inc. Health and Welfare Plan for Active Employees SPD 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-Payment from your HRA.

Contact Information

Mail Service Drug Option (Mail Order Pharmacy Service)

CVS Caremark

P.O. Box 659539

San Antonio, TX 78265-9539

Phone: 1-844-758-0767

Website: caremark.com

Prescriptions - Prior Authorization

CVS Caremark
P.O. Box 6590
Lee's Summit, MO 64064-6590
Phone: 1-844-758-0767
Website: caremark.com

Filing Retail Prescription Claims
CVS Caremark Claims Department
P.O. Box 52136
Phoenix, AZ. 85072-2136
Phone: 1-844-758-0767
Website: caremark.com

For general information
American Airlines Benefits Service Center
DEPT 00749
P.O. Box 64116
The Woodlands, TX 77387-4116
Phone: 1-888-860-6178
Fax: 1-847-554-1884

Additional Rules That Apply to the Plan

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.

Use of Terms

- The term "Plan" as used in these procedures refers to the American Airlines, Inc. DFW ConnectedCare Plan, 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:

QMCSO Center
P.O. Box 299082
Lewisville, TX 75029-9082
Fax: +1 847.442.0899

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 U.S. Department of Health & Human Services (Office of Child Support Enforcement) website for more information on QMCSOs and NMSNs, and 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 Plan benefits 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 benefits/plans, your Company sponsored benefits under the Plan will coordinate to avoid duplication of payment for the same expenses. The Plan 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 benefits were your only coverage.

For example, if your dependent is covered by another benefit/plan and the Plan is his or her secondary coverage, the Plan pays only up to the maximum benefit amount payable under the Plan, and only after the primary benefit/plan has paid.

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 Plan 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 coverage changes, 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" 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 the Plan and Medicare are paid according to federal regulations. In case of a conflict between the Plan's 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. 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, you must process a Life Event with the American Airlines Benefits Service Center to end benefits under the Plan.

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 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.go.

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 by calling 1-877-KIDS NOW (1-877-543-7669) or visit https://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 by dialing 1-866-444-EBSA (3272) or visit the U.S. Department of Labor's EBSA website .

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 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	
KENTUCKY – Medicaid	**LOUISIANA – 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 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Employee
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

COBRA

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 the COBRA administrator (i.e., the American Airlines Benefits Service Center). The COBRA administrator 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 Plan provides 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.

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 an 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 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 the COBRA administrator about electing continuation of coverage through COBRA.

Solicitation of Coverage Following a Qualifying Event

In the event of a Qualifying Event (as shown above as for your dependents only), you must notify American Airlines Benefits Service Center by processing a Qualifying Event within 60 days of the event. You can process most Life Events on the American Airlines Benefits Service Center. For more information, see "Life Events" in the *Making Changes During the Year* section.

Enrolling for Coverage

Following notification of any Qualifying Event (see "Life Events" in the *Making Changes During the Year* section), the American Airlines Benefits Service Center will advise the COBRA administrator, who in turn will notify you or your dependents of the right to continuation of coverage. When you process your Life Event, you should provide your dependent's address (if different from your own) where the COBRA administrator can send solicitation information.

You (or your dependents) must provide written notification of your desire to elect to purchase continuation of coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage, or else you lose your right to elect to continue coverage. See "Contact Information" for the COBRA administrator's address.

You and your dependents may each independently elect continuation of coverage. Once you elect continuation of coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election.

If you waive continuation of coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify Benefits Service Center before your 60-day election period expires.

Note: If you are 65 or older and Medicare-eligible, Medicare is 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. Contact the American Airlines Benefits Service Center to have the necessary form (CMS L564) completed.

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 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 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 the COBRA administrator 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 American Airlines Benefits Service Center immediately, but no later than three months after you make your first COBRA premium payment in order for you to be eligible

for a refund. 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 1-888-880-6178.

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 employer) within 60 days after your Plan coverage ends because of the Qualifying Event listed above. You may also have the right to enroll in coverage through a state-based or federally facilitated healthcare exchange under PPACA. You will also have the same special enrollment rights at the end of continuation of coverage if you get continuation of coverage for the maximum time available to you.

Additional Questions

If you have any additional questions on continuation of coverage under COBRA, you should contact American Airlines Benefits Service Center.

Claims Procedures

Time Frame for Initial Claim Determination

Your claim for benefits will be processed under the procedures described below.

For claims under the Plan, 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 Claims Administrator[2] 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 Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit, or a failure to provide or make a payment, in whole or in part, for a benefit.

For **Urgent Care claims**, if you fail to provide the Claims Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claims Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The Claims 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

[2] For purposes of the "Claims Procedure" chapter only: the term "Claims Administrator" refers to CVS Caremark with respect to prescription drug benefits, and WebTPA with respect to medical benefits.

For **pre- and post-service claims**, a 15-day extension may be allowed to make a determination, provided that the Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claims 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 Claims Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan's procedures for filing a **pre-service claim**, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving **Urgent Care**) following the 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.

If You Receive an Adverse Benefit Determination

The Claims 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,
- The Claims Administrator is required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale,
- Date of service, the health care Provider, the claim amount,
- The denial code and corresponding meaning,
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for internal appeal or external review, and will not trigger the start of an internal appeal or external review),
- A description of the Program Administrator's or Insurer's standard, if any, used in denying the claim,
- A description of the external review process, if applicable,
- 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.

Effect of Failure to Submit Required Claim Information

If the Claims 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 Program Administrator's request for information or upon a demonstration to the satisfaction of the Claims Administrator that under the circumstances the Program Administrator's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the Program Administrator, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the Claims 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 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 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 to 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 Plan, has a two-tiered appeal process—referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the Claims Administrator that rendered the adverse benefit determination. Second Level Appeals are also conducted by the Program Administrator. (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.

First Level Appeal

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Claims 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 Claims 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 Claims 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 60 days of receipt of your First Level Appeal
- For Urgent Care claims—within 72 hours of receipt of your First Level Appeal

Second Level Appeal

Upon your receipt of the First Level Appeal decision notice upholding the prior denial—if you still feel you are entitled to the denied/withheld benefit—you must file a Second Level Appeal with the Claims Administrator.

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 Claims Administrator, 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 Claims Administrator 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

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 Claims Administrator.

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 Claims Administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond 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 Claims 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 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,

  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,
- 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,
- 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; and (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,
- Date of service, the health care Provider, the claim amount,
- The denial code and correspondent meaning,
- 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),
- A description of the Claims Administrator's or Insurer's standard, if any, used in denying the claim,
- A description of the external review process, if applicable, 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.

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

If the Plan Administrator or Claims Administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review, you may pursue a civil action under ERISA § 502(a). 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 Claims Administrator that the violation was for

good cause, was committed in a good faith exchange of information between you, or was due to matters beyond the Plan Administrator's or Program Administrator's control).

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

If an external reviewer or court rejects your request for immediate review because it finds that the Plan Administrator or Claims Administrator met the standards for exception (*de minimis* violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or Claims Administrator will notify you of your opportunity to file the internal appeal of your claim. The 12-month claim filing limit will begin to run upon your receipt of the Plan Administrator's or Claims Administrator's notice.

The External Review Process

After you have exhausted (of have been deemed to have exhausted) your internal appeal rights under the benefit plan(s), you have the right to request an external review of your adverse benefit determination. This external review process is defined by federal law—and Plan benefits 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" or "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 Care Task Force, the Advisory Committee on Immunization Practices, or the Centers for Disease Control

- adverse determination that brings into question if the benefit plan is complying with the non-quantitative treatment limitations in the Mental Health Parity and Addiction Equity Act (such as methods and limitations on medical management)
- Adverse benefit determinations related to the Plan's compliance with protections under the "No Surprises Act" ("NSA") such as:
    - Patient cost-sharing and surprise billing for emergency services;
    - Whether a claim for care received is coded correctly and accurately reflects the treatments received; and
    - the associated NSA protections related to patient cost-sharing and surprise billing.

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.

For more information on how to file an external review visit https://my.aa.com/appeals

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

Plan Name & Number
American Airlines, Inc. DFW ConnectedCare Plan (523)

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, MD 8A203
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

Street address (do not mail to this address):
1 Skyview Drive, MD 8A203
Fort Worth, Texas 76155

American Airlines, Inc. has delegated certain Plan administrative duties to the Network Administrator, Baylor Scott & White Quality Alliance ("BSWQA"). BSWQA oversees the provision of covered services and related utilization management and Clinical Integration Program services under the Plan. BSWQA also oversees the Claims Administrator' performance of certain administrative responsibilities as well as claims and appeals administration.

BSWQA has in turn, delegated certain of its administrative duties to the Claims Administrator with respect to medical benefits, WebTPA. WebTPA is available to provide information regarding eligibility, enrollment, benefit coverage, health benefit options, solutions, and costs, available providers and their network status, status of out-of-pocket maximum, claims decisions, status of claims, and instructions for filing claims and appeals. In addition, WebTPA has agreed by contact with the Plan to process health care claims and appeals. WebTPA can be reached at 1-800-784-5473 effective 01/02/2020.

American Airlines, Inc. has also delegated certain Plan administrative duties related to prescription drug benefits to CVS Caremark and WebTPA with respect to prescription drug benefits.

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

Agent for Service of Legal Process

Senior Vice President, Chief People Officer

American Airlines, Inc.

Mailing address:

Mail Drop 8A200
P.O. Box 619616
DFW Airport, TX 75261-9616

Express Delivery address:

1 Skyview Drive, MD 8A203

Fort Worth, Texas 76155

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Plan Type

Medical benefits

Plan Funding

Benefits and other Plan expenses will be paid from Plan assets, including contributions by Eligible Employees, rebates and other amounts received by the Plan and from the Company's general assets.

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 Commitment to Employment

Nothing in the Plan shall be construed as a commitment or agreement upon the part of any person to continue 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.

Confidentiality of Claims

The Company and its agents (including the Claims 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 Claims Administrator receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the Claims Administrator may pay all or part of the benefit to:

- Your guardian
- Your estate
- Any institution or person (as payment for expenses in connection with the claim)
- Any one or more persons among the following relatives: your 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 applicable benefit 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 its delegate) 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 Plan (and its delegate) 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

You have the right to 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
DEPT 00749
P.O. 64116
The Woodlands, TX 77387-4116
1-888-860-6178

For information about your claims, contact the appropriate Claims Administrator or Plan Administrator at the addresses and phone numbers located in the "Contact Information" section.

Glossary of Terms

American Airlines Benefits Service Center or Benefits Service Center: 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

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.

Child: Your

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Spouse, Common Law Spouse as defined by the Plan
- Stepchild
- Special Dependent, if you meet all of the requirements listed in the section "Dependent Eligibility Requirements – Generally" in the chapter "Eligibility and Enrollment"

Claims Administrator: WebTPA, or any other entity with which BSWQA contracts to administer claims and appeals and other administrative duties under the Plan and determine Medical Necessity.

Clinical Integration Program: The program the Network Administrator has developed for reviewing and sharing information across Providers, patients and sites and implementation of, among other things, best practices to ensure that the health care services provided to you and your Eligible Dependents are Medically Necessary, of high quality and provided at an appropriate level of care in a timely and cost-effective manner.

Company: American Airlines, Inc. and any successor thereto.

Co-Pays or Co-Payments: The specific dollar amount you must pay for certain covered services.

Deductible: The amount of Eligible Expenses a person or family must pay before the Plan will begin reimbursing Eligible Expenses. **Disabled Dependent Child:** A Child who meets all of the criteria listed in the section

"Coverage for a Disabled Dependent Child."

Eligible Dependent: See the section "Dependent Eligibility" in the chapter "Eligibility and Enrollment" for information on dependent eligibility requirements under the Plan.

Eligible Expenses: The expenses that the Plan covers in whole or in part, which must be Medically Necessary services, supplies, care and treatment of non-occupational injuries or illnesses when ordered by a licensed Physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage.

Emergency Medical Condition: "Emergency Medical Condition" means 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: (i) placing the person's health (or, for a pregnant woman, the health of the woman or her unborn child in serious jeopardy); (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily 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.

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.

Hire Date: The first date that you were on the U.S. payroll of American Airlines, Inc. as a Regular Employee.

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.

Married Employees: Employees of the Company who are married (legal or common law) to other employees of the Company.

Medical Necessity: As determined by the Claims Administrator's policy governing medical necessity, a procedure, service, equipment or supply that is: (i) appropriate for the symptoms, diagnosis or treatment of a medical condition; (ii) provided for the diagnosis or direct care and treatment of the medical condition; (iii) within the standards of good medical practice and within the organized medical community; (iv) not primarily

for the convenience of the patient or the patient's doctor or other provider; and (v) the most appropriate (as defined herein) procedure, service, equipment or supply that can be safely provided. "Most appropriate" means: (i) there is valid scientific evidence (e.g., through InterQual Criteria, MCG, formerly Milliman Care Guidelines) demonstrating that the expected health benefits from the procedure, service, equipment or supply are clinically significant and produce a greater likelihood of benefit, without disproportionately greater risk of harm or complications, for the Participant with the particular medical condition being treated than other possible alternatives; (ii) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and (iii) for hospital stays, acute care as an inpatient is necessary due to the kind of services the Participant is receiving or the severity of the medical condition, and safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Network: A group of Physicians, hospitals, pharmacies and other medical service Providers who have agreed, via contract with the Network Administrator to provide their services at negotiated rates.

Network Administrator: The third-party organization with which the Company maintains a contract to manage benefit claims and manage a Network of Providers and care facilities. The Network Administrator for the Plan is Baylor Scott & White Quality Alliance ("BSWQA").

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
- A parent, Child, sister or brother of you or your Spouse.

Plan Administrator: American Airlines, Inc., or its authorized delegate, is the Plan Administrator. The Plan Administrator maintains sole responsibility for the Plan and the benefits it provides. The Plan Administrator has the sole discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, including entitlement to benefits. The Plan Administrator also has the sole discretion to determine all matters relating to interpretation and operation of the Plan and may contract with third parties to provide some or all of these services to participants.

Plan Document: A formal written document or documents that establish the terms of employer sponsored group coverage. The American Airlines, Inc. DFW ConnectedCare Plan Document along with the American Airlines, Inc. DFW ConnectedCare Plan Summary Plan Description constitute the Plan Document for purposes of ERISA, together with the documents that they incorporate by reference.

Plan Sponsor: American Airlines, Inc. is the Plan Sponsor.

PPACA: The Patient Protection and Affordable Care Act.

Provider: The licensed individual or institution that provides medical services or supplies. Providers include Physicians, hospitals, surgical facilities, pharmacies, and other covered medical service Providers.

Qualifying Event: A change in your status that causes you to lose eligibility for coverage 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, 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.

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.

Social Security Disability Benefits (SSDB): Disability benefits paid by the Social Security Administration to individuals and their families who qualify.

Special Dependent: A child for whom you are the legal guardian or custodian.

Spouse: Refers to both a “Spouse” and a “Common Law Spouse,” as those terms are defined in the section “Determining a Spouse (SP), 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.

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 when you are required to pay ongoing contributions or premiums in order to maintain coverage under the Plan.

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 Claims Administrator determines whether care is Urgent Care or Immediate Care.

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.