

American Airlines, Inc. PPO Plan


Summary Plan Description

Effective January 1, 2026

SUMMARY PLAN DESCRIPTION

This document summarizes the main provisions of the American Airlines, Inc. PPO Plan (Plan), effective as of January 1, 2026, and serves as the Summary Plan Description (SPD) for Medical, Prescription Drug, and Voluntary Long-Term Care program benefits under the Plan. Please note that this SPD only describes the Medical, Prescription Drug, and Voluntary Long-Term Care program benefits available under this Plan. You may also be eligible for other health and welfare benefits offered by American Airlines, Inc. (“American Airlines” or “the Company”), including dental, vision, spending accounts, wellness programs, life insurance, AD&D insurance, and long-term disability benefits. For a description of other health and welfare benefits offered by the Company, please see the SPDs available on my.aa.com.

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

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

Please read this SPD carefully and share it with your family members who are eligible for coverage or for whom you've elected coverage. If you have any questions about the benefits information contained in this SPD, contact [American Airlines Benefits Service Center](#) at 1-888-860-6178.

Grandfathered Health Plan Notice

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

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

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About Your Participation – Active Employees

This section includes important information about:

- [Eligibility to participate in the Plan;](#)
- [When coverage begins;](#)
- [An overview of Life Events;](#)
- [When coverage ends.](#)

Eligibility

Eligibility for YOU

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

- An active, full-time or part-time employee of American Airlines, Inc. in the maintenance and related groups who are covered by collective bargaining agreements entered into between Legacy US Airways, Inc. and the International Association of Machinists and Aerospace Workers (“IAM”), and were covered by such agreements prior to the March 26, 2020 ratification of the Joint Collective Bargaining Agreement between Legacy US Airways, Inc. and the IAM. A former employee of the Company who was eligible for coverage under the Plan the day before a separation or inactive status from the Company and is subject to a written separation agreement, collectively bargained agreement or Company policy that includes coverage for a pre-determined period of time following the separation.

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

For eligibility provisions relating to retirees and their eligible Dependents, please see the [“Retiree Health Coverage”](#) Section.

Eligibility During a Leave of Absence or Furlough

If you take a Company-approved leave of absence, you may continue or stop participation in the Plan, within 60 days of the start of your unpaid leave of absence and also within 60 days of your return from the leave of absence provided you are still eligible to participate in the Plan at that time. If you make no changes to the elections in place for you (and your eligible Dependents) within 60 days, your elections will remain in place until the earliest of (a) the date you make an election change due to a Life Event (see the "[An Overview of Life Events](#)" Section of this SPD for more information on Life Events) or during an annual enrollment in which you are eligible to participate, (b) the date you stop making any required premium payments, or (c) the date you (or your eligible Dependents) are no longer eligible for coverage under the Plan. You may not enroll additional Dependents for coverage under the Plan unless you experience a Life Event (see the "[An Overview of Life Events](#)" Section of this SPD for more information on Life Events). If you waive coverage at the beginning of or during a leave of absence or furlough, you will not be able to re-enroll for coverage until you return to active status or retire.

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

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

Eligibility for Your Dependents

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

Eligible Dependents include:

- Your Spouse;
- Your child(ren) who is/are age 26 and under at any time in a calendar year;

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

Supporting documentation for eligible Dependent children

The Company will require you to provide supporting documentation for eligible Dependent children and for other Dependents within 31 days of the date the documentation is requested from the American Airlines Benefits Service Center. This information includes verification of relationship. Notice will be provided via email and/or paper correspondence mailed to your address on file. If you fail to provide the requested information within the requested timeframe of 31 days, your Dependents will not be eligible to receive coverage under the Plan. When your Dependent children are no longer eligible to participate in the Plan, you must notify the [American Airlines Benefits Service Center](#).

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

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

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

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

Surviving Spouses and Other Eligible Surviving Dependents

In the event you die while covered under the Plan, your surviving Spouse and your surviving dependent child(ren) may be eligible to continue participation per company policy or collective bargaining agreement, if applicable. If they are eligible and they are not enrolled in the Plan, they may choose to enroll within 60 days of your date of death. Information will be provided to your surviving Spouse and eligible Dependent child(ren) upon notification of your death.

When Coverage Begins

Annual Enrollment

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

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

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

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

Note: Beginning January 1, 2021, if you drop medical coverage under the Plan, you can never at any future date re-enroll in medical coverage under this Plan.

Coverage Levels

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

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

Paying for Coverage

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

If you are on an unpaid Company approved leave of absence or furlough for more than 35 days, your payment will be made to a third-party administrator on an after-tax basis.

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

Generally, your contributions for benefits elected under the Plan are taken from your paycheck on a pre-tax basis automatically, without any required action from you. However, in certain circumstances, such as if you reduce your hours, your paycheck may not be sufficient to pay the required contributions. A notification advising you that benefit plan contributions are unable to be collected from your paycheck will be sent once you reach an unpaid balance exceeding \$1,000. In the event paychecks continue to be insufficient, and your balance increases to an amount exceeding \$1,500, payroll contributions will stop indefinitely, and a monthly billing statement will be generated for payment.

Once your billing statement is generated, you must pay the required contributions for your benefits by the due date on each billing statement. If at any time you fail to Timely Pay for your benefits, your benefits may terminate and you may not resume participation in the Plan until the earliest of: (i) a HIPAA Special Enrollment Event (including Special Enrollment for Medicaid and CHIP) that allows you to enroll, or (ii) the next Plan year.

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

An Overview of Life Events

The following table provides a detailed look at various circumstances that may be considered Life Events under the Plan, as well as what changes to medical, dental, and vision may be permitted, according to IRS regulations. For further information regarding health care spending account and change of status events, please refer to your Flexible Benefit Plan Summary Plan Description.

- You must register the Life Event within 60 days of the event with the American Airlines Benefits Service Center. You must submit proof of the dependent's eligibility to the American Airlines Benefits Service Center within 31 days of the date the documentation is requested. Proof of eligibility will not be considered unless it is submitted after the date you receive the request from the American Airlines Benefits Service Center. Note that the request will come in the form of an email and/or a mailing to your address on file. **If you miss the 60-day deadline, or the 31-day deadline to provide proof of dependent eligibility, your Life Event change will not be processed.** You will have to wait until the next Annual Enrollment Period or experience another Life Event, whichever happens earlier, to make changes to your benefits.
- If you register your Life Event within 60 days of the event (as applicable), your changes are retroactive to the date the Life Event occurred (or the date Proof of Good Health is approved, as applicable).

If You Experience the Following Life Event...	Then, You May be Able to...
You become eligible for Company-provided benefits for the first time	Enroll online through the American Airlines Benefits Service Center .
Your Spouse or eligible Dependent child dies	Medical: <ul style="list-style-type: none">• You lose a Spouse or eligible Dependent child: Stop coverage for your lost Spouse or eligible Dependent child (dependent coverage may be subject to QMCSO). Start coverage for yourself or your eligible Dependent child if

<p>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)</p> <ul style="list-style-type: none"> To add a natural child to your coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth 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. 	<p>the loss of your Spouse results in loss of eligibility under your Spouse's plan.</p> <ul style="list-style-type: none"> 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 Medical Benefit Options. Change in your, your Spouse's or your eligible Dependent child's employment: If you/your Spouse or your eligible Dependent child gains eligibility under the other employer's plan, you can drop yourself, your Spouse and/or your eligible Dependent child. If you/your Spouse or your eligible Dependent child loses eligibility or employer contribution under the other employer's plan, you can add yourself, your Spouse, and/or your eligible Dependent child. If you change Medical Benefit Options, your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option.
<p>You get legally married (including common law marriage), divorced, legally separated, or have your marriage annulled</p> <p>OR</p>	
<p>You change your employment with an employer other than the Company</p> <p>OR</p> <p>Change in Spouse's eligible Dependent child's employment or other health coverage</p> <p>OR</p> <p>Your Spouse's eligible Dependent child's employer no longer contributes toward health coverage</p> <p>OR</p> <p>Your Spouse's eligible Dependent child's employer no longer covers employees in your Spouse's/Eligible Dependent child's position</p>	
<p>Your covered eligible Dependent child no longer meets the Plan's eligibility requirement, i.e.:</p> <ul style="list-style-type: none"> If the Dependent attains the age at which he/she is no longer eligible to be covered as your eligible Dependent If the Dependent marries and enrolls in his/her Spouse's employer group health plan 	<p>Medical:</p> <ul style="list-style-type: none"> Stop coverage for your Spouse's eligible Dependent child (Dependent coverage may be subject to QMCSO). You may change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option.

	<p>Additionally: Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible Dependent's address.</p>
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If You Experience the Following Life Event...	Then, You May be Able to...
<p>Your benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is “significant”)</p> <p>OR</p> <p>Your contribution amount is significantly increased or decreased by the Company (Plan Administrator/Sponsor will determine whether or not a change is “significant”)</p>	<p>Make changes to the applicable benefit options:</p> <ul style="list-style-type: none"> • The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
<p>You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMCSO) that requires you to provide health care coverage for a child</p>	<p>Medical:</p> <ul style="list-style-type: none"> • Start coverage for your Eligible Dependent child named in the QMCSO • If required by the terms of the QMCSO, you must change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option.
<p>You or your eligible Dependents enroll in Medicare or Medicaid or CHIP coverage</p>	<p>Medical:</p> <ul style="list-style-type: none"> • Stop coverage for the affected eligible Dependent.

If You Experience the Following Life Event...	Then, You May be Able to...
Your eligible Dependents lose Medicare, Medicaid or CHIP coverage	Medical: <ul style="list-style-type: none"> • Start coverage the affected eligible Dependent.
Your eligible Dependents become eligible for Medicaid or CHIP coverage	Medical: <ul style="list-style-type: none"> • Start coverage for the affected Spouse or eligible Dependent child. • If you are adding a Spouse or eligible Dependent child, you can change your Medical Benefit Option. If you change, your Deductible and Out-of-Pocket amounts will transfer to your newly elected Medical Benefit Option.
Your Spouse or your eligible Dependent child become eligible for/lose eligibility for and become enrolled/disenrolled in government-sponsored Tricare coverage	Medical: <ul style="list-style-type: none"> • Stop coverage for yourself if you gain eligibility • Start coverage for your Spouse if he/she loses eligibility • Stop coverage for your Spouse if he/she gains eligibility • Start coverage for your eligible Dependent child if he/she loses eligibility • Start coverage for your eligible Dependent child if he/she gains eligibility

If You Experience the Following Life Event...	Then, You May be Able to...
<p>You move to a new home address:</p> <ul style="list-style-type: none"> • Update both your home AND alternate/benefit addresses on the Update my information page of Jetnet. • Submit a revised Federal Form W-4 Form for payroll tax purposes. The form is available online through the Pay and Compensation page of American Airlines Benefits Service Center • Provide your new address and current emergency contact numbers to your manager/supervisor, as well. • If you are enrolled in a PPO Medical Benefit Option and you move to a location where a PPO Medical Benefit Option is available you may elect a self-funded Medical Benefit Option. • If a PPO Medical Benefit Option Network is not available, you must choose an Out-of-Area Medical Benefit Option, or you may waive coverage if you have other coverage (such as your Spouse's employer-sponsored plan). • Contact American Airlines Benefits Service Center and a representative will assist you with your election. If you are enrolled in a PPO Medical Benefit Option and you do not process your relocation Life Event within 60 days of your move, you will stay in your selected Medical Benefit Option. If you move or relocate to a new location within the last two months of the year, contact American Airlines Benefits Service Center so they can ensure your elections are filed for this current year and for next year. 	<p>Medical:</p> <ul style="list-style-type: none"> • You may change Medical Benefit Options if your existing Medical Benefit Option is unavailable in your new location, or if your new location offers a new Medical Benefit Option not available in your old location.
<p>You become disabled</p>	<p>Notify: Your manager/supervisor can download a Disability Claim Form.</p> <p>Complete and submit: Your claim for disability benefits.</p>

If You Experience the Following Life Event...	Then, You May be Able to...
You start an unpaid leave of absence	<p>Access the American Airlines Benefits Service Center to register your “Going on Leave of Absence” life event and update your benefit elections. A confirmation statement showing your choices, the monthly cost of benefits, etc. will display.</p> <p>Your cost depends on: The type of leave you are taking</p> <p>Medical:</p> <ul style="list-style-type: none"> • Stop coverage • Stop Spouse coverage • Stop eligible Dependent child coverage
You return from an unpaid leave of absence	<p>Go to the American Airlines Benefits Service Center, register your “Return to Work” Life Event and make selections or changes to your benefits.</p> <p>Medical:</p> <ul style="list-style-type: none"> • Start coverage for your Spouse/Domestic Partner (dental and vision only) • Start coverage for your eligible Dependent Child
You or your Dependent are newly eligible for COBRA	<p>Medical</p> <ul style="list-style-type: none"> • Change Medical Benefit Option

If You Experience the Following Life Event...	Then, You May be Able to...
You die	Continuation of Coverage: Your eligible Dependents can either contact your manager/supervisor or a survivor support representative at the American Airlines Benefits Service Center to assist with all benefits and privileges, including the election of continuation of coverage, if applicable.
You end your employment with the Company or you are eligible to retire	Review: “ When Coverage Ends ” in the <i>General Enrollment</i> section. Review: The information you receive regarding continuation of coverage through COBRA. Contact: American Airlines Benefits Service Center for information on retirement.
You transfer to another workgroup	Medical: <ul style="list-style-type: none"> • Changes are allowed only to the extent that the change in workgroup affects benefit eligibility • Start/Stop coverage for your Spouse and/or your eligible Dependent child (dependent coverage may be subject to QMCSO). • You may change LUS Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option.
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: <ul style="list-style-type: none"> • Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) • Employer contributions for the other coverage stopped • Other coverage was COBRA and the maximum COBRA coverage period ended 	Medical coverage: <ul style="list-style-type: none"> • Start coverage for your affected Spouse • Start coverage for your affected eligible Dependent child • You may change LUS Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option.

If You Experience the Following Life Event...	Then, You May be Able to...
<ul style="list-style-type: none"> • 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 	
<p>You, your Spouse or your Dependent Child enroll in other employer-sponsored coverage.</p>	<p>You may make the following changes if they are on account of, and correspond with, the change made under the other employer-sponsored coverage:</p> <p>Medical:</p> <ul style="list-style-type: none"> • Stop coverage for yourself, Spouse and Dependent Child
<p>Your Spouse, or your Dependent Child stop coverage under other employer-sponsored coverage.</p>	<p>Medical:</p> <ul style="list-style-type: none"> • Spouse and Dependent Child

Special Enrollment Periods

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

Special Enrollment for Loss of Coverage

A special enrollment period applies if you or a Dependent did not enroll during the annual enrollment period or initial enrollment period (for newly hired employees), provided that you request enrollment within 60 days after your other coverage ends, and the following requirements are satisfied:

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

Coverage will become effective as of the first day following the loss of coverage. Failure to notify the Company of your loss of coverage within 60 days of the loss will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

Special Enrollment for Addition of a Dependent

A special enrollment period applies if you add a Dependent due to marriage, birth, adoption, or placement for adoption, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. Coverage added due to marriage, birth, adoption or placement for adoption will become effective as of the date of the event.

Failure to notify the Company of your marriage, birth, adoption, or placement for adoption within 60 days of the event will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period.

Special Enrollment for Medicaid and CHIP

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

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

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

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

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

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

When Coverage Ends

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

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

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

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

Your Medical Options

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

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

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

Claims Administrator Responsibilities

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

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.

Care Advisor

Starting October 1, 2025, when you need help navigating your health benefits, you will reach out directly to your Claims Administrator.

There When You Need Help

Your care advisor can help you manage your health, navigate the health care system and make the most of all the programs and resources American offers.

With your care advisor , you'll receive personalized help with:

- Finding a provider
- Understanding covered services
- Supporting a new diagnosis
- Managing chronic conditions
- Handling claim payment questions

What to Expect

Your Care Advisor

Your care advisor can answer questions such as:

- Will this procedure be covered?
- Why was I billed for this test?
- I was just diagnosed with diabetes. What should I do next?
- What questions should I ask my doctor?
- What other American benefit programs might be helpful now?

Proactive Outreach

Your care advisor may reach out to offer support with a new or chronic condition, or if you've had a recent inpatient stay.

Confidentiality

They are bound by state and federal privacy laws to safeguard your information and use it only for the purposes for which it was disclosed.

How to Connect with BCBS



Phone

Call your care advisor directly at 877-235-9258. You can speak with your care advisor directly between 7:30 am and 6pm CST Monday through Friday or reach out to customer service anytime.

Online

Access the BCBS "Blue Access for Members" profile with your AA ID and password to send secure messages to your care advisor. (First-time users will need to register; after that you can sign on with your AA ID and password.)

App

Download the free BCBS mobile app from the Apple App Store or Google Play (Apple app | Android app). The app allows you to send secure messages to or call your care advisor, access your virtual ID card, or view your explanation of benefits (EOBs) or claims and bills.

How to Connect with UHC

Phone

Call your care advisor directly at 800-213-5755. You can speak with your care advisor directly between 7am and 7pm CST Monday through Friday or leave a message.

Online

Access the UHC member portal with your AA ID and password to send secure messages to your care advisor.

App

Download the free UHC mobile app from the Apple App Store or Google Play (Apple app | Android app). The app allows you to send secure messages to or call your care advisor, access your virtual ID card, or view your explanation of benefits (EOBs) or claims and bills.

Centers of Excellence Surgery

Lantern is a network of high-quality surgery providers, known as centers of excellence, partnering with the Plan to provide eligible employees and their Eligible Dependents enrolled in the PPO 80/60 and PPO 90/70 Medical Benefit Options with access to surgery providers. Benefits of Lantern also include payment consolidation and one-on-one guidance and support as you prepare for, undergo and recover from surgery. This is a voluntary program.

The PPO Plan

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

The PPO Plan includes two coverage options from which to choose for eligible active employees and three coverage options from which to choose for eligible retired employees. These options vary based on the amounts of your annual Deductible and Out-of-Pocket Maximum, and Coinsurance levels. The amount of the contribution that you will be required to pay also varies based on the PPO option you elect. Current information about the contribution costs will be provided each year during annual enrollment.

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

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

Using Preferred and Non-Preferred Providers

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

When You See In-Network Program Providers

When you receive care from an In-Network provider, your Out-of-Pocket costs are less than they would be if you received care from an Out-of-Network provider. For example, when you use an In-Network provider, your annual Deductible for covered services is lower than the amount required for such services from an Out-of-Network provider. In addition, after you pay any applicable Co-pays and/or Coinsurance, you will not be subject to any balance billing for charges from In-Network providers. Your Claims Administrator can help you find In-Network Providers.

When You See Out-of-Network Providers

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

The PPO Plan includes separate annual Out-of-Pocket Maximum amounts for In-Network and Out-of-Network care. When you reach these Out-of-Pocket Maximums, the Plan will pay 100% of your eligible expenses for the rest of the calendar year, (excluding Co-pays, charges above the R&C limit, or charges not otherwise covered by the Plan).



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

Please note that your Co-pays for medical services do not count toward satisfying the annual Deductible or the annual Out-of-Pocket Maximum.

Out-of-Network Provider Exceptions

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

- (1) Covered Person receives emergency services for an Emergency Medical Condition.
- (2) Covered Person receives services by an Out-of-Network Provider in an In-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 an In-Network Provider. If you receive these services, the Out-of-Network Providers cannot balance bill you.
- (2) Covered Person receives certain items and services by an Out-of-Network Provider in an In-Network facility. In this case, the cost share will generally be based on the recognized amount calculated in accordance with ERISA § 716. The cost share will generally not be greater than the amount that would have been charged if such services were provided by an In-Network Provider. If you receive these services, the Out-of-Network Providers cannot balance bill you, unless you give written consent.
- (3) Covered Person receives covered air ambulance services. In this case, the cost sharing will be based on the lesser of the qualifying payment amount (calculated in accordance with ERISA § 716) or the billed amount for the services. The cost share requirements will be the same requirements that would apply if the services were provided by an In-Network Provider of air ambulance services. If you receive these services, the Out-of-Network Providers cannot balance bill you.

Finding In-Network Providers

You can find an In-Network provider by:

- Visiting my.aa.com;
- Calling your Claims Administrator

Groups of Providers

Please note that groups of providers (such an association of physicians or clinics) may have some providers that are In-Network providers and other providers that are Out-of-Network providers. Just because some providers in the group are In-Network, does not mean all providers in the group are In-Network. To determine whether a particular provider is In-Network, call your Claims Administrator

Behavioral Health Providers and Facilities

Your Claims Administrator can assist you when locating In-Network local participating providers, facilities, and additional resources. If you choose to receive care outside the network, you can use the following eligible licensed behavioral health care providers:

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

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

Schedule of PPO Plan Benefits

An Overview of PPO Plan Benefits

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

Schedule of PPO Plan Benefits						
Feature	PPO 80/60		PPO 90/70		PPO 100/80 (eligible retired employees only)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (1 person/2 or more people)	\$450/\$900	\$900/\$1,800	\$225/\$450	\$450/\$900	\$225/\$450	\$450/\$900
Coinsurance	The Plan pays 80% of discounted In-Network fees, after annual deductible	The Plan pays 60% of Reasonable and Customary (R&C) charges, after annual deductible	The Plan pays 90% of discounted In-Network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted In-Network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Annual Out-of-Pocket Maximum (1 person/2 or more people)	\$3,000/\$6,000	\$6,000/\$12,000	\$1,500/\$3,000	\$3,000/\$6,000	\$225/\$450	\$3,000/\$6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Medical Office Services						
Doctor's Office Visits	\$25 Co-pay for primary doctors; \$40 Co-pay for specialists	The Plan pays 60% of R&C charges, after annual deductible	\$25 Co-pay for primary doctors; \$40 Co-pay for specialists	The Plan pays 70% of R&C charges, after annual deductible	\$25 Co-pay for primary doctors; \$40 co-pay for specialists	The Plan pays 80% of R&C charges, after annual deductible

Schedule of PPO Plan Benefits

Feature	PPO 80/60		PPO 90/70		PPO 100/80 (eligible retired employees only)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Telehealth Provided by Doctor on Demand	\$20 Co-pay for Telehealth visit	Not covered	\$20 Co-pay for Telehealth visit	Not covered	\$20 co-pay for Telehealth visit	Not covered
Retail/Convenience clinic	\$25 Co-pay	The Plan pays 60% of R&C charges, after annual deductible	\$25 Co-pay	The Plan pays 70% of R&C charges, after annual deductible	\$25 Co-Pay	The Plan pays 80% of R&C charges, after annual deductible
Preventive Care <i>includes routine physicals and well child care</i> (no limit on visits until attaining age 5, then one routine physical per year)	\$25 Co-pay	Not covered	\$25 Co-pay	Not covered	\$25 co-pay	Not covered
OB/GYN Exams	\$25 Co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to Deductible and Coinsurance	\$25 Co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to deductible and coinsurance	\$25 co-pay	Annual well woman exam not covered except for pap smears and mammograms. Visits related to illness subject to deductible and coinsurance

Schedule of PPO Plan Benefits

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

Schedule of PPO Plan Benefits

Feature	PPO 80/60		PPO 90/70		PPO 100/80 (eligible retired employees only)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Surgery	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 90% of discounted In-Network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted In-Network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Maternity Care						
Obstetric Services (including office visits provided by a gynecologist or midwife)	\$25 co-pay (initial visit only); thereafter, the Plan pays 80% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 60% of R&C charges, after annual deductible	\$25 co-pay (initial visit only); thereafter, the Plan pays 90% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 70% of R&C charges, after annual deductible	\$25 co-pay (initial visit only); thereafter, the Plan pays 100% of discounted in-network fees, after annual deductible for other obstetric services including delivery charges	The Plan pays 80% of R&C charges, after annual deductible
Hospital Charges (including newborn nursery care)	The Plan pays 80% of discounted in-network fees, after annual deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 90% of discounted In-Network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted In-Network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Prescription Drugs (benefits provided Pharmacy Claims Administrator)						
Retail Co-pay¹ (up to 34-day supply)	\$15 generic \$30 preferred brand \$50 non-preferred brand	Not covered	\$15 generic \$30 preferred brand \$50 non-preferred brand	Not covered	\$15 generic \$30 preferred brand \$50 non-preferred brand	Not covered
Mail Order Co-pay² (> 34-day supply and up to 90-day supply) ²	\$30 generic \$60 preferred brand \$100 non-preferred brand	Not covered	\$30 generic \$60 preferred brand \$100 non-preferred brand	Not covered	\$30 generic \$60 preferred brand \$100 non-preferred brand	Not covered

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

¹ Maintenance medications will be charged at full cost on the fourth retail fill

²90-day supply of medications can be filled at certain retail pharmacies. Please see the Smart90 section for more details

Schedule of PPO Plan Benefits

Feature	PPO 80/60		PPO 90/70		PPO 100/80 (eligible retired employees only)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health and Chemical Dependency						
Inpatient Care	The Plan pays 80% of discounted In-Network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 60% of R&C charges, after annual deductible <i>No visit maximum</i>	The Plan pays 90% of discounted In-Network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 70% of R&C charges, after annual deductible <i>No visit maximum</i>	The Plan pays 100% of discounted in-network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 80% of R&C charges, after annual deductible <i>No visit maximum</i>
Alternative Mental Health Care Center (residential treatment)	The Plan pays 80% of discounted In-Network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 60% of R&C charges, after annual deductible <i>No visit maximum</i>	The Plan pays 90% of discounted In-Network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 70% of R&C charges, after annual deductible <i>No visit maximum</i>	The Plan pays 100% of discounted in-network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 80% of R&C charges, after annual deductible <i>No visit maximum</i>
Alternative Mental Health Care Center (intensive Outpatient and partial hospitalization)	The Plan pays 80% of discounted In-Network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 60% of R&C charges, after annual deductible <i>No visit maximum</i>	The Plan pays 90% of discounted In-Network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 70% of R&C charges, after annual deductible <i>No visit maximum</i>	The Plan pays 100% of discounted in-network fees, after annual deductible <i>No visit maximum</i>	The Plan pays 80% of R&C charges, after annual deductible <i>No visit maximum</i>
Outpatient Care	\$25 co-pay <i>No visit maximum</i>	The Plan pays 60% of R&C charges, after annual deductible <i>No visit maximum</i>	\$25 co-pay <i>No visit maximum</i>	The Plan pays 70% of R&C charges, after annual deductible <i>No visit maximum</i>	\$25 co-pay <i>No visit maximum</i>	The Plan pays 80% of R&C charges, after annual deductible <i>No visit maximum</i>
Other Coverage						
Emergency Room	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)
Urgent Care	\$40 co-pay	The Plan pays 60% of R&C charges, after annual deductible	\$40 co-pay	The Plan pays 70% of R&C charges, after annual deductible	\$40 co-pay	The Plan pays 80% of R&C charges, after annual deductible

Schedule of PPO Plan Benefits

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

Schedule of PPO Plan Benefits

Feature	PPO 80/60		PPO 90/70		PPO 100/80 (eligible retired employees only)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Chiropractic Care Maintenance care is not covered. 20 visit limit per calendar year applies. Visits above 20 per year subject to ongoing medical necessity review.	\$40 co-pay	Not covered	\$40 co-pay	Not covered	\$40 co-pay	Not covered
Home Health Care (100-visit maximum per year). Visits above 100 per year subject to ongoing medical necessity review.	The Plan pays 100% of discounted In-Network fees	Not covered	The Plan pays 100% of discounted In-Network fees	Not covered	The Plan pays 100% of discounted in-network fees	Not covered
Hospice Care	The Plan pays 100% of discounted In-Network fees, after annual deductible.	Not covered	The Plan pays 100% of discounted In-Network fees, after annual deductible.	Not covered	The Plan pays 100% of discounted In-Network fees, after annual deductible.	Not covered
Skilled Nursing Care Facility (60-day maximum per year combined for in- and out-of- network care)	The Plan pays 80% of discounted In-Network fees, after annual deductible	The Plan pays 60% of R&C charges, after annual deductible	The Plan pays 90% of discounted In-Network fees, after annual deductible	The Plan pays 70% of R&C charges, after annual deductible	The Plan pays 100% of discounted in-network fees, after annual deductible	The Plan pays 80% of R&C charges, after annual deductible
Ambulance Services³	The Plan pays 80% of discounted In-Network fees, after annual deductible.	The Plan pays 80% of R&C charges, after annual deductible.	The Plan pays 90% of discounted In-Network fees, after annual deductible.	The Plan pays 90% of R&C charges, after annual deductible.	The Plan pays 100% of discounted In-Network fees, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.

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

Schedule of PPO Plan Benefits

Feature	PPO 80/60		PPO 90/70		PPO 100/80 (eligible retired employees only)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
All other covered and medically necessary services including, but not limited to: Medical Supplies (blood, oxygen, prosthetics) and Dialysis Services.	The Plan pays 80% of discounted In-Network fees, after annual deductible.	The Plan pays 60% of R&C charges, after annual deductible.	The Plan pays 90% of discounted In-Network fees, after annual deductible.	The Plan pays 70% of R&C charges, after annual deductible.	The Plan pays 100% of discounted in-network fees, after annual deductible.	The Plan pays 80% of R&C charges, after annual deductible.
COVID-19 Tests and Related Services.* <i>See Covered Expenses section for details and limitations.</i>	The Plan pays 80% of discounted In-Network fees, after annual deductible.	The Plan pays 60% of R&C charges, after annual deductible.	The Plan pays 90% of discounted In-Network fees, after annual deductible.	The Plan pays 70% of R&C charges, after annual deductible.	The Plan pays 100% of discounted in-network fees, after annual deductible.	The Plan pays 80% of R&C charges, after annual deductible.

Important Notes about PPO Plan Benefits

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

Pre-certifying Care for Certain Medical Services and Behavioral Health Services

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

When You See In-Network Providers

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

When You See Out-of-Network Providers

When you see providers that are not part of the PPO network, notification is *your* responsibility. Before any in-patient surgical procedure or hospital stay (including emergency admissions, and skilled nursing care facilities), you, your doctor, or someone else familiar with your situation must contact your Claims Administrator to pre-certify your care in advance. A \$250 penalty for failure to pre-certify will apply, which does not count toward satisfying the annual deductible or annual out-of-pocket

maximum. You can review more information about how R&C is determined in the [Glossary](#), under “Reasonable and Customary Charges”.

If You Need Emergency Care

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

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



What constitutes a mental health or chemical dependency emergency?

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

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

Filing a Claim

When You See In-Network Providers

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

When You See Out-of-Network Providers

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

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

The Out-of-Area Program (“OOA”)

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

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

The Out-of-Area Program offers two coverage options from which to choose for eligible active employees and three coverage options from which to choose for eligible retired employees. These options vary based on the amounts of your annual deductible, annual out-of-pocket maximum, and coinsurance levels.

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

Schedule of Out-of-Area Program Benefits

An Overview of Out-of-Area Program Benefits

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

Schedule of Out-of-Area Program Benefits			
Feature	OOA 80	OOA 90	OOA 100 (eligible retired employee only)
Annual Deductible (1 person/2 or more people)	\$450/\$900	\$225/\$450	\$225/\$450
Coinsurance	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Annual Out-of-Packet Maximum (1 person/2 or more people)	\$3,000/\$6,000	\$1,500/\$3,000	\$225/\$450
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Medical Office Services			
Doctor’s Office Visits	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Telehealth Provided by Doctor on Demand	\$20 co-pay	\$20 co-pay	\$20 co-pay
Retail/Convenience Clinic	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

Preventive Care <i>includes routine physicals and well child care</i> (no limit on visits until age 5, then one routine physical per year)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
OB/GYN Exams	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

Schedule of Out-of-Area Program Benefits			
Feature	OOA 80	OOA 90	OOA 100 (eligible retired employees only)
X-Rays and Lab Tests	The Plan pays 100% of R&C charges, after meeting annual deductible, if performed in doctor's office as part of office visit. If performed in outpatient facility, the Plan pays 100% of R&C charges for lab charges and 80% of R&C charges for x-rays and related services	The Plan pays 100% of R&C charges, after meeting annual deductible, if performed in doctor's office as part of office visit. If performed in outpatient facility, the Plan pays 100% of R&C charges for lab charges and 90% of R&C charges for x-rays and related services	The Plan pays 100% of R&C charges, after annual deductible.
Immunizations (No age limitation)	The Plan pays 80% of charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Inpatient Hospital Care			
Room Allowance (semi-private room covered; private room covered only when medically necessary)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Surgery	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Maternity Care			
Obstetric Services (including office visits provided by a gynecologist or midwife)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Hospital Charges (including newborn nursery care)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Prescription Drugs (benefits provided through Pharmacy Claims Administrator)			
Retail Co-pay¹ (up to 34-day supply)	\$15 generic \$30 preferred brand \$50 non-preferred brand	\$15 generic \$30 preferred brand \$50 non-preferred brand	\$15 generic \$30 preferred brand \$50 non-preferred brand

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

¹ Maintenance medications will be charged at full cost on the fourth retail fill

Schedule of Out-of-Area Program Benefits			
Feature	OOA 80	OOA 90	OOA 100 (eligible retired employees only)
Mail Order Co-pay² (> 34-day and up to 90-day supply)	\$30 generic \$60 preferred brand \$100 non-preferred brand	\$30 generic \$60 preferred brand \$100 non-preferred brand	\$30 generic \$60 preferred brand \$100 non-preferred brand
Mental Health and Chemical Dependency			
Inpatient Care	The Plan pays 80% of R&C charges, after annual deductible <i>No day maximum</i>	The Plan pays 90% of R&C charges, after annual deductible <i>No day maximum</i>	The Plan pays 100% of R&C charges, after annual deductible <i>No day maximum</i>
Alternative Mental Health Care Center (residential treatment)	The Plan pays 80% of R&C charges, after annual deductible <i>No day maximum</i>	The Plan pays 90% of R&C charges, after annual deductible <i>No day maximum</i>	The Plan pays 100% of R&C charges, after annual deductible <i>No day maximum</i>
Alternative Mental Health Care Center (intensive Outpatient and partial hospitalization)	The Plan pays 80% of R&C charges, after annual deductible <i>No day maximum</i>	The Plan pays 90% of R&C charges, after annual deductible <i>No day maximum</i>	The Plan pays 100% of R&C charges, after annual deductible <i>No day maximum</i>
Telehealth Provided by Doctor on Demand	\$20 co-pay	\$20 co-pay	\$20 co-pay
Outpatient Care	The Plan pays 80% of R&C charges, after annual deductible <i>No visit maximum</i>	The Plan pays 90% of R&C charges, after annual deductible <i>No visit maximum</i>	The Plan pays 100% of R&C charges, after annual deductible <i>No visit maximum</i>
Other Coverage			
Emergency Room	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Urgent Care	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Durable Medical Equipment (some Durable Medical Equipment may have certain limitations, such as one custom pair of shoe inserts per benefit period)	\$500 per year at 100% of R&C, then the Plan pays 80% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first \$500 paid has been met	\$500 per year at 100% of R&C, then the Plan pays 90% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first \$500 paid has been met	\$500 per year at 100% of R&C, then the Plan pays 100% of R&C charges, after annual deductible. Prior Plan Approval must be obtained after first \$500 paid has been met

² 90-day supply of medications can be filled at certain retail pharmacies. Please see the Smart90 section for more details

Schedule of Out-of-Area Program Benefits			
Feature	OOA 80	OOA 90	OOA 100 (eligible retired employee only)
Physical and Occupational Therapy (40-visit maximum per year). Visits above 40 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Speech Therapy (20-visit maximum per year). Visits above 20 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Chiropractic Care Maintenance care is not covered. 20 visit limit per calendar year applies. Visits above 20 per year subject to ongoing medical necessity review.	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Home Health Care (100-visit maximum per year). Visits above 100 per year subject to ongoing medical necessity review.	The Plan pays 100% of R&C charges	The Plan pays 100% of R&C charges	The Plan pays 100% of R&C charges
Hospice Care	The Plan pays 100% of R&C charges, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.	The Plan pays 100% of R&C charges, after annual deductible.
Skilled Nursing Care Facility (60-day max. per year)	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
Ambulance Services⁷	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

⁷ Air transport and ambulance service between facilities must be medically necessary as determined by the Claims Administrator.

Schedule of Out-of-Area Program Benefits			
Feature	OOA 80	OOA 90	OOA 100 (eligible retired employees only)
All other covered and medically necessary services including, but not limited to: Medical Supplies (blood, oxygen, prosthetics) and Dialysis Services	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible
COVID-19 Tests and Related Services* <i>See Covered Expenses section for details and limitations.</i>	The Plan pays 80% of R&C charges, after annual deductible	The Plan pays 90% of R&C charges, after annual deductible	The Plan pays 100% of R&C charges, after annual deductible

Important Notes about Out-of-Area Program Benefits

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

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

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

Notification is *your* responsibility. Before any in-patient surgical procedure or hospital stay (including emergency admissions and skilled nursing care facilities), you, your doctor, or someone else familiar with your situation must contact your Claims Administrator to pre-certify your care in advance. For emergency admissions to a hospital or mental health or chemical dependency treatment facility, you do not need to call your Claims Administrator first before being admitted. In this case, benefits will be paid at normal plan levels as long as you (or someone on your behalf) call your Claims Administrator within 48 hours after the emergency admission. If you do not call within 48 hours, no benefits will be paid.

Filing a Claim (Out-of-Area Program)

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

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

Medical Services Covered Under the Plan

In general, the PPO Plan and Out-of-Area Programs cover a wide range of covered health services and supplies your doctor prescribes or authorizes to treat an illness or injury. See the “[Schedule of PPO Plan Benefits](#)” and “[Schedule of Out-of-Area Program Benefits](#)” sections of this SPD for a summary of covered services. The information below is meant to provide further detail about some, but not all, of the services listed in the “[Schedule of PPO Plan Benefits](#)” and “[Schedule of Out-of-Area Program Benefits](#)” sections of the SPD. Be sure to check the “[Schedule of PPO Plan Benefits](#)” and the “[Schedule of Out-of-Area Program Benefits](#)” sections of this SPD to determine whether your service is covered.

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

Bariatrics:

Medically necessary services or expenses associated with the treatment of obesity, weight reduction or dietary control will be covered only as follows:

- One surgical procedure per lifetime. It is your responsibility to contact your Claims Administrator to discuss your eligibility and surgical options covered under this Plan. Failure to do so may result in denial of your claim. Benefits will not be provided for reversals or reconstructive procedures
- Non-GLP-1 weight loss drugs for the treatment of obesity, subject to prior authorization requirements.
- GLP-1 drugs for the treatment of Type-2 diabetes.



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 or other Life-Threatening Conditions, as determined by the Third Party Administrator and as required by law. These costs will be subject to the Plan's otherwise applicable deductibles and limitations and do not include items that are

provided for data collection or services that are clearly inconsistent with widely accepted and established standards of care or otherwise payable or reimbursable by another party.

Cochlear implants:

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

Colonoscopy:

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

COVID-19 Tests and Related Items and Services

- COVID-19 Tests: The Plan will cover a COVID-19 test only when ordered and performed by your primary care provider or other medical professional. Such test will be subject to the deductible and coinsurance shown in the Schedule of PPO Benefits chart.
- 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.
- 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 the deductible and coinsurance shown in the Schedule of PPO Benefits chart.
- 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.

Diagnostic mammograms:

- In-Network: Subject to a co-pay, regardless of whether it is performed in an office setting or in a facility. If it is performed in an office setting, a co-pay is charged for the office visit during which the mammogram is performed, but no additional co-pay is charged for the mammogram.
- Out-of-Network: The deductible applies, then Out-of-Network Reasonable & Customary co-insurance applies.

- A maximum of two mammograms per year are covered (combined In-Network and Out-of-Network) for any reason. After the two mammograms, an unlimited number are covered if medically necessary.

Gender Reassignment/Sex Changes:

- The Gender Reassignment Benefit (GRB) provides coverage for gender reassignment for the treatment of gender dysphoria.
- If no In-Network provider is available within 30 miles of an employee's residence, a gap exception will need to be obtained. Contact your Claims Administrator for more information.
- The surgical benefit is available to employees and their eligible Dependents age 18 and over enrolled in a Medical Benefit Option.
- This GRB is available to the employee and their eligible Dependents (age 18 and over for the surgical benefit) only one time during the entire time the employee/eligible Dependent is covered under the Plan.
- An employee who receives the benefit under the GRB for active employees cannot receive any additional benefits under the GRB for retirees. However, if you have not received the maximum GRB under the medical plan for active employees, you may receive a balance GRB, not to exceed a combined \$10,000 travel reimbursement.
- **GRB Coverage.** The Plan pays the following benefits:
 - Continuous hormone replacement (hormones of the desired gender), including laboratory testing to monitor the safety of continuous hormone therapy.
 - Evaluation and diagnosis by a psychological professional and psychotherapy, as set forth in standard treatment protocols.
 - One genital revision surgery (either male to female or female to male, as applicable) and one bilateral mastectomy or one bilateral augmentation mammoplasty, as applicable to the desired gender.
- **Surgical Benefit.** Surgical benefits are limited to one bilateral mastectomy or bilateral augmentation mammoplasty, and one genital revision surgery (either male to female or female to male, as applicable) for the entire time the employee is covered under this Plan. Subsequent surgical revisions, modifications or reversals are excluded from coverage. Coverage is limited to treatment performed by In-Network Providers.
- **Cosmetic Surgeries:** Procedures primarily aimed to enhance appearance and/or physical modification, to resemble secondary sex characteristics of the chosen/reassigned gender such as hair removal, liposuction/body contouring, thyroid cartilage shaving, plastic surgery of eyelids/eyes/lips/chin, facial bone reduction, face lifts, voice modification surgery, nose modification, skin resurfacing, and any other cosmetic surgeries are covered if Medically Necessary.
- **GRB Prescription Drug and Mental Health Treatment.** Prescription drugs and mental health treatment associated with the GRB are considered under the Plan's behavioral and mental health and prescription drug provisions; subject to applicable provisions, limitations and exclusions.
- **Travel Reimbursement.** See "[Travel and Lodging Reimbursement](#)" for information about when travel and lodging expenses may be reimbursed.

- **Pre-Certification for the GRB.** You must have approval from the Claims Administrator **both** at the time you begin your treatment and at the time, you are admitted for surgery. Your failure to obtain Pre-Certification **both** at the time you begin treatment and at the time you are admitted for surgery will result in denial of your claims.

Mammograms (including 3-D mammograms) (routine screening or preventive):

In-Network, routine-screening mammograms are covered under all Medical Benefit Options at 100%, as described in the U.S. Preventive Services Task Force A or B recommendations. Please click here to view those recommendations: [Search Results | United States Preventive Services Taskforce \(uspreventiveservicestaskforce.org\)](https://www.uspreventiveservicestaskforce.org).

Pregnancy:

Prenatal and delivery are covered by provided by a Physician or midwife who is registered, licensed, or certified by the state in which he or she practices.

- 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.

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 (at In-Network Providers and In- Network facilities only) is covered for the treatment of prostate cancer and other diagnoses as determined by the Claims Administrators' medical policy.

- This benefit is subject to an overall maximum of \$50,000 per episode when used to treat prostate cancer. For purposes of calculating this maximum, covered expenses incurred under the PPO 80/90/100, the OOA 80/90/100, the CORE/STANDARD/HIGH COST COVERAGE medical option under the American Airlines, Inc. Health and Welfare Plan for Active Employees, and the DFW ConnectedCare Plan (in certain zip codes) will be aggregated. If there is a recurrence of prostate cancer following a period of time when the cancer could not be detected, this is considered a different episode and coverage will be available again, up to the maximum of \$50,000 per episode.
- The overall maximum of \$50,000 applies only to the proton beam therapy delivery and does not apply to treatment planning, imaging, physician consultations, professional services or other associated ancillary charges.

- The following limitations apply:
 - The service or procedure must be performed by an In-Network Provider and be administered in an In-Network facility (unless a network gap exception has been approved by the Claims Administrator).
 - The benefit requires Pre-Certification.
- Services received at an Out-of-Network Provider or Out-of-Network facility are excluded. See the “Medical Expenses Not Covered” section, “Proton Beam Therapy” for details.

Repetitive Transcranial Magnetic Stimulation (RTMS):

Claims for RTMS will be referred for further review.

Retail Clinic Visits:

If you go to an In-Network retail clinic inside of retail pharmacies, the eligible expense is subject to the Physician’s office visit Co-pay, or Deductible and Co-Insurance.

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

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

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

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

Routine hearing screening (performed with wellness exam):

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

Telehealth:

The Plan will cover live face-to-face video consultations for medical benefits for participants enrolled in one of the self-funded benefit options. These medical benefits are offered by Doctor on Demand, a telehealth service offering video medical visits through a secure mobile application.

Travel and Lodging Reimbursement:

- Travel and lodging assistance is only available if:
 - (1) You receive care at an eligible Center of Excellence (COE) for one of the following:
 - Transplant
 - Cancer
 - Congenital heart disease
 - Bariatric surgery

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

- These treatments and procedures are performed at limited locations in the United States, and most patients will need to travel outside their immediate home area. If travel is required for a treatment or procedure because it is not offered in your immediate home area, travel to an In-Network Provider (for gender reassignment surgery) or a Center of Excellence (COE) and lodging expenses will be reimbursed up to a maximum of \$10,000, regardless of your Claims Administrator, even if you change administrators. To be eligible for reimbursement, travel must be over 50 miles away from your home and must be by air, rail, bus or car. The \$10,000 covers you and one caretaker to travel with you for In-Network surgery only (for gender reassignment surgery) or a treatment or procedure at a Center of Excellence. You are only allowed to travel In-Network (for gender reassignment surgery) or to a Center of Excellence within the 48 contiguous United States. Itemized receipts will be required by your Claims Administrator. Contact your 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.

Treatment and Observation rooms:

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

Wigs and hairpieces:

The wig must be prescribed by a Physician for a covered medical or mental health condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery, severe burns, or trichotillomania. 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.

Medical Services NOT Covered Under the Plan

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

The following services are excluded from coverage:

- Services and supplies that are not medically necessary covered health services, as determined by your Claims Administrator;
- Custodial care: care essentially designed to assist individuals to meet their activities of daily living, such as but not limited to services which constitute personal care (including: help in walking and getting in and out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diet and supervision of medications which can usually be self-administered and which does not entail or require continuous attention of trained medical personnel);
- Cosmetic procedures and supplies, except when reconstructive/cosmetic surgery is necessary as a result of Sickness, Injury or Congenital Anomaly, or to comply with the requirements of The Women's Health and Cancer Rights Act of 1998. (See *the "Additional Rules That Apply to Your Medical Coverage" section of this SPD.*) Certain Cosmetic Surgeries and supplies are covered under Gender Reassignment Benefits, as described above. Examples of procedures that are excluded from coverage include: rhinoplasty (nose), mentoplasty (chin), rhytidoplasty (face lift), glabellar rhytidoplasty, (space between eyebrows) surgical planeing (dermabrasion), blepharoplasty (eyelid), mammoplasty (reduction, suspension or augmentation), superficial chemosurgery (chemical peel) and liposuction;
- Treatment or tests performed on an inpatient basis that could have been performed safely and effectively on an outpatient basis;
- Experimental/Investigational or unproven procedures, unless the Plan has agreed to cover them as stated in the Glossary;
- Medically necessary services or expenses associated with the treatment of obesity, weight reduction or dietary control:
 - beyond one surgical procedure per lifetime. It is your responsibility to contact your Claims Administrator to discuss your eligibility and surgical options covered under this Plan. Failure to do so may result in denial of your claim. Benefits will not be provided for reversals or reconstructive procedures;
 - GLP-1 drugs are not covered except for the treatment of Type-2 diabetes
- Services or supplies not needed for diagnosis or treatment of a specific illness or injury;
- Services or expenses provided by a physician or other health care provider related to the covered person by blood or marriage;



- Services or supplies you received before you had coverage under the Plan, or after your coverage under the Plan ends;
- Services or supplies payable by Medicare, or any other government or private program;
- Private duty services provided by sitters or companions. Private duty services by Registered Nurses or Licensed Practical Nurses will also be excluded unless the services are part of an approved home health care or hospice program;
- Reversals of tubal ligations or vasectomies;
- Infertility treatment, services and associated expenses for artificial insemination including In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT); Zygote Intrafallopian Transfer (ZIFT) procedures; embryo transport; surrogate parenting; donor semen and related costs including collection and preparation;
Note: Diagnostic testing to determine the cause of infertility and prescription medication to treat infertility is covered under the Plan.
- Prescription drugs purchased at a doctor's office, skilled nursing facility, hospital or any other place that is not a pharmacy licensed to dispense drugs in the state where it is operated;
- Prescription medications prescribed or consumed in dosage, quantity, or for condition(s) not approved by the US Food and Drug Administration, and prescription medications used in a manner, quantity, dosage, or route of administration not approved by the US Food and Drug Administration for such medication.
- Any service or treatment for complications resulting from any non-covered procedures;
- Any service or supply rendered to a covered person for the diagnosis or treatment to improve or restore sexual function;
- Marriage, family or child counseling for the treatment of premarital, marital, family or child relationship dysfunction;
- Food supplements including infant formula available over the counter. Coverage of food supplements is restricted to sole source nutrients which are not available over the counter or without a prescription;
- Prescription drugs used for cosmetic purposes or hair growth;
- Travel whether or not recommended by a physician, except in connection with medically necessary travel for an organ transplant, cancer treatment, congenital heart disease treatment, bariatric surgery, joint/spine procedures, gender reassignment surgery, subject to and only if approved in accordance with the Travel and Lodging Reimbursement Guidelines;
- Durable Medical Equipment over \$500 when required preauthorization is not obtained;
- Services and supplies related to human organ and tissue transplants when the required pre-approval is not obtained;
- Any service or supply the covered person is not legally obligated to pay;

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

hypnotism, massage therapy, rolfing (holistic tissue massage), and other forms of alternative treatments as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institute of Health; and

- Routine hearing examinations.

Mental Health and Chemical Dependency Benefit Limitations and Exclusions

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

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

participant provides the behavioral health Claims Administrator with a lien against such claim for damages or relief in a form and manner satisfactory to the Plan;

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

Additional Rules That Apply to Your Medical Coverage

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

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

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

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

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

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

Example

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

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

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

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

Your Prescription Drug Benefit

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

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

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

- [The pharmacy Claims Administrator's responsibilities](#);
- [A summary of prescription drug benefits at In-Network pharmacies and through the mail order program](#); and
- [Other Important Information about Your Prescription Drug Benefits](#).

Claims Administrator Responsibilities

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

An Overview of Your Prescription Drug Program Benefits Through Participating Retail Pharmacies

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

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

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

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

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

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

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

Through Non-Participating Retail Pharmacies

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

Through the Mail Order Program

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

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

Up to a 90-day supply	When you use the mail order program or Maintenance Choice Program
Generic drug	\$30
Preferred brand-name drug	\$60
Non-preferred brand-name drug	\$100

Some generic drugs at mail order will have a \$10 co-pay subject to change at any time.

Using the Mail Order Program

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

Maintenance Choice

As part of your prescription drug benefit, you and your covered dependents are eligible for the Maintenance Choice Program. You may use this option to purchase a 90-day supply of the Prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You can order medications on a 90-day supply basis through the Maintenance Choice Program at a local CVS or Safeway-owned pharmacy, such as Tom Thumb, Randall's, or Vons, at a Kroger Pharmacy or Costco Pharmacy, or through the CVS Mail Order Pharmacy. 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.



About “vacation supplies” and prescriptions filled outside the United States

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

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

Other Important Information about Your Prescription Drug Benefits

Quantity Limits for Certain Drugs

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

Generic Substitution/Dispense As Written

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

Prior Authorization

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

Step Therapy

Step Therapy helps ensure your safety and that you receive clinically appropriate medication based on your prescription history. The Step Therapy Treatment guidelines are in accordance with current medical literature, manufacturer recommendations and U. S. Food and Drug Administration guidelines. The Plan may

require a review for certain drugs under this program before providing coverage to determine if other cost-effective therapies are available and have been tried. To inquire if a drug is subject to Step Therapy, contact your PBM.

Your Voluntary Long-Term Care Plan

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

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

The Long-Term Care Plan

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

Claims Administrator Responsibilities

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

How to File a Claim

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

Retiree Health Coverage

Eligibility for You

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

- You are less than age 65, and have attained the minimum retirement age of 55 as determined by Legacy US Airways’ corporate policy or the minimum age as required under a collective bargaining agreement (between Legacy US Airways and a labor union) that regulates the terms and conditions of your employment; and
- You retired from either an active or leave/furlough payroll status that was based in the US prior to the date indicated for your workgroup below; and
- You have at least five (5) years of service with Legacy US Airways, unless otherwise specified in your collective bargaining agreement.

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

- You are a former Flight Simulator Engineer or a Flight Crew Training Instructor who was covered by the collective bargaining agreements entered into between US Airways and the TWU and who retired prior to January 1, 2018;
- You are a former Dispatcher who was covered by the collective bargaining agreements entered into between US Airways and the TWU and who retired prior to January 1, 2017;
- You are a former Agent/Representative/Planner (ARP) employee of the Company who was represented by the Communications Workers of America and the International Brotherhood of Teamsters (“CWA-IBT”) and retired prior to January 1, 2017;
- You are a former flight attendant who retired prior to January 1, 2016;
- You are a former pilot who retired prior to January 1, 2015;
- You are a former Officer, Management, Support Staff (OMSS) employed by the Company who retired prior to January 1, 2015; or
- You are a former employee in the maintenance and related groups who was represented by collective bargaining agreements between Legacy US Airways, Inc. and the IAM who retired prior to March 26, 2020.

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

Eligibility for Your Dependents upon Retirement

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

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

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

When Coverage Begins

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

Coverage Levels

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

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

Paying for Coverage

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

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

Making Changes after Retirement

In general, after you make your retiree health elections, you will not be able to increase your level of coverage in the future. However, you may change your level of coverage after retirement if a Life Event occurs, as outlined in the chart below. Changes must be made within 60 days following the event. You can decrease or terminate your level of coverage at any time after your retirement.

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

In the Event of:	What You May Do:
An address change that results in a change into or out of your coverage under the PPO network	<ul style="list-style-type: none">▪ May change coverage option and coverage level. Change must be made within 60 days.
<i>For pre-65 retirees participating in a PPO Plan only</i>	
You (if you Retired Prior to March 1, 2005 and retain access to post-65 benefits) or your Spouse attaining age 65 <i>Coverage Effective Date is the first of the month following attainment of age 65</i>	<ul style="list-style-type: none">▪ May change coverage option.▪ May not increase coverage level.▪ May decrease or drop coverage at any time.
Marriage	<ul style="list-style-type: none">▪ May change coverage option.▪ May change coverage level to add your Spouse and new Dependents.▪ May decrease or drop coverage at any time. <i>Documentation is required.</i>

In the Event of:	What You May Do:
Divorce	<ul style="list-style-type: none"> ▪ Must drop Spouse coverage within 60 days. ▪ <i>Former Spouse is eligible for COBRA up to 60 days after divorce date.</i> ▪ May change your coverage option. ▪ May change coverage level to drop Spouse and add/drop Dependents. ▪ May decrease or drop coverage at any time. <i>Documentation is required.</i>
Birth or Adoption of a Child, Legal Guardianship or other Gain of Dependency Status	<ul style="list-style-type: none"> ▪ May change coverage option. ▪ May change coverage level. <i>Documentation may be required.</i> ▪ May decrease or drop coverage at any time.
Retiree Death	<ul style="list-style-type: none"> ▪ May change your coverage option. ▪ May decrease or drop coverage at any time. <i>Surviving Dependents may be eligible for coverage.</i>
Dependent Death	<ul style="list-style-type: none"> ▪ May change coverage option. ▪ May change coverage level. ▪ May decrease or drop coverage at any time. <i>Note: If your Spouse dies while covering eligible Dependents under another plan, you may add Dependents to your coverage.</i>
Spouse Gains Employment/Coverage	<ul style="list-style-type: none"> ▪ May drop self and Dependents from coverage within 60 days. ▪ May decrease or drop coverage at any time. <i>Documentation is required.</i>
Spouse Loses Employment/Coverage	<ul style="list-style-type: none"> ▪ May elect, waive or change coverage level or coverage option within 60 days. ▪ May add Spouse and Dependents. <i>Documentation is required.</i>
Loss of Dependent's Eligibility	<ul style="list-style-type: none"> ▪ May decrease or waive coverage ▪ May change coverage option if notified within 60 days of the event date. <i>Documentation of loss of eligibility is required.</i> ▪ May decrease or drop coverage at any time.
Dependent Regains Eligibility	<ul style="list-style-type: none"> ▪ May change coverage option. ▪ May increase coverage level. <i>Documentation of Dependent eligibility is required; only Dependents causing the event may be added.</i> ▪ May decrease or drop coverage at any time.
Address Change/Relocation—that results in a transfer into or out of the service area	<ul style="list-style-type: none"> ▪ May change coverage option. ▪ May not change coverage level. ▪ May decrease or drop coverage at any time.

How to Make Changes to Your Elections

To change your elections under the Plan, contact the [American Airlines Benefits Service Center](#) at 1-888-860-6178.

You must notify [American Airlines Benefits Service Center](#) of a Life Event within 60 days of the event if you want to change your benefit elections.

When Coverage Ends

In general, your Plan coverage will end for you when:

- You stop making required contributions;
- You die;
- You are no longer eligible to participate in the Plan; or
- The Plan is terminated.

Coverage for your Spouse or eligible Dependents will end when:

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

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

Surviving Spouses and Other Eligible Surviving Dependents

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

Coordination with Medicare for Retirees

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

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

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

Example

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

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

Important Reminder:

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

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

Additional Rules that Apply to the Plan

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

Qualified Medical Child Support Order (QMCSO)

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

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement. By enrolling in the Plan and applying for benefits from the Plan, you and your covered eligible 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 eligible Dependents automatically assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury, including another group health plan, insurer or individual. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval, or approval from the Plan's authorized or designated agent for subrogation-and- reimbursement recoveries.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100 percent of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a dependent Child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

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

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

This section explains how the Plan coordinates coverage between the Plan and any other benefits/plans that provide coverage for you or your eligible Dependents.

If you or any other covered eligible Dependents have primary coverage (see “[Which Plan Is Primary](#)” in this section) under any other group medical benefits/plans, your Company-sponsored Medical Option will coordinate to avoid duplication of payment for the same expenses. The benefit program will take into account all payments you have received under any other benefits/plans and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical Benefit Option were your only coverage.

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

The maximum benefit payable depends on whether the In-Network or Out-of-Network Providers are used. When this Plan is secondary, the Eligible Expense is the primary plan's allowable expense (for primary plans with Provider Networks, this will be the Network allowable expense; for primary plans that base their reimbursement on reasonable and customary or usual and prevailing charges, the allowable expense is the Maximum Out-of-Network Charge (“MOC”)). If both the primary plan and this Plan do not have a Network allowable expense, the Eligible Expense will be the greater of the two plans' reasonable and customary or usual and prevailing charges. The maximum combined payment you can receive from all plans may be less than 100 percent of the total Eligible Expense.

If you or your eligible Dependent is hospitalized when coverage begins, your prior coverage is responsible for payment of medical services until you are released from the hospital. If you have no prior coverage, the benefit program will pay benefits only for the portion of the hospital stay occurring after you became eligible for coverage under the benefit program.

If you or your eligible Dependent is hospitalized when your benefit program for coverage changes from one Medical Benefit Option to another, your prior coverage is responsible for payment of Eligible Expenses until you or your eligible Dependent is released from the hospital.

The Plan's coordination of benefits rules apply regardless of whether a claim is made under the other plan. If a claim is not made, benefits under the Plan may be delayed or denied until an explanation of benefits is issued showing a claim made with the primary plan.

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

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

The Plan has first priority with respect to its right to reduction, reimbursement and subrogation. The Plan will not coordinate benefits with an HMO or similar managed care plan where you only pay a copayment or fixed dollar amount.

Other Plans

The term "other group medical benefit/plan" in this section includes any of the following:

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

Which Plan Is Primary

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

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee

- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under Medical Insurance Benefits and Medicare are paid according to federal regulations. In case of a conflict between Medical Benefit Options provisions and federal law, federal law prevails.
- The Plan is always secondary to any motor vehicle policy that may be available to you, including personal injury protection or no-fault coverage. If the Plan pays benefits as a result of injuries or illnesses resulting from the acts of another party, the Plan has a right of reimbursement or subrogation as to the benefits paid. Please see the Plan's Subrogation and Reimbursement provision.
- If the coordination of benefits is on behalf of a covered Child:
 - a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise.
- For a stepchild or unmarried child age 26 and over who is disabled and dependent on you, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the other plan has a gender rule, that plan determines which plan is primary.

Coordination with Medicare

If you (or one of your eligible 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 Eligible 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 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 eligible Dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare benefits for Prescription drug benefits), the Plan pays secondary if:

- You (or your Eligible Dependent) are covered by Medicare, do not have end-stage renal disease, and you are not currently working for the Company, 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 eligible Dependent) are age 65 or over and the Plan would otherwise be the primary payer because you are still working, you or your eligible 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 your annual deductible, if any.

When Medicare is the primary payer, no benefits will be payable under this Plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

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.

Substance Use Disorder Records. If you were treated by a health care provider or program that is subject to the federal privacy laws under 42 CFR Part 2, the Plan will obtain your written authorization before using or disclosing your Part 2 Records for purposes of treatment, payment, or health care operations. The Plan may rely on your written authorization for its own future uses and disclosure of such records for treatment, payment, or health care operations under the Plan.

Substance use disorder treatment records received from a programs subject to 42 CFR Part 2, or testimony relaying the content of such records, may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless: (1) you provide written consent; or (2) the Plan receives a court order accompanied by a subpoena or other legal requirement compelling disclosure and you, or the holder of your substance use disorder treatment record, are provided notice and an opportunity to be heard.

Other Privacy Laws. Under the HIPAA privacy and security rules, the Plan may be required to comply with other more stringent state or federal privacy laws that require greater limits on

disclosure of your PHI, such as 42 CFR Part 2 related to substance use disorder treatment records.

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. The Plan is required to abide by the terms of the notice that is currently in effect. The Plan is required to notify you if there is a breach of your unsecured PHI. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. If there is a material change to any provisions of this notice, the Plan will distribute a revised notice.

Organized Health Care Arrangement

The Plan is part of an organized health care arrangement with the plans listed on the first page of this notice. The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.

Questions?

If you have questions or would like more information about the Plan's privacy policies, you may contact the [American Airlines Benefits Service Center](#) at 888-860-6178.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You cannot be retaliated against for filing such a complaint.

Plan Service Providers

American Airlines, Inc. and/or the Plan generally may share, without your consent, your contact information and other information the Plan has about you with Plan service providers so that these services providers can perform services under the Plan. Accordingly, a service provider might contact you about the service provider's services or offerings connected with the Plan, invite you to participate in surveys concerning the service provider's performance, or for other purposes allowed by the Plan. Before sharing your information with a service provider, consistent with HIPAA and other privacy laws, American Airlines, Inc. and/or the Plan would obtain the service provider's written agreement to safeguard your information and use it only for the purposes for which it was disclosed to the service provider.

The Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits group health plans from using "genetic information" about employees (and their eligible Dependents or other family members) for setting or adjusting premium rates, for underwriting purposes, and for determining eligibility for enrollment in the group health plan. For example, under GINA a

plan cannot require or request that an employee or family member undergo a genetic test prior to or as a condition of enrollment under the plan. Also, restrictions are placed on the collection and use of family medical history information prior to enrollment. Specifically, the rules prohibit the use of rewards or incentives for completion of family medical histories prior to enrollment. GINA does not restrict genetic testing as ordered by a medical provider or the use of family medical history or genetic testing data to enhance plan benefits after enrollment has occurred and a medical provider has been consulted. GINA became effective for the Plan on January 1, 2010.

Workers' Compensation

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

Rescission in Event of Fraud

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

Qualifying Events for Continuation Under Federal Law (COBRA)

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

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

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

Qualifying Events

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

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

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

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

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

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

- If you, your Spouse or your Dependent(s) experience a second qualifying event within the original 18-month period that was due to termination of employment or reduction in hours, they (but not you) may extend the COBRA continuation period for up to an additional 18-months (for a total of up to 36-months from the original qualifying event).
- If you (the Employee) become entitled to Medicare (even if it was not a qualifying event for your covered eligible Dependents because their coverage was not lost or reduced) and then a second qualifying event due to either your termination of employment or reduction in hours of work happens within 18-months, your eligible Dependents may

elect COBRA continuation for up to 36-months from the date you became entitled to Medicare.

- If you or your Dependent is determined to be disabled by the Social Security Administration at any time during the first 60 days of COBRA continuation coverage, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11-months (for a total of up to 29-months) if the original qualifying event was termination or reduction in hours. To qualify for this disability extension, the Plan Administrator must be notified of the person's disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify the Plan Administrator within 30 days after this determination.

Important Note

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

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation coverage upon your divorce or loss of your Child's Dependent status under the Plan, you or one of your eligible Dependents must notify the Plan Administrator of your divorce or loss of Dependent status within 60 days of the later of the date of the event or the date the individual would lose coverage under the Plan. Your covered eligible Dependents will then be provided with instructions for continuing their health coverage. Individuals already on COBRA continuation must notify the Plan Administrator within the same time frame if a divorce or loss of a child's Dependent status occurs that would extend the period of COBRA coverage for your Spouse or Dependent child(ren).

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

Electing and Paying for COBRA Continuation Coverage

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

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

Premium Due Date

If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation coverage, but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your COBRA continuation coverage will be terminated retroactively to the last day for which timely payment was made and cannot be reinstated.

Cost of COBRA Continuation of Coverage

Continuing Coverage

The cost of COBRA continuation of coverage is 102 percent of the full cost of Plan coverage. The cost of continuing COBRA continuation coverage during an extended period for disability is 150 percent of the full cost of Plan coverage.

Coverage During the Continuation Period

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

When COBRA Continuation Coverage Ends

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

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

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

- Group health coverage for all Employees is terminated.

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

Continuation of Coverage for Employees in the Uniformed Services

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

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

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstate medical coverage under another Company-sponsored plan with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave. You may not reinstate coverage under this Plan, however.

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 reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days; or
- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Continuation of Coverage While on a Family and Medical Leave

Under the Family and Medical Leave Act (FMLA), eligible employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected benefits during this time. If you take this unpaid leave and wish to continue your coverage under the Plan, you will be billed directly on a monthly basis, at the same rates applicable before the unpaid leave began.

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

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

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

Continuation of Coverage for Retirees

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

Claims Procedures

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

Time Frame for Initial Claim Determination

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

- 72 hours after receipt of an **urgent care claim** (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification); and
- 15 days after receipt of a **pre-service claim**.

For **post-service claims** (claims that are submitted for payment after receiving medical care), the appropriate Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit or a failure to provide or make a payment, in whole or in part, for a benefit under the Plan.

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

- The appropriate Claims Administrator’s receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For **pre- and post-service claims**, a 15-day extension may be allowed to make a determination, provided that the appropriate Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the appropriate Claims Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your failure to submit necessary information, the applicable claim administrator’s time frame for making a benefit determination is tolled or suspended from the date the appropriate Claims Administrator

sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan's procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the Plan's knowledge of such failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that is:

- A communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; or
- A communication that names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is required.

Urgent Care Claims

Urgent care claims are a special type of pre-service claim which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function; 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 with an average knowledge of health and medicine will determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

Note that the Claims Administrators make the initial claims determination for all benefits. If the Claims Administrator denies the claim, the initial notice of denial of an urgent care claim may be provided orally, provided that written notification is provided to you within three days after the oral notification.

Concurrent Care Claims

There are two types of concurrent care claims: 1) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and 2) where an extension is requested beyond the initially-approved period of time or number of treatments. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours after receipt of your claim, provided your request is made at least 24 hours prior to the end of the approved course of treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent claim, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: *Any reduction or termination of a course of treatment will be considered an adverse benefit determination unless the reduction or termination of such course of treatment is the result of a Plan amendment or Plan termination.*

If You Receive an Adverse Benefit Determination

The appropriate Claims Administrator will provide you with a written notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination;
- References to the specific Plan provisions on which the benefit determination is based;
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under 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; and
- If the adverse benefit determination concerns a claim involving **urgent care**, a description of the expedited review process applicable to the claim.

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. An application for a First Level Appeal can be found at <https://my.aa.com/forms-notice>, which must accompany your request for a First Level Appeal. 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. An application for a Second Level

Appeal can be found at <https://my.aa.com/forms-notice>, which must accompany your request for a Second Level Appeal. The EBC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing within 90 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

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

Note that the Claims Administrators determine the second level of appeal for all benefits.

You have the right to:

- Authorize a representative to act on your behalf, as long as such designation is in writing and submitted to the Claims Administrator.
- Submit written comments, documents, records and other information relating to the claim for benefits;
- Upon a request, and free of charge, reasonable access to, and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document record, or other information is treated as “relevant” to your claim if it:
 - Was relied upon in making the benefit determination;
 - Was submitted, considered, or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination;
 - Demonstrates compliance with the administrative processes and safeguards required in making the benefits determination; and
 - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination;
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination;
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person’s subordinate;
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit

determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental);

- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision; and
- In the case of a claim for urgent care, an expedited review process in which:
 - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination; and
 - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile, or other available similarly prompt method.
- Ordinarily, a decision regarding your appeal will be reached within:
 - 72 hours after receipt of your request for review of an urgent care claim;
 - 15 days after receipt of your request for review of a pre-service claim; or
 - 30 days after receipt of your request for review of a post-service claim.

The notice of an adverse benefit determination on appeal, from the appropriate Claims Administrator/Claims Fiduciary, will contain all of the following information:

- The specific reason(s) for the adverse benefit determination;
- References to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- You may not bring a lawsuit to recover benefits under this Plan until you have exhausted all levels of appeals (2 levels) offered through the administrative process described in this Plan. No legal action to recover benefits under the Plan may be filed beyond three years after the date a final decision is made on your claim for benefits. The three-year statute of limitations on suits for all benefits shall apply in any forum where the Beneficiary may initiate such suit.

External Review

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

- Clinical reasons/medical judgment (medical judgment includes a decision based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a decision that a treatment is experimental or investigational);
- Rescission of coverage (coverage that was cancelled or discontinued retroactively);
- Adverse determination related to the benefit plan's compliance with "No Surprises Act" ("NSA") protections such as:
 - Patient cost-sharing and surprise billing for emergency services;
 - Patient cost-sharing and surprise billing protections related to care provided by nonparticipating providers at participating facilities;
 - Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections; and
- 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; or as otherwise required by applicable law.

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

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

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

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

- All relevant medical records;
- All other documents relied upon by the Claims Administrator in making a decision on the case; and

- All other information or evidence that you or your Physician has already submitted to the Claims Administrator.

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

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

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

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

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

How to Contact Your Claims Administrators/Claims Fiduciaries

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



Claims Administrator/ Claims Fiduciary	Phone Number	Web Site Address
United Healthcare Services, Inc. (UHC - RETIREES/UHC-ACTIVES) (medical benefits)	1-800-213-5755	https://memberforms.uhc.com/Memberappealsandgrievances.html
Blue Cross Blue Shield of Texas	1-877-235-9258	www.bcbstx.com/americanairlines
CVS Caremark (prescription drug benefits)	1-844-758-0767	caremark.com

Plan Administration

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

Plan Name & Number

American Airlines, Inc. PPO Plan (517)

Plan Sponsor

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

American Airlines, Inc., or its authorized delegate

Mailing address:

Mail Drop 8A203

P.O. Box 619616

DFW Airport, TX 75261-9616

Street address (do not mail to this address):

1 Skyview Drive

Fort Worth, Texas 76155

The American Airlines, Inc. PPO Plan is a group health plan providing medical benefits, including, including prescription drug, mental health and chemical dependency benefits.

Plan Administrator

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

American Airlines, Inc., or its authorized delegate

Mailing address:

Mail Drop 8A203

P.O. Box 619616

DFW Airport, TX 75261-9616

Street address (do not mail to this address):

1 Skyview Drive

Fort Worth, Texas 76155

American Airlines, Inc. has delegated certain administrative functions to Alight Solutions, including answering questions about eligibility on behalf of American Airlines, Inc. Alight

Solutions can be reached at: 1-888-860-6178

American Airlines, Inc. has also delegated certain administrative functions to the Claims Administrators . The Claims Administrators are available to provide information regarding eligibility, enrollment, benefit coverage, health benefit options, solutions, and costs, available providers and their network status, status of deductible or out-of-pocket maximum, claims decisions, status of claims, and instructions for filing claims and appeals.

The Plan Administrator (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the Plan described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the Plan Administrator (or its delegate(s)) made pursuant to the Plan described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The Plan Administrator may delegate this discretionary authority to selected service providers. In certain circumstances, for all purposes of overall costs savings or efficiency, the Plan Administrator (or its delegate(s)) may, in their sole discretion, offer benefits for services that would not otherwise be covered. The fact that the Plan Administrator (or its delegate(s)) do this in any particular case shall not in any way be deemed to require the Plan Administrator (or its delegate(s)) to do so in similar cases.

The Plan Administrator for Second Level Claim Appeals for
Administrative/Eligibility/Enrollment:

Employee Benefits Committee (EBC) American Airlines, Inc.
Mail Drop 8A201
P.O. Box 619616
DFW Airport, TX 75261-9616

Agent for Service of Legal Process

The name, address and telephone number of the 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
Mail Drop 8A203
Fort Worth, TX 76155

Legal process also can be served on the Plan Administrator.

Identification Number

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

Plan Year

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

Organizations Providing Administrative Services under the Plan

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

Type of Benefits	Claims Administrators and Navigator
Medical	<p>Claims Administrators:</p> <p>United HealthCare (UHC) American Airlines, Inc. Medical Claim Unit P.O. Box 30555 Salt Lake City, UT 84130-0551 Website: www.myuhc.com</p> <p>BlueCross BlueShield of Texas P.O. Box 660044 Dallas, TX 75266-0044 Website: www.bcbstx.com/americanairlines</p>
Prescription Drugs	<p>Claim Administrator:</p> <p>Mail Order Pharmacy Service: CVS Caremark P.O. Box 659639 San Antonio, TX 78265-9539 Phone: 1-844-758-0767 Website: caremark.com</p> <p>Claim Administrator:</p> <p>Prescriptions – Prior Authorization:</p> <p>CVS Caremark P.O. Box 6590 Lee's Summit, MO 64064-6590 Phone: 1-844-758-0767 Website: caremark.com</p>

	<p>Claim Administrator: Filing Retail Prescription Claims: CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Phone: 1-844-758-0767 Website: caremark.com</p> <p>Navigators: Phone: 833-346-3929 (1-833-FIND-WAY) Website: my.aa.com</p> <p>Is available to provide information regarding retail, mail order and specialty prescription benefit options, prescription drug benefit options, solutions, and costs, available pharmacies and their network status, medication management services, claims decisions, status of claims, and instructions for filing claims and appeals. Also provides care management services (including a nurse line) and case management services for certain conditions.</p>
Voluntary Long-Term Care	<p>Claims Administrator: Unum Life Insurance Company of America 2211 Congress Street Portland, ME 04122</p>

Plan Funding

The Plan is a self-insured plan for benefits provided through the PPO and OOA Medical Benefit Options. American Airlines, Inc. has contracted with third party administrators to administer these Medical Benefit Options. For the Medical Benefit Options, benefits are paid from employee contributions, as applicable, and from the general assets of American Airlines, Inc. The Voluntary Long-Term Care Program is a fully insured benefit that is paid entirely with employee contributions.

Plan Document

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

You can request a copy of the Plan documents by contacting:
American Airlines Benefits Service Center
Dept. 00749

P.O. Box 64116
The Woodlands, TX 77387-4116
Phone: 1-888-860-6178

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

Future of the Plan

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

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

Limitation on Assignment

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

Required Benefit Notices

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

Group Health Plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., your physician, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Pre-Certification. For information on Pre-Certification, contact your Plan Administrator.

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

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

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

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. 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.flmedicaidtprecovery.com/flmedicaidtprecovery.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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
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: KIHIPPI.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov 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

<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP

<p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</p> <p>Phone: 1-800-692-7462</p> <p>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)</p> <p>CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>Website: http://www.eohhs.ri.gov/</p> <p>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: https://www.scdhhs.gov</p> <p>Phone: 1-888-549-0820</p>	<p>Website: http://dss.sd.gov</p> <p>Phone: 1-888-828-0059</p>
TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services</p> <p>Phone: 1-800-440-0493</p>	<p>Utah's Premium Partnership for Health Insurance (UPP)</p> <p>Website: https://medicaid.utah.gov/upp/</p> <p>Email: upp@utah.gov</p> <p>Phone: 1-888-222-2542</p> <p>Adult Expansion Website: https://medicaid.utah.gov/expansion/</p> <p>Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/</p> <p>CHIP Website: https://chip.utah.gov/</p>
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access</p> <p>Phone: 1-800-250-8427</p>	<p>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</p> <p>Medicaid/CHIP Phone: 1-800-432-5924</p>
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
<p>Website: https://www.hca.wa.gov/</p> <p>Phone: 1-800-562-3022</p>	<p>Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/</p> <p>Medicaid Phone: 304-558-1700</p> <p>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
<p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</p> <p>Phone: 1-800-362-3002</p>	<p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</p> <p>Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human
Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

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

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report nine (9) months after the end of the plan year or two (2) months after the SAR is due (if an extension has been granted by the IRS).

Continue Group Health Plan Coverage

- Continue group health coverage for yourself, Spouse or eligible Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible 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 plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court.

If it should happen that the plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For general information contact:

American Airlines Benefits Service Center

DEPT 00749

P.O. Box 64116

The Woodlands, TX 77387-4116

1-888-860-6178

Your Employment

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

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

Glossary

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

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

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

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

- 2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- 3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Claims Administrators — The third-party organizations with which American Airlines, Inc. maintains contracts to maintain provider networks, and adjudicate claims for American Airlines, Inc. PPO Plan participants.

Claims Fiduciaries — The parties designated by American Airlines, Inc. to make initial claims determinations, including review of claims appeals for benefits under the Plan. The decision of the applicable claims fiduciary upon review of claims appeals is final and binding.

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

Company — American Airlines, Inc.

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

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

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

Co-pay/Co-payment — The fixed amount you pay up front for certain services covered under the Plan.

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

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

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

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

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

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

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

Experimental/Investigational Services — Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, procedures, drug therapies, medications or devices that at the time the health care providers and Claims Administrators make a treatment/coverage/claims determination, are: not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use; not identified in the American Hospital Formulary Service or the United States Pharmacopoeia of Dispensing Information as appropriate for the proposed use; not subject to review and approval by any institutional review board for the proposed use (devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or not the subject of an ongoing Clinical Trial and meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight. If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the health care providers and Claims Administrator may, at their discretion, consider an otherwise Experimental or Investigational Service to be a [Covered Health Service](#) for that Sickness or condition. Prior to such consideration, it must be determined that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

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

In-Network — Refers to benefits and services you receive from doctors, dentists, hospitals, pharmacies, and other service providers that contract with the Claims Administrators.

Generally, your benefits under the Plan are higher (and your out-of-pocket expenses lower) when you use In-Network services.

Life Event — Certain circumstances or changes that occur during your life that allows you or your Dependents to make specific changes in coverage options outside the annual enrollment period. The Internal Revenue Service dictates what constitutes Life Events.

Life-Threatening Condition — Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

Medical Benefit Options – The medical coverage offered by the Company to eligible employees to provide benefits for eligible employees and covered Dependents in the event of an illness or injury. The Company offers the following Medical Benefit Options:

- PPO (two options for eligible active employees and three options for eligible retired employees)
- OUT-OF-AREA (two options for eligible active employees and three options for eligible retirees employees))

Medicare — The hospital and medical insurance program sponsored by the United States Government.

Medical Necessity — A medical or dental service or supply required for the diagnosis or treatment of a non-occupational, accidental injury, illness or pregnancy. The benefit option determines Medical Necessity based on and consistent with standards approved by the Claims Administrator’s medical personnel. To be Medically Necessary, a service, supply, or inpatient confinement must meet all of the following criteria:

- Ordered by a Physician (although a Physician’s order alone does not make a service Medically Necessary)
- Appropriate (commonly and customarily recognized throughout the Physician’s profession) and required for the treatment and diagnosis of the illness, injury or pregnancy
- Unavailable in a less intensive or more appropriate place of service, diagnosis, or treatment that could have been provided instead of the service, supply or treatment
- Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications
- Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health for a Life-Threatening or seriously debilitating condition. The treatment must be

considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications.

A service or supply to prevent illness must meet the above conditions to be considered Medically Necessary. Services that are educational, Experimental or Investigational, or Unproven in nature are not considered to be Medically Necessary unless otherwise covered by the Plan.

In the case of inpatient confinement, the length of confinement and hospital services and supplies are considered Medically Necessary to the extent the Claims Administrator determines them to be:

- Appropriate for the treatment of the illness or injury
- Not for the patient's scholastic education, vocation or training
- Not custodial in nature
- A determination that a service or supply is not Medically Necessary may apply to all or part of the service or supply

Mental Health/Chemical Dependency Condition — A nervous, mental, or chemical dependency condition that is (i) a clinically significant behavioral or psychological syndrome or pattern; (ii) associated with present distress or substantial or material impairment of the patient's ability to function in one or more major life activities (for example, employment); (iii) not merely an expectable response to a particular event (for example, the death of a loved one); (iv) listed as an Axis I disorder (other than a V Code of the DSM-IV, or its replacement).

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

Out-of-Area — Refers to medical, mental health and chemical dependency, and dental care received through the Out-of-Area Medical Benefit Option of the American Airlines, Inc. PPO Plan. Out-of-area is different from Out-of-Network. You are eligible to participate in the Out-of-Area medical program only if you live outside a PPO Plan network service area as defined by the Claims Administrator.

Out-of-Network — Refers to benefits and services received from doctors, dentists, hospitals, and other service providers that are not part of the medical and dental Claims Administrator's networks. The Plan includes Out-of-Network benefits for medical, and mental health and chemical dependency. Prescription drugs are available In-Network only. Generally, your benefits under the Plan are lower (and your Out-of-Pocket expenses higher) when you use Out-of-Network services.

Out-of-Pocket Maximum — An annual individual or family limit on the amount you spend out of your own pocket for expenses that the Plan does not cover in full, including Deductibles but excluding Co-payments.

Pharmacy Benefit Manager (PBM) — The prescription drug benefits provider and Claims Administrator for the Medical Benefit Options prescription drug benefits.

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

Plan Administrator — In its role as Plan Administrator, American Airlines maintains sole responsibility of the American Airlines, Inc. PPO 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.

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

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

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

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

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

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

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

Reasonable and customary fee limits can also be impacted by the number of services or procedures you receive during one medical treatment. Under the Plan, when reviewing a claim for reasonable and customary fee determination, the Claims Administrator looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (often referred to as “coding fragmentation” or “unbundling”) usually results in higher physician’s charges that if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

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

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

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

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

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