

# ***Retiree Benefits Guide***

## ***(For Retirees who retired prior to 11/01/12)***

American Airlines provides retirees with a comprehensive benefits package designed to help you meet the health and insurance needs of you and your eligible dependents.

To help you make the most of your retiree benefits, this Guide describes the major provisions of the benefits and explains how you can use them effectively.

The benefits described in this Guide include:

- Retiree Medical Benefit Options, specifically:
  - Retiree Standard Medical (RSM) Option
  - Retiree Value Plus Option
  - Retiree HMO (RHMO)
- Supplemental Medical Plan
- Medicare Coverage
- Retiree Life Insurance Benefit
- Long-Term Care Insurance

### **Additional Important Information**

In addition to the descriptions of the benefits provided and how each plan works, this Summary Plan Description also provides general and plan specific information in the:

- About this Guide section
- Retiree Eligibility section
- Retiree Enrollment section
- Life Events section
- Additional Rules section
- Plan Administration section
- Reference Information section, including:
  - A Contacts list
  - The Glossary
  - The Archives of older versions of the Guide



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# About This Guide

This Health & Life Benefits Guide for Retirees (“Guide”) contains the legal plan documents and the summary plan descriptions (SPDs) for the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries and the American Airlines, Inc. Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries and the Long Term Care Insurance Plan for Employees of participating AMR Corporation Subsidiaries (the “Plans”) as it pertains to retiree medical, supplemental medical, long term care and life insurance coverages.

The provisions of this Guide apply to eligible retirees (who retired prior to 11/01/2012) of the participating subsidiaries of AMR Corporation (who were on the United States payroll), spouses, dependents and surviving spouses who are covered under the benefit program for Retirees.

The Company reserves the right to modify, amend or terminate any of the Plans, any program described in this Guide, or any part thereof, at its sole discretion. Changes to the Plans generally will not affect claims for services or supplies received before the change.

Only the Pension Benefits Administration Committee (PBAC) is authorized to change the Plans. From time to time, you may receive updated information concerning changes to the Plans. Neither this Guide nor updated materials are contracts or assurances of compensation, continued employment or benefits of any kind.

In the event of a conflict between the Plans’ provisions contained in this Guide and the provisions contained in any insurance policy(ies) (for fully insured program(s)), the insurance policy (for fully insured program(s)) shall govern in all cases with respect to retirees covered by such insurance policy(ies).

## Important

An adversary proceeding between American Airlines and the Retiree Committee appointed by the Bankruptcy Court (representing retirees who commenced retiree medical benefits prior to November 1, 2012) is underway in the Bankruptcy Court, the outcome of which may result in changes to the Plan and/or benefit programs for retirees. The Company reserves the right to modify, amend or terminate any of the Plans, any program described in the Health & Life Benefits Guide (Guide) for Retirees, or any part thereof, at its sole discretion. Changes to the Plans generally will not affect claims for services or supplies received before the change. If it becomes necessary to change the Plan(s) or any programs associated with the Plan(s), we will notify you promptly.

### **Voluntary Offerings Provided by American Benefits Consulting (ABC)**

American makes accessible for employees the opportunity to enroll in: Hyatt Legal, Group Homeowners’ and Automobile Insurance, Veterinary Pet Insurance, LifeLock, Group Accident and Critical Illness Insurance at a discounted rate. At the request of the employee, American facilitates the post-tax payroll deductions to pay for these voluntary offerings. American does not assume any plan sponsorship for the Voluntary Offerings provided by American Benefits Consulting. The details of these offerings are not included or governed in this Employee Benefits Guide (Summary Plan Descriptions). Please go to [www.AAaddedbenefits.com](http://www.AAaddedbenefits.com) or call 1-855-550-0706 to contact ABC directly for information about these benefits.

# Retiree Eligibility

You may enroll yourself and request to enroll your eligible dependents in the Retiree Medical Benefit effective the first day immediately following your last day on active payroll.

- Here are the Retiree Medical Benefit options:
  - Retiree Standard Medical Option for under age 65 retirees and their dependents
  - Retiree Standard Medical Option (for age 65 and over retirees and their spouses/DPs) - Only for Pilot, Flight Attendant and TWU-Represented employees who retired on or before October 31, 2012. Only for Agents, Representative, Planner employees who retired on or before December 31, 2010.
  - Retiree Value Plus Option (for under age 65 retirees and their dependents)
  - Retiree HMO (for under age 65 retirees and their dependents who in Puerto Rico)
- Spouses, common law spouses, Company-recognized Domestic Partners and dependent children are eligible for coverage in the under 65 Retiree Medical Benefit.
- You must provide [Proof of Eligibility](#) if you are adding a new dependent to coverage.

## Determination of Eligibility - Retiree Value Plus Option and RHMO

You are eligible for the Retiree Value Plus Option only if you reside where a network administrator offers a network. You are eligible for the Retiree HMO (RHMO) only if you reside in Puerto Rico.

Your eligibility is determined by the ZIP code of your Jetnet alternate address on record. Jetnet allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence). Since many retirees maintain more than one residence, you may list both addresses in Jetnet; however, your alternate address determines your eligibility. If you do not have an alternate address listed in Jetnet, your eligibility is based on your permanent address.

If you do not reside where your network/claims administrator or RHMO offers a network, you will be offered the Retiree Standard Medical Option.

## In This Section

- Retiree Medical Benefit Eligibility
  - Retiree Medical Eligibility Requirements
  - Additional Eligibility Requirements
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- Retirees Married to an Active Employee or Other American Airlines Retiree
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  - Proof of Eligibility
  - Dependents of Deceased Retirees
  - Common Law Spouses and Company-recognized Domestic Partners
  - Parents and Grandchildren
- Ineligibility

## Retiree Medical Benefit Eligibility

### Retirements on or before October 31, 2012

\*An adversary proceeding between American Airlines and the Retiree Committee appointed by the Bankruptcy Court (representing retirees who commenced retiree medical benefits prior to November 1, 2012) is underway in the Bankruptcy Court, the outcome of which may result in changes to the Plan and/or benefit programs for retirees. The Company reserves the right to modify, amend or terminate any of the Plans, any program described in the Health & Life Benefits Guide (Guide) for Retirees, or any part thereof, at its sole discretion. Changes to the Plans generally will not affect claims for services or supplies received before the change. If it becomes necessary to change the Plan(s) or any programs associated with the Plan(s), we will notify you promptly.

### **Pilot/ Flight Engineer/ Flight Attendant/ TWU-Represented Retirees who retired on or before October 31, 2012, and Agent/Representative/Planner Retirees who retired on or before December 31, 2010:**

You may enroll yourself and request enrollment for your eligible dependents in the Retiree Medical Benefit effective the first day of the month following your retirement date, if you meet the eligibility requirements described in this Retiree Eligibility section of this Retiree Benefits Guide.

When you met the eligibility requirements and retired, your Retiree Medical Benefit coverage and Retiree Life Insurance coverage became effective. In most cases, when you retired directly from active payroll, coverage began automatically for the Retiree Standard Medical option; however, in some cases it is necessary to contact HR Services to activate your coverage.

If you elected to enroll in the Retiree Value Plus, you enrolled via the [Benefits Service Center](#) and you must timely pay the required ongoing monthly contributions to begin and maintain this coverage.

If you have other coverage available (such as your spouse's employee coverage) and wanted to defer your entry into the Retiree Medical Benefit, you must have contacted HR Services. For all workgroups except Pilots, you may defer entry only once.

If you are in this category of retirees, you ARE eligible for the Retiree Life Insurance Benefit.\*

**Retirements on or before October 31, 2012**

\*An adversary proceeding between American Airlines and the Retiree Committee appointed by the Bankruptcy Court (representing retirees who commenced retiree medical benefits prior to November 1, 2012) is underway in the Bankruptcy Court, the outcome of which may result in changes to the Plan and/or benefit programs for retirees. The Company reserves the right to modify, amend or terminate any of the Plans, any program described in the Health & Life Benefits Guide (Guide) for Retirees, or any part thereof, at its sole discretion. Changes to the Plans generally will not affect claims for services or supplies received before the change. If it becomes necessary to change the Plan(s) or any programs associated with the Plan(s), we will notify you promptly.

**Agent/Representative/Planner Retirees Pre-65 who retired on or after January 1, 2011 but on or before October 31, 2012, and Officers, Management/Specialists, Support Staff Retirees Pre-65 who retired on or before October 31, 2012:**

If you meet your eligibility requirements, you must contact HR Services to initiate your Retiree Medical Benefit. You will be required to timely pay the required ongoing contributions.

You enroll via the [Benefits Service Center](#) and to activate your coverage and make timely payment of the required contributions for coverage.

If you have other coverage available (such as your spouse's employee coverage) and want to defer your entry into the Retiree Medical Benefit, you must contact HR Services. You may defer entry only once.

If you are in this category of retirees, you ARE eligible for the Retiree Life Insurance Benefit.\*

**Agent/Representative/Planner Retirees age 65 or over who retire on or after January 1, 2011 but on or before October 31, 2012, and Officers/Management/Specialists/Support Staff Retirees age 65 or over who retired on or before October 31, 2012:**

You are not eligible for Company-sponsored Retiree Medical Benefits. However, you may be eligible for fully insured Medicare Supplement insurance that you can purchase directly from UnitedHealthcare. See the "[Contact Information](#)" under the Reference Information section for information regarding UnitedHealthcare Medicare Supplement plans. If you are in this category of retirees, you ARE eligible for the Retiree Life Insurance Benefit.\*

**Retirements on or before October 31, 2012**

\*An adversary proceeding between American Airlines and the Retiree Committee appointed by the Bankruptcy Court (representing retirees who commenced retiree medical benefits prior to November 1, 2012) is underway in the Bankruptcy Court, the outcome of which may result in changes to the Plan and/or benefit programs for retirees. The Company reserves the right to modify, amend or terminate any of the Plans, any program described in the Health & Life Benefits Guide (Guide) for Retirees, or any part thereof, at its sole discretion. Changes to the Plans generally will not affect claims for services or supplies received before the change. If it becomes necessary to change the Plan(s) or any programs associated with the Plan(s), we will notify you promptly.

**Retirees who live in Puerto Rico, are Pre-65, and retired on or before October 31, 2012:**

In addition to all requirements stated above, if you are eligible for and wish to enroll in the Retiree HMO, you must actively enroll via the [Benefits Service Center](#). You must timely pay the required ongoing monthly contributions to begin and maintain this coverage.

If you are in this category of retirees, you ARE eligible for the Retiree Life Insurance Benefit. \*

## Retiree Medical Eligibility Requirements

**If you are a TWU-Represented employee retired on or before October 31, 2012 or Flight Attendant retired on or after January 1, 2002 but on or before October 31, 2012, then...**

### ***Benefits Begin When You Retire or Terminate If You...***

- Are at least age 55, and
- Have at least 10 years of Company seniority, and
- Have continuously prefunded for at least 10 consecutive years immediately preceding retirement or you came from a workgroup that did not require prefunding or you began prefunding when first eligible and prefunded until you retired and you meet all the other criteria for retiree medical coverage (age and seniority).
- If you are disabled, you must:
  - Have at least 10 years of Company seniority and:
  - Have applied for Social Security disability benefits before the end of your one-year sick leave, and
  - Have been approved to receive Social Security disability benefits with an effective date that falls during your one-year sick leave and
  - Have continuously prefunded since you were first eligible.

### ***Benefits May Also Begin at Age 55 or a Later Date If You...***

- Have at least 15 years of Company seniority, and
- Are between ages 50 and 55 when employment ends, and
- Have qualified to leave the Company under the 50 to 55 Rule on or prior to October 31, 2012, and
- Meet all the other criteria for retiree medical coverage (age and seniority).

***If you are a Flight Attendant who was hired after January 1, 2002 (or a former TWA LLC employee who became an American Airlines, Inc. employee on January 1, 2002) but retired on or before October 31, 2012, you must have:***

- Continuously prefunded for at least the ten (10) years immediately preceding retirement in order to receive the Retiree Medical Benefit.
- Flight Attendants (and former TWA LLC employees who became American Airlines, Inc. employees on January 1, 2002) who retired on or prior to October 31, 2012, who have prefunded continuously since January 1, 2002, (or since first eligible to prefund) and who meet all the other criteria for retiree medical coverage (age and seniority).

**If you are a Flight Attendant who terminated employment under Article 30 on or before September 12, 2012, then...**

### ***Benefits Begin When You Terminate If You...***

- Have at least 20 years of Company seniority, and
- Terminate employment under Article 30 between ages 45 and 55.
- You qualify for \$20,000 of maximum medical benefit in the Retiree Standard Medical Option coverage.



**If you are a Flight Attendant who terminates under Article 30 after September 12, 2012, you will not be eligible for retiree medical benefits.**

**If you are a Pilot who retires on or before October 31, 2012, then...**

***Benefits Begin When You Retire or Terminate, and May Also Begin at Age 50 or a Later Date If You...***

- Have at least 10 years of Company seniority and are age 50 or over.
- Benefits May Begin If You are Disabled and are Receiving:
  - Disability benefits from the Pilot Retirement Benefits Program.

**If you are an Officer, Management/Specialist, Support Staff retiree under age 65, then...**

***Benefits Begin When You Retire or Terminate If You...***

- Are at least age 55, and
- Have at least 10 years of Company seniority.
- If you are disabled, you must:
  - Have at least 10 years of Company seniority, and
  - Have applied for Social Security disability benefits before the end of your one-year sick leave, and
  - Have been approved to receive Social Security disability benefits with an effective date that falls during your one-year sick leave, and
  - Make your first payment by the due date (or before the end of the 30-day grace period allowed for payment).

***Benefits May Also Begin at Age 55 and Up to Attaining Age 65 If You...***

- Have at least 15 years of Company seniority, and
- Are between ages 50 and 55 when employment ends, and
- Have qualified to leave the Company under the 50 to 55 Rule, and
- Make your first payment by the due date (or before the end of the 30-day grace period allowed for payment).

**If you are an Officer, Management/ Specialist, Support Staff retiree age 65 or over, then...**

Retiree medical benefits terminate at age 65. There is no retiree medical coverage offered for Officer, Management/Specialist or Support Staff retirees age 65 or over.

**If you are an Officer, Management/ Specialist, Support Staff hired on or after January 1, 2010, you are eligible for retiree medical benefits if you...**

- Have at least 10 years of Company seniority, and
- Are at least 55 years of age.

You will have access to retiree medical benefits, but you must pay 100% of the ongoing monthly contribution costs for coverage (the Company does not subsidize



any portion of your retiree medical contributions). You must timely pay the required ongoing monthly contributions during your retirement.

**If you are an Agent, Representative or Planner retiree under age 65 and retire on or after January 1, 2011, then...**

***Benefits Begin When You Retire or Terminate If You.***

- Are at least age 55, and
- Have at least 10 years of Company seniority at American Airlines or an AMR subsidiary that is eligible to participate in the Retiree Medical Benefit, and
- Make your first payment by the due date (or before the end of the 30-day grace period allowed for payment).
  - If you are disabled, you must:
    - Have at least 10 years of Company seniority, and
    - Have applied for Social Security disability benefits before the end of your one-year sick leave, and
    - Have been approved to receive Social Security disability benefits with an effective date that falls during your one-year sick leave.

**If you are an Agent, Representative or Planner retiree age 65 or over and retire on or after January 1, 2011, then...**

Retiree medical benefits terminate at age 65. There is no retiree medical coverage offered for Agent, Representative or Planner retirees age 65 or over.

**If you are an Agent, Representative or Planner and retired on or before December 31, 2010, then...**

***Benefits Begin When You Retire or Terminate If You...***

- Are at least age 55
- Have at least 10 years of Company seniority, and
- Have continuously prefunded for at least 10 consecutive years immediately preceding retirement or you came from a workgroup that did not require prefunding or you began prefunding when first eligible and prefunded until you retired and you meet all the other criteria for retiree medical coverage (age and seniority).
- If are disabled, you must:
  - Have at least 10 years of Company seniority, and
  - Have applied for Social Security disability benefits before the end of your sick leave, and
  - Have been approved to receive Social Security disability benefits with an effective date that falls during your one-year sick leave, and
  - Have continuously prefunded since you were first eligible.

**Prefunding Applicable to TWU-Represented retiree or Flight Attendant retirees retiring after January 1, 2002 but on or before October 31, 2012.**

If you are a TWU-Represented retiree or Flight Attendant retiring after January 1, 2002 or a former TWA LLC employee who became an American Airlines, Inc. employee on January 1, 2002, and you retire on or before October 31, 2012, you are only eligible for the Retiree Medical Benefit if you have prefunded. The rate you paid for prefunding was based on your date of hire and the age at which you began prefunding, as explained in the prefunding solicitation package you receive when you are first eligible to prefund.

Your contributions accumulate in a trust fund to pay medical benefits for prefunding participants. (There are three separate trust accounts — one for employees represented by the TWU-Represented, one for employees represented by APFA and one for non-union employees.) If you retire on or before October 31, 2012, you must have prefunded for at least 10 consecutive years immediately before your retirement. If you previously worked in a work group that did not require prefunding and you began to prefund when you were first eligible and continue prefunding until your retirement and you meet the other age and seniority criteria, you will qualify for Retiree Medical Benefit coverage.

For more information about prefunded and postfunded benefits, see “[Paying for Coverage](#)” in the Retiree Enrollment section.

**Prefunding Applicable to Agent/Representative/Planner retired on or after January 1, 2002 but before January 1, 2011**

If you are an Agent/Representative/Planner retiring on or after January 1, 2002 and before January 1, 2011, or are a former TWA LLC employee who became an American Airlines, Inc. employee on January 1, 2002, you are only eligible for the Retiree Medical Benefit if you have prefunded. The rate you paid for prefunding was based on your date of hire and the age at which you began prefunding, as explained in the prefunding solicitation package you receive when first eligible to prefund.

Your contributions accumulate in a trust fund to pay medical benefits for prefunding participants. (There are three separate trust accounts — one for employees represented by the TWU-Represented, one for employees represented by APFA and one for non-union employees.) If you retire on or after January 1, 2002 but before January 1, 2011, you must have prefunded for at least the 10 consecutive years immediately before your retirement or since you were first eligible to prefund. If you previously worked in a workgroup that did not require prefunding and you began to prefund when you were first eligible and continue prefunding until your retirement and you meet the other age and seniority criteria, you qualify for Retiree Medical Benefit coverage.

For more information about prefunded and postfunded benefits, see “[Paying for Coverage](#)” in the Retiree Enrollment section.

## **Prefunding for Employees with Banked Sick Hours who retire on or prior to October 31, 2012**

If you are retiring and receive and bank sick hours, you may use those credits to apply towards prefunding your retiree medical benefits. For more information, see the Policy section on the eHR Center.

## **Postfunded Retiree Medical Benefit for Agent, Representative and Planner Employees — Under Age 65 ONLY Retiring on or after January 1, 2011**

Agent, Representative and Planner employees no longer prefund Retiree Medical Benefit coverage. These retirees fund their Retiree Medical Benefit through required monthly ongoing contribution payments during their retirement.

Retirees must post-fund (pay during your retirement) in order to maintain Retiree Medical Benefit coverage. Your first payment is due when you enter the Retiree Medical Benefit. Your timely payment must be received before your Retiree Medical Benefit coverage will begin.

You may enter the Retiree Medical Benefit when you first become eligible or you may defer entry to a later date, if you have other coverage. To enter the Retiree Medical Benefit, you must complete the applicable enrollment form (referenced earlier in this section) and return it to HR Services, along with your first full contribution payment. Once you have entered the Retiree Medical Benefit, if you stop making monthly contribution payments at any time or if you fail to make your required monthly contribution payment by the due date (or within the 30-day grace period allowed for payment) your Retiree Medical Benefit will terminate and you will not be permitted to re-enter the Retiree Medical Benefit. See the section [“Retiree Participants Who Elect to Move Between the RSM Option and Retiree Value Plus Option”](#) under “Maximum Medical Benefit” in the Retiree Medical Benefits Options Overview section.

You may defer entry in the Retiree Medical Benefit to a later date, if you have other coverage (e.g., if you are covered as a dependent under your spouse’s active medical coverage or you obtain active medical coverage from another employer).

For more information about prefunded and postfunded benefits, see [“Paying for Coverage”](#) in the Retiree Enrollment section.

## **Postfunded Retiree Medical Benefit for Officers, Management/Specialists and Support Staff Employees — Under Age 65 ONLY**

Officer, Management/Specialist and Support Staff employees no longer prefund Retiree Medical Benefit coverage. These retirees fund their Retiree Medical Benefit through required monthly ongoing contribution payments during their retirement.

Retirees must post-fund (pay during your retirement) in order to maintain Retiree Medical Benefit coverage. Your first payment is due when you enter the Retiree Medical Benefit. Your timely payment must be received before your Retiree Medical Benefit coverage will begin.

You may enter the Retiree Medical Benefit when you first become eligible or you may defer entry to a later date, if you have other coverage. To enter the Retiree Medical Benefit, you must complete the enrollment and make your first contribution payment. Once you have entered the Retiree Medical Benefit, if you stop making monthly contribution payments at any time or if you fail to make your required monthly contribution payment by the due date (or within the 30-day grace period allowed for payment) your Retiree Medical Benefit will terminate and you will not be permitted to re-enter the Retiree Medical Benefit. See the section [“Retiree Participants Who Elect to Move Between the RSM Option and Retiree Value Plus Option”](#) under “Maximum Medical Benefit” in the Retiree Medical Benefits Options Overview section.

You may defer entry in the Retiree Medical Benefit to a later date, if you have other coverage (e.g., if you are covered as a dependent under your spouse’s active medical coverage or you obtain active medical coverage from another employer).

For more information about prefunded and postfunded benefits, see [“Paying for Coverage”](#) in the Retiree Enrollment section.

## Additional Eligibility Requirements

### Retiree Value Plus Eligibility

In addition to meeting the eligibility requirements for the Retiree Medical Benefit coverage, if you voluntarily elect to participate in the Retiree Value Plus Option, you must also meet all of the following requirements:

- Meet all other retiree eligibility requirements, as defined in the provisions of the Retiree Medical Benefits
- Be under age 65
- Have not reached your maximum medical benefit under a Company-sponsored medical benefit (this includes all medical benefits for active employees and the Retiree Standard Medical Option)
- Reside where your network/claims administrator offers a network (your eligibility is based upon the ZIP code of your alternate address, as reflected in Jetnet)
- Did not terminate employment under Article 30 (this applies to Flight Attendants only)
- Did not elect to waive or elect to voluntarily and permanently opt out of the Retiree Medical Benefit
- Did not retire under the 1995 SVEOP (Special Voluntary Early Out Program)
- Are not a TWA retiree

You are eligible for the Retiree Value Plus Option only if you reside where a network/claims administrator offers a network. Your eligibility is determined by the ZIP code of your Jetnet alternate address on record. Jetnet allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence). Since many retirees maintain more than one residence, you may list both addresses in Jetnet; however, your alternate address determines your eligibility. If you do not have an alternate address listed in Jetnet, your eligibility is based on your permanent address.

If you do not reside where your network/claims administrator offers a network, you will be offered the Retiree Standard Medical Option.

### **RHMO Eligibility (Puerto Rico retirees under age 65 only)**

You are eligible for the RHMO Option only if you reside in Puerto Rico. Your eligibility is determined by the ZIP code of your Jetnet alternate address. Jetnet allows you to list two addresses — a Permanent Address (for tax purposes or for your permanent residence) and an Alternate Address (for a P.O. Box or street address other than your permanent residence). Since many retirees maintain more than one residence, you may list both addresses in Jetnet; however, your Alternate Address determines your geographical eligibility for the RHMO Option. If you do not have an Alternate Address listed in Jetnet, your eligibility is based on your Permanent Address.

In addition to meeting all other eligibility requirements for the Retiree Medical Benefit coverage, if you voluntarily elect to participate in the Retiree HMO (RHMO) Option, you must also meet all of the following requirements:

- Meet all other retiree eligibility requirements, as defined in the provisions of the Retiree Medical Benefits
- Be under age 65
- Have not reached your maximum medical benefit under a Company-sponsored medical benefit (this includes all medical benefits for active employees and the RHMO)
- Reside where the RHMO offers a network (your eligibility is based upon the ZIP code of your alternate address, as reflected in Jetnet)
- Did not terminate employment under Article 30 (this applies to Flight Attendants only)
- Did not elect to waive or elect to voluntarily and permanently opt out of the Retiree Medical Benefit
- Did not retire under the 1995 SVEOP (Special Voluntary Early Out Program)
- Are not a TWA retiree

### **Pilot, Flight Attendant and TWU-Represented Retirees, under age 65, retiring on or before October 31, 2012**

- If you are eligible for Retiree Medical Benefits, you may cover your spouse or Company-recognized Domestic Partner; however your spouse or Company-recognized Domestic Partner must be covered under the same Retiree Medical Benefit option that you elect.
- If your spouse or Company-recognized Domestic Partner is an active American Airlines or American Eagle Employee: he or she may complete a Life Event via the Benefits page of Jetnet within 60 days following your change in coverage to add you as a dependent under the active medical benefits. You must take action to defer your entry into the Retiree Medical Benefit (contact HR Services).
- If your spouse or Company-recognized Domestic Partner is a retiree of a different workgroup: you must each maintain your own coverage.

**Pilot, Flight Attendant, and TWU-Represented Retirees age 65 or over, retiring on or before October 31, 2012**

- If you are eligible for Retiree Medical Benefits, you may cover your spouse or Company- recognized Domestic Partner; however your spouse or Company-recognized Domestic Partner must be covered under the same Retiree Medical Benefit option that you elect.
- If your spouse or Company-recognized Domestic Partner is an active American Airlines or American Eagle Employee: He or she may complete a Life Event via the Benefits page of Jetnet within 30 days following your change in coverage to add you as a dependent under the active medical benefits. You must take action to defer your entry into the Retiree Medical Benefit (contact HR Services).
- If your spouse or Company-recognized Domestic Partner is a retiree of a different workgroup: You must each maintain your own coverage.

**Agent, Representative and Planner Retirees Who Retired On or Before December 31, 2010**

- If you are eligible for Retiree Medical Benefits, you may cover your spouse or Company- recognized Domestic Partner; however your spouse or Company-recognized Domestic Partner must be covered under the same Retiree Medical Benefit option that you elect.
- If your spouse or Company-recognized Domestic Partner is an active American Airlines or American Eagle employee: He or she may complete a Life Event via the Benefits page of Jetnet within 30 days following your change in coverage to add you as a dependent under the active medical benefits. You must take action to defer your entry into the Retiree Medical Benefit (contact HR Services).
- If your spouse or Company-recognized Domestic Partner is a retiree of a different workgroup: You must each maintain your own coverage.

**Agent, Representative and Planner Retirees Age 65 or Over Who Retire On or After January 1, 2011**

There is no retiree medical coverage offered for Agents, Representatives and Planner retirees age 65 or over.

- If your spouse or Company-recognized Domestic Partner is an active American Airlines or American Eagle employee: He or she may complete a Life Event via the Benefits page of Jetnet within 30 days following your change in coverage to add you as a dependent under the active medical benefits.
- If your spouse or Company-recognized Domestic Partner is a retiree of a different workgroup: You are eligible to become a dependent under your spouse's or Company- recognized Domestic Partner's retiree medical coverage.



**Spouses and Company-recognized Domestic Partners of Agents, Representative and Planner Staff Retirees Age 65 or Over Who Retire On or After January 1, 2011**

There is no retiree medical coverage offered for Agents, Representatives and Planner retirees and their spouses or Company-recognized Domestic Partners age 65 or over who retire on or after January 1, 2011.

- If your spouse or Company-recognized Domestic Partner is age 65 or over when you reach age 65: Your spouse or partner will lose his or her coverage under the Retiree Medical Benefit when you reach age 65.
- If your spouse or Company-recognized Domestic Partner is under age 65 when you reach age 65: Your spouse or Company-recognized Domestic Partner will lose his or her coverage under the Retiree Medical Benefit when you reach age 65. Your spouse is then eligible for continuation of retiree medical coverage under COBRA for either 36 months or when he or she becomes Medicare eligible, whichever first occurs.
- If your spouse or Company-recognized Domestic Partner is age 65 or over or reaches age 65 before you do: He or she is or will be eligible for Medicare and loses coverage under the Retiree Medical Benefit. However, they may be eligible to purchase Medicare Supplement Insurance from UnitedHealthcare.

**Officers, Management/Specialists and Support Staff Retirees Age 65 or Over ONLY**

There is no retiree medical coverage offered for Officer, Management/ Specialist or Support Staff retirees age 65 or over.

- If your spouse or Company-recognized Domestic Partner is an active American Airlines or American Eagle employee: He or she may complete a Life Event via the Benefits page of Jetnet within 30 days following your change in coverage to add you as a dependent under the active medical benefits.
- If your spouse or Company-recognized Domestic Partner is a retiree of a different workgroup: You are eligible to become a dependent under your spouse's or Company- recognized Domestic Partner's retiree medical coverage.

**Spouses and Company-recognized Domestic Partners of Officers, Management/Specialists and Support Staff Retirees Age 65 or Over ONLY**

There is no retiree medical coverage offered for Officer, Management/Specialist or Support Staff retirees and their spouses or Company-recognized Domestic Partners age 65 or over.

- If your spouse or Company-recognized Domestic Partner is age 65 or over when you reach age 65: Your spouse or partner will lose his or her coverage under the Retiree Medical Benefit when you reach age 65.
- If your Spouse or Company-recognized Domestic Partner is under age 65 when you reach age 65: Your spouse or Company-recognized Domestic Partner will lose his or her coverage under the Retiree Medical Benefit when you reach age 65. Your spouse is then eligible for continuation of retiree medical coverage

under COBRA for either 36 months or when he or she becomes Medicare eligible, whichever first occurs.

- If your spouse or Company-recognized Domestic Partner is age 65 or over or reaches age 65 before you do: He or she is or will be eligible for Medicare and loses coverage under the Retiree Medical Benefit. However, they may be eligible to purchase Medicare Supplement Insurance from UnitedHealthcare.

## Retiree Life Insurance Eligibility

If you retired on or before October 31, 2012, you are eligible for Retiree Life Insurance even if you didn't prefund Retiree Medical Benefit coverage or if you elect not to pay for postfunded Retiree Medical Benefit coverage. Dependents are not eligible for Retiree Life Insurance. See the [Retiree Life Insurance Benefit section](#) for more information.



## Retirees Married to an Active Employee or Other American Airlines Retiree

**If you retired on or before October 31, 2012 and are married to an active employee:**

You may be covered as a dependent if you are married to an active employee of American Airlines or a participating AMR Corporation subsidiary. You are allowed to defer entry only once.

As your active spouse's dependent, your medical maximum benefit will be unlimited.

If you lose your dependent status (because you divorce, are subject to a protective order, end a Company-recognized Domestic Partner relationship or the active employee dies) or when the active employee retires or terminates employment, you will begin the retiree coverage you previously deferred. You must contact HR Services to activate your Retiree Medical Benefit coverage.

Note: If you are a retiree of the Officer Management/Specialist and Support Staff workgroup, this only applies if you are under age 65. If you are a retiree of the Agent, Representative and Planner workgroup (and retired on or after January 1, 2011), this only applies if you are under age 65. If you are a retiree of the Pilot, Flight Attendant or TWU-Represented workgroup, and retired on or before October 31, 2012, this only applies if you are under age 65.

When both you and your spouse are retired, each of you must maintain your retiree coverage on an individual basis — that is, each of you has your own individual Retiree Medical Benefit coverage and you file your claims separately, just as you did as an active employee. By maintaining your Retiree Medical Benefit separately, the death of your spouse or a divorce will not jeopardize your eligibility for the Retiree Medical Benefit.

### **AA Retirees Married to AA Retirees of Participating AMR Corporation Subsidiaries**

If you and your spouse are each eligible for the Retiree Medical Benefit as retirees, you must each maintain your own individual Retiree Medical Benefit coverage. By maintaining your Retiree Medical Benefit separately, the death of your spouse or a divorce will not jeopardize your Retiree Medical Benefit eligibility.

If you are an Agent, Representative and Planner or Officer, Management/Specialist or Support Staff retiree, you cannot cover your spouse as a dependent unless your spouse is also an Agent, Representative and Planner or Officer, Management/Specialist or Support Staff retiree. If your spouse is not an Agent, Representative and Planner or Officer, Management/Specialist or Support Staff retiree, he or she is required to maintain his or own Retiree Medical Benefit, based on his or her workgroup.

If your spouse's workgroup does not offer Retiree Medical Benefit coverage or your spouse worked for a subsidiary and did not meet the eligibility requirements for the Retiree Medical Benefit, you may cover your spouse as a dependent under your Retiree Medical Benefit coverage.

Eligible dependent children: If both spouses are concurrently covered by the Retiree Medical Benefit, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year, unless the parents elect otherwise. Contact HR Services to make this adjustment. If one spouse is covered as an active employee under the Flexible Benefits Program, the benefit program for Pilots or the benefit program for Flight Attendants, the children are covered under the parent who is an active employee. Children cannot be covered under both parents' health benefits.

## Eligibility During Disability

If you become disabled after you have begun using your Retiree Medical Benefit, your eligibility is not affected by the disability. If you become disabled as an active employee, your eligibility for Retiree Medical Benefit depends on your workgroup. Effective April 1, 2011, employees who enter the Retiree Medical Benefit because of a Social Security Disability Award have the choice of selecting either the Retiree Standard Medical Option or the Retiree Value Plus Option or the Retiree HMO, if you are under age 65 and reside in Puerto Rico.

### **Agent, Representative and Planners and Officers, Management/Specialists, Support Staff, TWU-Represented employees and Flight Attendants:**

If you become disabled, you may be eligible to begin using your Retiree Standard Medical Option or Retiree Value Plus Option coverage (or the Retiree HMO, if you are under age 65 and reside in Puerto Rico) under certain conditions. After Company-sponsored health coverage ends, you may begin using your Retiree Standard Medical Option or Retiree Value Plus Option coverage (or the Retiree HMO, if you are under age 65 and reside in Puerto Rico) if you meet all of the following criteria:

- You have at least 10 years of Company seniority
- You are age 55 or over or have applied for Social Security disability benefits before the end of your one-year sick leave
- You were approved for Social Security disability benefits with an effective date that falls within your one-year sick leave
- You pay the appropriate payments for coverage

### **Pilots and Flight Engineers on disability beginning prior to February 1, 2004:**

You are eligible for Retiree Standard Medical Option or Retiree Value Plus Option coverage (or the Retiree HMO, if you are under age 65 and reside in Puerto Rico) if you qualify for a disability benefit from your pension plan and remain disabled.

### **Pilots with a date of disability on or after February 1, 2004:**

While you remain disabled and are receiving disability benefits from the Pilot Long Term Disability Plan, you may maintain the same health and welfare benefits you had while you were an active employee. At age 65, when Pilot LTD Plan benefits terminate, you may retire and enter the Retiree Medical Benefit if you retired on or before October 31, 2012. If you are 65 and retire on or after November 1, 2012, you do not have Retiree Medical Benefits.

## Eligibility after Age 65

If you are an Agent, Representative and Planner, retiring on or after January 1, 2011 or Officer, Management/Specialist or Support Staff retiree, you will not have coverage in the Retiree Medical Benefit once you reach age 65. There is no retiree medical coverage offered for Agent, Representative and Planner retirees who retire on or after January 1, 2011 or Officer, Management/Specialist or Support Staff retirees and their covered dependents age 65 or over. However, you may be eligible to purchase Medicare Supplement insurance from UnitedHealthcare.

### **For Pilot, Flight Attendant, TWU-Represented workgroup retirees who retire on or before October 31, 2012:**

When you reach age 65, Medicare becomes your primary coverage and the Retiree Medical Benefit is secondary. Retiree Medical Benefit coverage continues for you and your eligible spouse with a reduced medical maximum benefit. You may also continue to cover your eligible spouse. However, coverage for dependent children ends. See the [Medicare Coverage](#) section.

If you are in the Retiree Value Plus Option and you reach age 65, your coverage reverts to the Retiree Standard Medical Option.

If you are in RSM Option and you reach age 65, you stay in the plan but your maximum medical benefit reduces. See “[Maximum Medical Benefit](#)” in the Retiree Medical Benefits Options Overview section.

Puerto Rico retirees enrolled in the Retiree HMO Option: At age 65, your Retiree HMO Option ends and you and your spouse automatically revert to RSM Option coverage. Since any of your remaining prefunding contributions were refunded to you when you enrolled in the RHMO Option, you will be required to timely pay the required ongoing monthly contributions to maintain RSM Option coverage.

## Dependent Eligibility

Under the Retiree Medical Benefit, an eligible dependent is an individual (other than the retiree covered by the Retiree Medical Benefit) who is related to the retiree in one of the following ways:

- Spouse or Company-recognized Domestic Partner not covered as an employee or retiree under a medical benefit sponsored by the Company

For retirees under age 65, an eligible dependent may also include:

- Unmarried child under age 19
- Unmarried incapacitated child age 19 or over who maintains legal residence with you
- Unmarried child age 19 through 22, if the child is registered as a full-time student at a school/educational institution in a program of study leading to a degree or certification (proof of continuing eligibility will be required from time to time) and either:
  - The child maintains legal residence with you; or
  - You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

If, for medical reasons, the child is required to reduce or terminate his or her studies, coverage will be continued for up to 12 months (one year). The child must be under a physician's care and statements must be provided from the attending physician and school/educational institution to your network/claims administrator. After 12 months (one year), coverage will end unless the child returns to school/education institution full-time or meets the definition of an incapacitated child.

## Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Company-recognized Domestic Partner as defined by the Plan
- Stepchild, if the child lives with you, and you (the employee) either jointly or individually claim the stepchild as a dependent on your federal income tax return
- Stepchild of your Company-recognized Domestic Partner, if the child lives with you and your Company-recognized Domestic Partner claims the child on his or her federal income tax return and the tax return indicates the same address as yours
- Special Dependent, if you meet all of the following requirements:
  - You must have legal custody and legal guardianship of the child.
  - The child must maintain legal residence with you and be dependent on you for maintenance and support.

- You must submit a [Statement of Eligibility for Special Dependent form to HR Services](#) and HR Services must approve the form. (Complete and return the form to HR Services, along with copies of the official court documents awarding you custodianship or guardianship of the child.)
- You must receive confirmation from HR Services notifying you of its determination.
- HR Services will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 60 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by HR Services. If you submit the request after the 60-day time frame, the child will not be added to your coverage.
- Child you are required to provide coverage for under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a National Medical Support Notice issued by a state agency (see [“Qualified Medical Child Support Order \(QMCSO\)”](#) in the Additional Health Benefit Rules section).

## Coverage for an Incapacitated Child

An “incapacitated child” age 19 or over is eligible if all of the following criteria are met:

- The child was covered as your dependent under this Plan before reaching age 19 (or age 23 if registered as a full-time student before reaching age 23).
- The child is mentally or physically incapable of self-support.
- You must file a [Statement of Dependent Eligibility for Incapacitated Child](#) within:
  - **For UnitedHealthcare:** Within 60 days of the date coverage would otherwise end
  - **For Blue Cross and Blue Shield of Texas:** Within 45 days of the date coverage would otherwise end
  - **For Aetna:** Within 90 days of the date coverage would otherwise end
  - **For the RHMO:** Contact Triple S. See [“Contact Information”](#) in the Reference Information section
- And your network/claims administrator then approves the application.
- The child continues to meet the criteria for dependent coverage under this Plan.
- You provide additional medical proof of incapacity as may be required by your network/claims administrator from time to time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your network/claims administrator determines the child is no longer incapacitated. If you elect to drop coverage for your child, you may not later reinstate it.
- And either:
  - The child maintains legal residence with you and is wholly dependent on you for maintenance and support
  - You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency (see [“Qualified Medical Child Support Order \(QMCSO\)”](#) in the Additional Health Benefit Rules section).

## Proof of Eligibility

As a reminder, AMR Corporation and its subsidiaries reserve the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct and may result in benefit or plan coverage termination and recovery of any overpaid benefits.

Whether you:

- Enroll dependents when you are first eligible to enroll in benefits, or
- Enroll new dependents at annual enrollment, or
- Enroll new dependents as the result of a Life Event,

You must submit to HR Services proof of the dependents' eligibility within 60 days of the date you enroll them. Proof that dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc., as detailed in the [Proof of Eligibility Requirements](#).

## Dependents of Deceased Retirees

### Coverage for Your Spouse — Pilot, Flight Attendant and Retirees

Coverage for your spouse depends on your spouse's age at the time of your death.

- If your spouse is under age 65 at the time of your death: Coverage for your spouse continues until your spouse reaches age 65, becomes eligible for Medicare or remarries, whichever occurs first. At that time, coverage ends.
- If your spouse is age 65 or over at the time of your death: Coverage for your spouse continues for six months following your death, even if your spouse is covered by Medicare or becomes eligible for Medicare during the six-month period.

### Coverage for Your Spouse — Agent, Representative, Planner and Officer, Management/Specialist and Support Staff Retirees

Coverage for your spouse depends on your spouse's age at the time of your death.

- If your spouse is under age 65 at the time of your death: Coverage for your spouse continues until the date you would have reached age 65, your spouse reaches age 65, your spouse becomes eligible for Medicare or remarries, whichever occurs first. At that time, coverage ends.
- If your spouse is age 65 or over at the time of your death: Coverage for your spouse terminates following your death. There is no retiree benefit coverage for retirees or surviving spouses age 65 or over in the Officer, Management/Specialist and Support Staff or the Agent Representative and Planner (who retire on or after January 1, 2011) workgroup.
- If you are over age 55 and working as an active employee: Your surviving spouse is eligible for Retiree Medical Benefit coverage if you die and were otherwise eligible for this coverage. This applies regardless of your spouse's age at the time of your death. Your spouse may continue coverage until he or she reaches age 65 or when the deceased retiree would have reached age 65, whichever occurs first. At that time, coverage ends.



When your spouse's coverage ends, he or she may be eligible to elect Continuation of Coverage under COBRA for up to 36 months. See "[COBRA Continuation of Coverage](#)" in the Additional Health Benefit Rules section for more information. If your Company-recognized Domestic Partner is covered under the Retiree Medical Benefit at the time of your death, coverage will continue for the 90 days immediately following your death. At the end of the 90-day period, your Company-recognized Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months. The 90 days of coverage are included in the 36 months. Dependent children of your Company-recognized Domestic Partner are eligible for COBRA for up to 36 months but do not receive the 90 days of coverage immediately following your death. If you are under age 65 at the time of your death, your spouse's medical maximum benefit will be reduced as described under "[Maximum Medical Benefit](#)" in the Retiree Medical Benefit Options Overview section.

### Coverage for Your Children

Coverage for your children ends upon your death. However, your children may elect Continuation of Coverage under COBRA. (See "[COBRA Continuation of Coverage](#)" in the Additional Health Benefit Rules section.)

## Determining a Spouse (SP), Domestic Partner (DOMESTIC PARTNER (DP)) or Common Law Spouse Eligibility

### Spouse (SP)

An opposite-sex spouse or same-sex spouse is referenced through this benefit guide as "Spouse". Please see the below definitions of opposite-sex spouse and same-sex spouse to understand eligibility requirements for spouse coverage under Americans benefits.

#### Opposite-Sex Spouse

Your opposite-sex spouse to whom you are legally married if you and your spouse were married outside the United States or the aforementioned territories/ protectorates, you and your spouse must have been legally married to you in the country/jurisdiction where your marriage took place. Your marriage must be legally documented via marriage certificate from the state or country government that permitted and certified your marriage. You and your spouse must not be married to, or have a DOMESTIC PARTNER (DP), common law, or other spouse-like relationship with any other person(s) at the same time you are married to each other.

#### Same-Sex Spouse

As a result of change to the federal Defense of Marriage Act (DOMA), the Plan(s) now recognizes same-sex marriage for purposes of benefit eligibility, provided you and your same-sex spouse were legally married in one of the states, territories, or protectorates that recognize same-sex marriage. Adding your same-sex spouse to your benefits affords your same-sex spouse the same eligibility and coverages available to any other company employee and his/her opposite-sex spouse. If you and your same-sex spouse were married outside the United States or the aforementioned territories/protectorates, you and your same-sex spouse must have been legally married in the country/jurisdiction where your marriage took place.



Your marriage must be legally documented via marriage certificate from the state or country government that permitted and certified your marriage. Furthermore, you and your same-sex spouse must not be married to, or have a DOMESTIC PARTNER (DP), common law, or other spouse-like relationship with any other person(s) at the same time you are married to each other. Requirements for your same-sex spouse to be eligible for coverage under the Plan(s) are:

- You and your same-sex spouse were legally married in one of the U.S. states, districts, territories, protectorates or other countries or jurisdictions that has legalized same-sex marriage

### **Common Law Spouse**

Common law spouses are eligible for enrollment in Plan benefits only if your common law marriage is recognized and deemed (certified) legal by the individual state where the employee resides, and only if the employee and spouse have fulfilled the state's requirements for common law marriage. To enroll your common law spouse for benefits, you must complete and return a Common Law Marriage Recognition Request and provide proof of common law marriage, as specified on the form. You and your common law spouse must not be married to, or have a DOMESTIC PARTNER (DP), common law, or other spouse-like relationship with any other person(s) at the same time you are in a common law marriage to each other. Requirements for your common law spouse to be eligible for coverage under the Plan(s) are:

Although criteria vary by state, the following guidelines usually apply:

- The couple cohabitates for a specified period of time established by the state.
- The persons recognize each other as husband and wife.
- The persons hold each other out publicly as husband and wife.

### **Company-Recognized Domestic Partners (DOMESTIC PARTNER (DP))**

Company-recognized Domestic Partners are defined by American Airlines, Inc. as two people in a spouse-like relationship who meet all of the following criteria:

- Are the same gender
- Reside together in the same permanent residence and have lived in a spouse-like relationship for at least six consecutive months
- Are both at least 18 years of age and are not related by blood in a degree that would bar marriage
- Are not legally married or the common law spouse or Company-recognized Domestic Partner of any other person
- Submit a complete and valid Declaration of Company-recognized Domestic Partnership from the Domestic Partner Enrollment Kit.

After reviewing the Company-recognized Domestic Partner Enrollment Kit, if you need additional information regarding benefits and privileges available to Company-recognized Domestic Partners, please contact HR Services (see "Contact Information" in the reference Information section).

Company-recognized Domestic Partners and their eligible dependent children are eligible to be covered under the Retiree Medical Benefits.

**Company-Recognized Domestic Partners (DOMESTIC PARTNER (DP)) (cont.)**

Company-recognized Domestic Partners may be eligible to participate in Health Maintenance Organizations (HMOs). Contact your HMO directly for eligibility criteria. Home-Based Representatives or Level 84 Premium Services Representatives and their dependents are not eligible to enroll in an HMO.

**Parents and Grandchildren**

Neither your parents nor grandchildren are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchild's legal guardian).

## Ineligibility

None of the following individuals are eligible to participate in this benefits program:

- A leased employee, as defined in section 414(n) of the Internal Revenue Code
- Any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker; this term includes any of the following former classifications:
  - Temporary employee
  - Provisional employee
  - Associate employee
- An independent contractor, or
- Any person:
  - Who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion)
  - Who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate, or
  - Whose compensation is reported to the Internal Revenue Service on a form other than a Form W-2, regardless of whether such person was treated as an employee for federal income tax purposes.

If a temporary worker becomes a regular employee and meets all of the other requirements to participate in the benefit program, without a break in service, all the time worked as a full-time temporary worker will be credited solely toward the eligibility requirement for life and health coverage. Under no circumstances will time worked as a temporary worker entitle you to retroactive group health and welfare benefits.

The Company reserves the right to alter, amend, modify or terminate Retiree Benefits or any part thereof at its discretion. Changes will not affect valid claims incurred before the change(s) allowed under the appropriate plan or program terms. For more information, contact HR Services (see "[COBRA Continuation of Coverage](#)" in the Additional Health Benefit Rules section).

# Retiree Enrollment

For retirees Pre-65, you have the opportunity to select benefits tailored to your individual needs and preferences each year during Annual Benefits Enrollment. The Annual Benefits Enrollment period is in the Fall. Retirees enroll online using the [Benefits Service Center](#).

- When you can initially enroll in retiree benefits depends on your age at retirement and your workgroup at retirement.
- The Plan year is January 1 through December 31.
- After Annual Benefits Enrollment is completed and the new benefit year has begun, you will only be able to make changes to your elections if you experience a Life Event that allows such a change.
- Life Event changes must be made within 60 days of the Life Event.
- If you want to add new dependents to your benefits, you must submit to HR Services proof that these dependents qualify as your eligible dependents within 60 days of the date you request coverage.

## The Benefits Service Center

The [Benefits Service Center](#) (the online enrollment tool) on Jetnet reflects the current benefits coverages available to you and the rates for those coverages. The [Benefits Service Center](#) is updated by the beginning of annual enrollment period with your benefits options and the new rates for the upcoming Plan year – January 1 through December 31.

## In This Section

- Enrollment — When Coverage Begins
  - Retiree Medical Benefit and Life Insurance Benefit Enrollment
  - Supplemental Medical Plan Enrollment
  - Long-Term Care Insurance Plan Enrollment
- Initial Enrollment — When You Retire
- Annual Benefits Enrollment
  - Waiving (“Opting Out” of) Retiree Medical Benefit — Retirees Age 65 or Older Only
- Paying for Coverage
  - Retiree Medical Benefits
  - Retiree Life Insurance Benefit
  - Supplemental Medical Plan
  - Long-Term Care Insurance Plan
- When Coverage Ends

## Enrollment — When Coverage Begins

**Pilot/ Flight Engineer/ Flight Attendant/ TWU-Represented Retirees who retired on or prior to October 31, 2012, and Agent/Representative/Planner Retirees who retired on or before December 31, 2010:**

When you met the eligibility requirements and retired, your Retiree Medical Benefit coverage and Retiree Life Insurance coverage became effective. In most cases, when you retired directly from active payroll, coverage began automatically for the Retiree Standard Medical option; however, in some cases it is necessary to contact HR Services to activate your coverage.

If you elected to enroll in the Retiree Value Plus, you enrolled via the [Benefits Service Center](#) and you must timely pay the required ongoing monthly contributions to begin and maintain this coverage.

See "[Supplemental Medical Plan Eligibility](#)" in the Supplemental Medical Plan section.

If you have other coverage available (such as your spouse's employee coverage) and wanted to defer your entry into the Retiree Medical Benefit, you must have contacted HR Services. For all workgroups except Pilots, you may defer entry only once.

If you are in this category of retirees, you ARE eligible for the Retiree Life Insurance Benefit.

**Agent/Representative/Planner Retirees Pre-65 who retired on or after January 1, 2011 but on or before October 31, 2012, and Officers, Management/Specialists, Support Staff Retirees Pre-65 who retired on or before October 31, 2012:**

If you meet your eligibility requirements, you must contact HR Services to initiate your Retiree Medical Benefit. You will be required to timely pay the required ongoing contributions.

You enroll via the [Benefits Service Center](#) and to activate your coverage and make timely payment of the required contributions for coverage.

If you have other coverage available (such as your spouse's employee coverage) and want to defer your entry into the Retiree Medical Benefit, you must contact HR Services. You may defer entry only once.

If you are in this category of retirees, you ARE eligible for the Retiree Life Insurance Benefit.

**Agent/Representative/Planner Retirees age 65 or over who retire on or after January 1, 2011 but on or before October 31, 2012, and Officers/Management/Specialists/Support Staff Retirees age 65 or over who retire on or before October 31, 2012:**

You are not eligible for Company-sponsored Retiree Medical Benefits. However, you may be eligible for fully insured Medicare Supplement insurance that you can purchase directly from UnitedHealthcare. See "[Contact Information](#)" under the Reference Information section for information regarding UnitedHealthcare Medicare Supplement insurance. If you are in this category of retirees, you ARE eligible for the Retiree Life Insurance Benefit.

**Retirees who live in Puerto Rico, are Pre-65, and retire on or before October 31, 2012:**

In addition to all requirements stated above, if you are eligible for and wish to enroll in the Retiree HMO, you must actively enroll via the [Benefits Service Center](#). You must timely pay the required ongoing monthly contributions to begin and maintain this coverage.

If you are in this category of retirees, you ARE eligible for the Retiree Life Insurance Benefit.

## Retiree Medical Benefit and Life Insurance Benefit Enrollment

The following information summarizes when your Retiree Medical Benefit and Life Insurance Benefit are effective, when your active coverage ends and how to activate the Retiree Medical Benefit.

Coverage Begins If You Are a...	Your Active Medical and Life Coverage Ends...	Your Retiree Coverage is Effective...	Your Coverage is Activated...
<p>Pilot, Flight Attendant, or TWU-Represented workgroup who retired before October 31, 2012 Or Agent, Representative or Planner who retired before January 1, 2010</p> <p><b>AND</b> you retired directly from active service with the Company at age 55 or over (age 50 or over for Pilots)</p>	<p>When your Retiree Medical Benefit begins (provided you do not defer) and Life Insurance Benefit begins. All other active benefits (such as accident insurance, etc.) end on your last day on active payroll.</p>	<p>If you retire before age 65, coverage is effective on the first day immediately following your last day on active payroll.</p> <p>If you retire at age 65 or later, coverage is effective the first of the month in which you attain age 65 or retire.</p> <p>If you attain age 65 on the first day of the month, coverage is effective on the first day of the month prior to your 65th birthday (this effective date coincides with the effective date of Medicare coverage).</p>	<p>Automatically, upon your retirement.</p>
<p>Agent, Representative or Planner who retired on or after January 1, 2011 but on or before October 31, 2012 Or Officer, Management / Specialist or Support Staff who retired on or before October 31, 2012,</p> <p><b>AND</b> you retire directly from active service with the Company at age 55 or over</p>	<p>When your Retiree Medical Benefit begins (provided you do not defer) and Life Insurance Benefit begins. All other active benefits (such as accident insurance, etc.) end on your last day on active payroll.</p>	<p>If you retire before age 65, coverage is effective on the first day immediately following your last day on active payroll.</p> <p>When you reach age 65, your Retiree Medical Benefit ends.</p>	<p><b>Pre-65:</b> Upon receipt of your enrollment and first timely payment to activate the Retiree Medical Benefit.</p> <p><b>Age 65 or over:</b> You are not eligible for coverage.</p>



Coverage Begins If You Are a...	Your Active Medical and Life Coverage Ends...	Your Retiree Coverage is Effective...	Your Coverage is Activated...
Flight Attendant or TWU-Represented Left under the 50 to 55 Rule prior to November 1, 2012	On your last day on active payroll, unless you choose to purchase Continuation of Coverage under COBRA.	<p>When you reach age 55. Employees over age 50 who have at least 15 years of Company seniority at the time they terminated employment are eligible to continue to participate in prefunding as follows:</p> <ul style="list-style-type: none"> <li>• If your employment terminated at age 50 or older, AND</li> <li>• You had 15 or more years of Company seniority, BUT</li> <li>• You have not yet continuously prefunded for at least 10 years and you want to remain eligible for Retiree Medical Benefit coverage, you must continue to prefund for the Retiree Medical Benefit until you have prefunded continuously for at least 10 years before you will be eligible to enter the Retiree Medical Benefit. If you stop prefunding before you reach a minimum of 10 years of continuous prefunding, you will receive a refund of the value of your prefunding contributions and you are no longer eligible for Retiree Medical Plan Benefits.</li> </ul>	<p>When you become eligible to retire and call HR Services to start your benefit.</p> <p>In order to become eligible to retire and begin your Retiree Medical Benefit coverage, you must attain at least age 55 AND have met the 10 year prefunding requirement.</p>

Coverage Begins If You Are a...	Your Active Medical and Life Coverage Ends...	Your Retiree Coverage is Effective...	Your Coverage is Activated...
Agent, Representative or Planner or Officer, Management/ Specialist or Support Staff left under the 50 to 55 Rule prior to November 1, 2012	On your last day on active payroll, unless you choose to purchase Continuation of Coverage under COBRA.	When you reach age 55. Employees over age 50 who had at least 15 years of Company seniority, AND are eligible to enter the Retiree Medical Benefit on a postfunded basis when they reach age 55 (will be required to timely pay ongoing contributions to maintain this coverage).	When you become eligible to retire and call HR Services to start your benefit.  In order to become eligible to retire and begin your Retiree Medical Benefit coverage, you must attain at least age 55 and have at least 15 years of Company service.
Disabled Flight Attendant, Disabled TWU-Represented workgroup employee, Disabled Agent/Representative /Planner, Disabled Officer, Management/Specialist, Support Staff  <b>AND</b> are Pre-65	At the end of one-year of unpaid sick leave or injury-on-duty leave, unless you elect to purchase COBRA coverage.	On the first of the month coinciding with or following your termination from COBRA coverage or at the end of one-year of unpaid sick leave or injury on-duty leave, if you meet the eligibility requirements.  You may elect the Retiree Standard Medical option or the Retiree Value Plus option (or the Retiree HMO, if you reside in Puerto Rico).	When you notify your supervisor and HR Services that you wish to begin using your retiree coverage or following your termination from COBRA coverage or at the end of one-year of unpaid sick leave or injury-on-duty leave, whichever occurs earlier, and your coverage is activated upon receipt of your first payment.
Pilot or Flight Engineer receiving a disability pension benefit from the Pilot Retirement Benefit Program <b>AND</b> are Pre-65	Upon commencement of your disability pension benefit.  This is true for all active coverages except Life Insurance.	On the first of the month in which your disability pension benefit begins. Your Retiree Medical Benefit is the Retiree Standard Medical option.  You may elect the Retiree Value Plus option (or the Retiree HMO, if you reside in Puerto Rico), but you must timely pay required ongoing contributions for this coverage.	Automatically when your disability pension benefit begins.

Coverage Begins If You Are a...	Your Active Medical and Life Coverage Ends...	Your Retiree Coverage is Effective...	Your Coverage is Activated...
Are a Pilot receiving a disability benefit from the American Airlines, Inc. Pilot Long-Term Disability Plan <b>AND</b> are Pre-65	At the end of the month in which you retire from your disability at age 60 to 65.	On the first of the month on or after your retirement from disability at age 60 to 65. Your Retiree Medical Benefit is the Retiree Standard Medical option.  You may elect the Retiree Value Plus option (or the Retiree HMO, if you reside in Puerto Rico), but you must timely pay required ongoing contributions for this coverage.	Automatically upon your retirement from disability.
Retire from a leave of absence and are Pre-65	At the end of the month in which you retire if you were enrolled in active benefits during the leave of absence.	On the first of the month on or after your termination from the leave of absence.	When you call HR Services to begin your retiree coverage and upon receipt of your first payment.

## Supplemental Medical Plan Enrollment

Effective January 1, 2011, the Supplemental Medical Plan is a retiree-only Plan. The Supplemental Medical Plan is available to retirees of all workgroups, except Pilots.

You may enroll in the Supplemental Medical Plan at the time you initiate your Retiree Medical Benefit. See “[Supplemental Medical Plan Eligibility](#)” information in the Supplemental Medical Plan section.

## Long-Term Care Insurance Plan Enrollment

If you are already enrolled in the Long-Term Care Insurance Plan, you may continue your coverage with MetLife. However, MetLife is no longer offering Long-Term Care Insurance after December 31, 2012.

## Initial Enrollment — When You Retire

HR Services will mail you a notification advising you of your enrollment options as a retiree and providing you information about how to enroll on the Retiree Benefits page of Jetnet. Review this information carefully and access the [Benefits Service Center](#) to review the benefits for which you are eligible. After reviewing this information, if you have questions, you may contact HR Services (see “[Contact Information](#)” in the Reference Information section).

Once the Company processes your retirement, you can log on to Jetnet through the retiree website and enroll in the Retiree Medical Benefit.

**If you are a Pilot or Flight Engineer retiree who retired on or prior to October 31, 2012**, you were automatically enrolled in the Retiree Standard Medical option at retirement and you were not required to pay any contributions for this coverage. If you preferred (and were eligible for) coverage under the Retiree Value Plus option, you must have taken action and enrolled for this coverage on Jetnet and you were required to make timely payment of the ongoing monthly contributions to begin and maintain this coverage. Keep in mind that you had 30 days from the date your retirement is processed to access Jetnet and enroll in the Retiree Value Plus option. At the end of this 30-day period, your opportunity for Retiree Value Plus option enrollment closed until the next Annual Benefits Enrollment period.

**If you are a Flight Attendant, TWU-Represented or Agent/Representative/ Planner (who retired on or before December 31, 2010) retiree**, you were automatically enrolled in the Retiree Standard Medical option at retirement and you were not required to pay ongoing monthly contributions to maintain this coverage, since you prefunded for Retiree Standard Medical (RSM) option coverage while you were an active employee. If you preferred (and were eligible for) coverage under the Retiree Value Plus option, you must have taken action and enrolled in this coverage in the [Benefits Service Center](#). You were required to make timely payment of the ongoing monthly contributions to begin and maintain this coverage. Keep in mind that you had 30 days from the date your retirement was processed to access the [Benefits Service Center](#) and enroll in the Retiree Value Plus option. At the end of this 30-day period, your opportunity for Retiree Value Plus option enrollment closed until the next Annual Benefits Enrollment period. If you elected the Retiree Value Plus and you stopped making timely payments, you were terminated from all Retiree Medical Benefit coverage. If you elected Retiree Value Plus, any remaining unused pre-funding contributions were refunded to you. If you later returned to the RSM option, you were required timely payment of ongoing contributions for the RSM option.

**If you are an Agent/Representative/Planner (who retired on or after January 1, 2011) Officer, Management/Specialist or Support Staff retiree Pre-65**, you are not automatically enrolled in any Retiree Medical Benefit options. Since you are required to timely pay ongoing monthly contributions to begin and maintain any Retiree Medical Benefit option coverage, you must take action and enroll in the Retiree Standard Medical option (or in the Retiree Value Plus option, if you are eligible for this option) on

Jetnet in order to begin and maintain retiree medical coverage. If you do not enroll on [Benefits Service Center](#) when you retire, you will have no Retiree Medical Benefits.

**If you are an Agent/Representative/Planner retiree age 65 or over retiring on or after January 1, 2011, or an Officer or Management/Specialist or Support Staff retiree age 65 or over**, you are not eligible for any of the Retiree Medical Benefit options.

**If you are a retiree residing in Puerto Rico and are Pre-65**, in addition to all requirements stated above, if you are eligible for and wish to enroll in the RHMO, you must actively enroll via the [Benefits Service Center](#). You must timely pay the required ongoing monthly contributions to begin and maintain this coverage.

### Special Note

If your spouse is an active employee (with a participating AMR Corporation subsidiary or with another company) and has medical coverage in which you can participate, you might want to defer entry into the Retiree Medical Benefit in favor of maintaining coverage as a dependent in your spouse's active employee medical coverage. If this is your choice, contact HR Services.

This will enable you to defer activation of your Retiree Medical Benefit coverage until a later date. You are allowed to defer your Retiree Medical Benefit only once.

## Annual Benefits Enrollment

Pre-65 retirees will have the opportunity to participate in annual benefit enrollment, which occurs during the Fall each year. This Annual Benefits Enrollment enables you to select your Retiree Medical option for the upcoming year.

During this time, you may elect to change your Retiree Medical option election from the Retiree Standard Medical option to the Retiree Value Plus option (if Retiree Value Plus option is offered in your area) or the Retiree HMO option (if you reside in Puerto Rico and are Pre-65). You may also elect to change your Retiree Medical option election from the Retiree Value Plus option to the Retiree Standard Medical option or the Retiree HMO option (if you reside in Puerto Rico and are Pre-65).

You may also make changes to dependents' enrollment during this time. You participate in enrollment via the [Benefits Service Center](#).

During Annual Benefits Enrollment, if you do not make a Retiree Medical Benefit election for the upcoming year, you will default into the same Retiree Medical Benefit as you are enrolled in for the current year. Your network administrator may change.

If future benefits or coverages become available to retirees and those benefits or coverages allow Annual Benefits Enrollment, you will be able to make your elections for such benefits or coverages during this Annual Benefits Enrollment period.

Once Annual Benefits Enrollment ends, your benefit elections for the upcoming plan year are recorded and "locked in", and you are not allowed to make changes to these elections unless you experience a Life Event that would enable you to make such changes. However, between the close of Annual Benefits Enrollment and the start of the new plan year (January 1 following Annual Benefits Enrollment), you may be permitted to CORRECT any erroneous elections you made during Annual Benefits Enrollment, as long as you make those corrections before the start of the new plan year.

For example, during Annual Benefits Enrollment for the upcoming plan year, you elected retiree HMO coverage, not realizing that retiree HMO coverage is available only to retirees in Puerto Rico. You discover your mistake. If you request correction of your mistake before the beginning of the upcoming plan year, your election correction is permitted. However, if you fail to discover

your mistake and fail to request correction until after the new plan year begins (such as on January 12), you will not be permitted to make any correction of your enrollment mistake unless you experience a Life Event. This is a rule set down by the federal government, and American Airlines cannot override this rule; to do so would jeopardize the benefit plan for all retirees.

Remember, these post-Annual Benefits Enrollment changes to your benefit elections are permitted to allow you to correct elections errors ONLY. Any other changes (such as: you have changed your mind about enrolling in a particular benefit, you want to change the network administrator you elected, etc.) are not permitted.

## Waiving (“Opting Out” of) Retiree Medical Benefit — Retirees Age 65 or Older Only

*This section is not applicable to Agent, Representatives and Planners who retire on or after January 1, 2011 and Officer, Management/Specialist and Support Staff retirees.*

Certain retirees (those who have retiree status from the military or certain federal government jobs) may also be eligible for retiree medical benefits provided by the United States Government — this coverage is known as “TRICARE for Life.” Because of the combination of Medicare and TRICARE for Life, coverages often provides a richer benefit (in some cases, 100% coverage) than the age 65 or over Retiree Medical Benefit (i.e., RSM option). These retirees may prefer the TRICARE for Life coverage to their Retiree Medical Benefit. If so, both the retiree and his or her spouse or Company-recognized Domestic Partner may elect to permanently opt out of the Retiree Medical Benefit in favor of TRICARE for Life.

Any retiree electing to opt out of the Retiree Medical Benefit in favor of TRICARE for Life should give careful consideration to his or her decision, as once the retiree and his or her spouse or Company-recognized Domestic Partner opt out of the Retiree Medical Benefit, they cannot reenter the Retiree Medical Benefit at a later date.

To opt out of the Retiree Medical Benefit in favor of TRICARE for Life, the retiree and his or her spouse should obtain a [Retiree Medical Plan Term Agreement Form](#) or contact HR Services, complete/date/sign it (both the retiree and spouse must sign) and return it to HR Services. HR Services will process your opt-out request and terminate your Retiree Medical Benefit upon receipt of the properly executed form. If you prefunded for your Retiree Medical Benefit and a balance remains in your prefunding account, you will receive a refund of the balance of the value of your prefunding contributions (with associated investment experience).

Company-recognized Domestic Partners are not eligible to participate in TRICARE for Life.



# Paying for Coverage

## Retiree Medical Benefits

For those who retired on or before October 31, 2012, the Retiree Medical Benefit is funded:

- Through Company contributions,
- By prefunding contributions made during active employment (if you were a participant in prefunding), and
- By postfunded required ongoing monthly contributions you make as a retiree.

## Pilots and Flight Engineers

Prior to November 1, 2012, the provisions of your collective bargaining agreement between the Allied Pilots Association (APA) and American Airlines, Inc. afforded you Retiree Standard Medical option coverage at no contribution cost to you. Had you elected Retiree Value Plus option as your selected retiree medical coverage, you were required to pay ongoing monthly contributions for the duration of your Retiree Value Plus option coverage (postfunding — see “[Paying for Postfunded Retiree Medical Benefit](#)” in this section). When your retiree medical coverage reverted to the Retiree Standard Medical option, you were not required to make contributions for this coverage.

## Flight Attendants Who Retired Prior to January 1, 2002

The provisions of your collective bargaining agreement between the Association of Professional Flight Attendants (APFA) and American Airlines, Inc. afforded you Retiree Standard Medical option coverage at no contribution cost to you. Had you elected Retiree Value Plus option as your selected retiree medical coverage, you were required to pay ongoing monthly contributions for the duration of your Retiree Value Plus option coverage (postfunding — see “[Paying for Postfunded Retiree Medical Benefit](#)” in this section). When your retiree medical coverage reverted to the Retiree Standard Medical option you were not required to make contributions for this coverage.

## Prefunding (Flight Attendant, TWU-Represented and Agent/Representative/Planner [who retired on or before December 31, 2010] retirees)

Only applies if you are a/an:

- Flight Attendant who retired on or after January 1, 2002 but on or before October 31, 2012,
- TWU-Represented workgroup retiree who retired on or before October 31, 2012, or
- Agent/Representative/Planner who retired on or before December 31, 2010,
- You are eligible for the Retiree Medical Benefit only if you prefunded (in addition to meeting the age and seniority criteria). The rate you paid for prefunding was based on your date of hire and the age at which you began prefunding, as explained in the prefunding solicitation package you received when you were first eligible to prefund.

If you elect to change your retiree medical coverage from the Retiree Standard Medical option to the Retiree Value Plus option (or if you retire and immediately elect the Retiree Value Plus option), you will be required to timely pay ongoing monthly contributions for the duration of your Retiree Value Plus option coverage (postfunding — see [“Paying for Postfunded Retiree Medical Benefit”](#) in this section). Upon your election of Retiree Value Plus option coverage, the balance of the value of your prefunding contributions (with associated investment experience) is refunded to you. When your retiree medical coverage reverts to the Retiree Standard Medical option (when you reach age 65 or earlier if you elect it), you will be required to pay ongoing monthly contributions for the duration of your Retiree Standard Medical option coverage.

### **Agent, Representative, Planner Employees Who Retired on or after January 1, 2011 but on or before October 31, 2012, and Officer, Management/ Specialist and Support Staff Employees**

Agent, Representative, Planner employees who retire on or after January 1, 2011 or Officer, Management/Specialist and Support Staff employees, do not prefund Retiree Medical Benefit coverage. These employees fund their Retiree Medical Benefit through required ongoing contribution payments during their retirement (postfunding).

Retirees must postfund (timely pay required ongoing contributions during your retirement) in order to maintain Retiree Medical Benefit coverage — irrespective of whether you choose the Retiree Standard Medical option or the Retiree Value Plus option or Retiree HMO (if you reside in Puerto Rico and are Pre-65). Your first payment is due when you enter the Retiree Medical Benefit.

### **Paying for Postfunded Retiree Medical Benefit**

You must make timely payment of the required contributions to maintain any Retiree Medical Benefit that is postfunded and you must make the initial contribution payment before your retiree medical coverage will begin. Once you are in the Retiree Medical Benefit, you will be billed monthly for coverage. The direct billing administrator (PayFlex — see [“Contact Information”](#) in the Reference Information section) for postfunding the Retiree Medical Benefit, will mail you monthly invoices prior to the month in which payment is due. The invoice provides you information including:

- The type(s) of coverage for which you are being billed,
- The time period of coverage being billed,
- The amount of contribution due,
- The due date of payment, and
- The ending date of the 30-day grace period allowed for payment,

As well as instructions for sending your payment, how to contact PayFlex and information about paying contributions via automatic bank draft.

Payments are due on the first of each month or before the end of the 30-day grace period allowed for payment. Payments must be postmarked by the due date or before the end of the 30-day grace period allowed for payment. If payment is not postmarked by the end of the grace period, your Retiree Medical Benefit will be terminated, without the possibility of reinstatement. (However, if you are a Pilot/Flight Engineer retiree who retired on or before October 31, 2012, or a Flight Attendant retiree who retired prior to January 1, 2002, you may revert to your Retiree Standard Medical option coverage and are not required to pay further contributions for this coverage.)

## Retiree Life Insurance Benefit

If you retired on or prior to October 31, 2012, you are eligible for Retiree Life Insurance.

## Supplemental Medical Plan

You are billed annually by HealthFirst TPA (see “[Contact Information](#)” in the Reference Information section) and must timely pay the required contributions annually to maintain this coverage.

## Long-Term Care Insurance Plan

You are billed by MetLife and must timely pay ongoing premiums to maintain this coverage. Please note that MetLife no longer offers Long Term Care Insurance, effective January 1, 2013. Those retirees who purchased this coverage prior to January 1, 2013 can continue their coverage with MetLife. However, no new coverage is available to retirees after December 31, 2012.

## When Coverage Ends

Coverage will end in the Retiree Medical Benefit in the following situations:

- **Agents, Representatives, Planners who retired on or after January 1, 2011 and Officer, Management/Specialist or Support Staff retirees:** Coverage ends when you reach age 65. Coverage ends for your spouse or Company-recognized Domestic Partner when he or she reaches age 65.
- **Agents, Representatives, Planners who retired on or after January 1, 2011 and Officer, Management/Specialist or Support Staff retirees Pre-65:** Coverage will end when you elect to discontinue payments, fail to make payments or when a payment is returned unpaid for insufficient funds (this is the same as discontinuing payment) or when your payment is not made timely (this means that the payment is not postmarked by the due date or before the end of the 30-day grace period allowed for payment).
- Coverage for a retiree or a dependent ends when he or she exhausts his or her individual medical maximum benefit.
- Coverage for your dependent children ends when you die or when you reach age 65, whichever occurs first. Coverage for a dependent also ends if the dependent no longer meets the eligibility requirements.
- When your dependents' coverage ends, he or she may be eligible for Continuation of Coverage under COBRA for up to 36 months. See "[When Coverage Ends](#)" in the Additional Rules section for more information.

# ***Life Events: Making Changes During the Year***

After annual enrollment is completed each year, and when the new benefit year begins on January 1, you may only change your elections if you experience a Life Event and your change is consistent with that event. Allowable changes vary by the type of Life Event you experience.

Life Event changes must be made within the 60-day time frame. If you miss the 60-day deadline, your Life Event change will not be processed. You will have to wait until the next annual enrollment period to make changes to your benefits.

## **In This Section**

- Life Events
- Special Life Event Considerations
- Benefits Not Affected by Life Events
- When Coverage Ends

## Life Events

When you experience a Life Event, remember these guidelines:

- Most Life Events are processed online through the [Benefits Service Center](#). Visit the Life Events Planning Page of Jetnet for a complete list of all Life Events and the correct procedures for processing your changes.
- If you process your Life Event within 60 days of the event, your changes are retroactive to the date the Life Event occurred.
- AMR Corporation and its affiliates reserve the right to request documented proof of Eligibility Dependent Criteria for benefits at any time. If you do not provide proof of eligibility when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct and may result in termination of benefits coverage.
- You must timely provide acceptable proof of eligibility to HR Services before your dependent(s) can be enrolled in benefits.

If you are an age 65 or older retiree, the only Life Event that will affect you is if you or spouse or Company-recognized Domestic Partner dies.

If you are adding new dependents to your benefits as a result of a Life Event, keep in mind that you must submit to HR Services proof that these dependents qualify as your eligible dependents within 60 days of the date you request coverage. Proof that the dependents you enroll qualify as your dependents includes documents, such as: official government-issued birth certificates, adoption papers, marriage licenses, etc., as detailed in the [Proof of Eligibility Requirements](#).

- Any change in your cost for coverage applies on the date the change is effective.
- You cannot enroll your dependents in coverage if you are not covered under the same benefits.
- You must designate a beneficiary. Periodically thereafter, you may want to update your beneficiary designations. You can make beneficiary changes on the [Benefits Service Center](#). Once you complete and submit the online beneficiary designation, it supersedes all previous designations.

Also see birth or adoption for other information regarding Life Events that may trigger allowable changes in coverage.

**Note:** If you are an age 65 or older retiree, the only Life Event that will affect you is if you or your spouse or Company-recognized Domestic Partner dies.

If...	Then...
<p><b>You become eligible for retiree medical benefits and are a Pilot, Flight Engineer, Flight Attendant, TWU-Represented or Agent, Representative or Planner retiree (who retired on or before December 31, 2010)</b></p>	<ul style="list-style-type: none"> <li>• You will be covered automatically under the Retiree Standard Medical Option effective the first day of the month following your retirement date.</li> <li>• If you are married to an active AMR subsidiary employee, you may want to consider deferring your entry into the Retiree Standard Medical Option and obtaining coverage as a dependent under your spouse's coverage to maintain a higher medical maximum benefit and other benefits that are not available after you retire. Call HR Services within 60 days of the date you retire to confirm whether you want to be covered as a dependent under your spouse's coverage.</li> <li>• You may enroll yourself and your spouse or Company-recognized Domestic Partner in the Supplemental Medical Plan.</li> </ul>
<p><b>You become eligible for retiree medical benefits and are an Agent, Representative or Planner retiree who retired on or after January 1, 2011 or an Officer, Management / Specialist or Support Staff retiree</b></p>	<ul style="list-style-type: none"> <li>• You must take action and enroll in your desired Retiree Medical Benefit — either the Retiree Standard Medical Option or the Retiree Value Plus Option — at the time of your retirement. You must pay timely monthly contributions in order to obtain and maintain Retiree Medical Benefit coverage.</li> <li>• If you are married to an active employee of a participating AMR Corporation subsidiary, you may want to consider coverage as a dependent under your spouse's plan to maintain a higher medical maximum benefit and other benefits that are not available after you retire. Call HR Services within 60 days of the date you retire to confirm whether you want to be covered as a dependent under your spouse's plan.</li> <li>• You may enroll yourself and your spouse or Company-recognized Domestic Partner in the Supplemental Medical Plan.</li> </ul>



If...	Then...
<p><b>You get married</b></p> <p><b>Or</b></p> <p><b>Declare a Company-recognized Domestic Partner</b></p>	<ul style="list-style-type: none"> <li>• <b>Medical:</b> You may add your spouse to your Retiree Medical Option. Call HR Services within 60 days following your marriage (or declare a Company recognized Domestic Partner) to add coverage effective the date you were married. Otherwise, you have to wait until the next annual enrollment period to add your spouse or Company-recognized Domestic Partner to your coverage.</li> <li>• <b>Life Insurance:</b> If you would like to make a change to your beneficiary designation on file with HR Services, you must submit a new <a href="#">Beneficiary Designation Form</a>. (For your protection, HR Services must receive the signed original of the completed form.)</li> <li>• <b>Supplemental Medical Plan (excluding Pilots):</b> You may enroll your spouse or Company-recognized Domestic Partner in your existing Supplemental Medical Plan. You must have already enrolled yourself in Supplemental Medical Plan coverage at the time you were eligible to enroll in order to cover your spouse or Company-recognized Domestic Partner. Contact HealthFirst TPA within 60 days following your marriage (or declaring a Company-recognized Domestic Partner) for instructions to enroll in coverage or add your eligible spouse/Company-recognized Domestic Partner effective the date of your marriage. See "<a href="#">Contact Information</a>" in the Reference Information section. You will also need to contact HR Services and inform them of your marriage/declaration of a Company-recognized Domestic Partner.</li> </ul>

If...	Then...
<p><b>You divorce or legally separate,</b></p> <p><b>or</b></p> <p><b>Your Company-recognized Domestic Partner relationship ends</b></p>	<ul style="list-style-type: none"> <li>• <b>Medical:</b> You must call HR Services within 60 days to delete your eligible spouse/Company-recognized Domestic Partner from your coverage. You are responsible for repayment of any benefits paid to an ineligible person if you fail to notify the Company of your divorce, legal separation or termination of your Company-recognized Domestic Partner relationship. Your eligible spouse/Company-recognized Domestic Partner will be solicited for continuation of medical coverage through COBRA</li> <li>• <b>Supplemental Medical Plan (excluding Pilots):</b> If your eligible spouse/Company-recognized Domestic Partner is enrolled in the Supplemental Medical Plan, you must contact HealthFirst TPA (see "<a href="#">Contact Information</a>" in the Reference Information section) within 60 days to cancel coverage for your eligible spouse/Company-recognized Domestic Partner. Your eligible spouse/Company-recognized Domestic Partner will be solicited for continuation of Supplemental Medical Plan coverage through COBRA. You also need to contact HR Services and inform them of your intention to cancel coverage. Provide HR Services with an address where the COBRA administrator can send information to your former spouse/Company-recognized Domestic Partner regarding Continuation of Coverage.</li> <li>• <b>Life Insurance:</b> If you would like to make a change to your beneficiary designation on file with HR Services, you must submit a new <a href="#">Beneficiary Designation Form</a>. (For your protection, HR Services must receive the signed original of the completed form.)</li> </ul>
<p><b>You or your eligible spouse/Company-recognized Domestic Partner becomes pregnant</b></p>	<ul style="list-style-type: none"> <li>• Contact: Healthmatters to enroll in the MaternityMatters program (see "<a href="#">Contact Information</a>" in the Reference Information section).</li> <li>• This does not permit you to make any changes in your benefit elections until the baby is born.</li> </ul>

If...	Then...
<b>You or your eligible spouse gives birth or adopts a child or has a child placed with you for adoption or you add eligible dependent(s) to your household</b>	<ul style="list-style-type: none"> <li>• <b>Medical:</b> Call HR Services within 60 days of the birth, adoption, placement for adoption or addition to your household to add your eligible dependent to your medical coverage effective the date of the event. Otherwise, you have to wait until the next annual enrollment period to add your child to your coverage. Filing a maternity claim does not add a child to your medical coverage.</li> <li>• <b>Life Insurance:</b> If you would like to make a change to your beneficiary designation on file with HR Services, you must submit a new <a href="#">Beneficiary Designation Form</a>. (For your protection, HR Services must receive the signed original of the completed form.)</li> </ul>
<b>Your covered dependent no longer meets the Plan's eligibility requirement</b>	<ul style="list-style-type: none"> <li>• Contact HR Services within 60 days of the date your dependent is no longer eligible for coverage. HR Services will update your records and the COBRA administrator will send your dependent information regarding Continuation of Coverage through COBRA.</li> </ul>
<b>You move to a new home address:</b>	<p>Contact:</p> <ul style="list-style-type: none"> <li>• Update your address online through the <a href="#">Update MY Information Page</a> of Jetnet.</li> <li>• Write to American Airlines Pension Administration and Retiree Services to update your address</li> <li>• Contact other organizations such as the American Airline Credit Union, C. R. Smith Museum and Medicare/Social Security Administration, to update your address</li> <li>• <b>Medical:</b> There are no changes to your Retiree Medical Option — including your network/claims administrator — unless you move to area where your current option is not available.</li> <li>• <b>Supplemental Medical Plan (excluding Pilots):</b> Contact HealthFirst to change your address.</li> </ul>
<b>You die:</b>	<ul style="list-style-type: none"> <li>• Your dependents should contact Survivor Support Services (through HR Services) and a Survivor Support Services representative will assist your survivors with all benefits and privileges available to them, including Continuation of Coverage through COBRA, if applicable.</li> </ul>

If...	Then...
<b>Your spouse/ Company-recognized Domestic Partner or dependent dies</b>	<ul style="list-style-type: none"> <li>• <b>Contact:</b> HR Services within 60 days of your spouse's/Company-recognized Domestic Partner's or dependent's death. HR Services will assist you in making the appropriate changes to your benefits.</li> <li>• <b>Life Insurance:</b> If you would like to make a change to your beneficiary designation on file with HR Services, you must submit a new <a href="#">Beneficiary Designation Form</a>. (For your protection, HR Services must receive the signed original of the completed form.)</li> </ul>
<b>Benefit coverages are significantly improved, lowered or lessened by the Company</b> (Plan Administrator/ Sponsor will determine whether or not a change is "significant")	<ul style="list-style-type: none"> <li>• Make changes to the applicable benefit coverages: 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.</li> </ul>
<b>You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMSCO) that requires you to provide health care coverage for a child</b>	<ul style="list-style-type: none"> <li>• Start or add coverage for the eligible dependent(s) and yourself. You cannot change benefit options at this time.</li> </ul>
<b>You, your spouse or your dependent enroll in Medicare or Medicaid</b>	<ul style="list-style-type: none"> <li>• <b>Medical:</b> Stop coverage for the eligible applicable person. You cannot change benefit options at this time.</li> <li>• <b>Supplemental Medical Plan (excluding Pilots):</b> Stop coverage for you or your eligible spouse.</li> </ul>

If...	Then...
<p><b>You and/or your eligible dependent(s) declined AA medical coverage because you or they had coverage else-where (external to AA), and any of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your eligible dependents in a Medical Benefit Option:</b></p> <ul style="list-style-type: none"> <li>• 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)</li> <li>• Employer contributions for the other coverage stopped</li> <li>• Other coverage was COBRA and the maximum COBRA coverage period ended</li> <li>• Exhaustion of the other coverages lifetime maximum benefit</li> <li>• Other employer-sponsored coverage is no longer offered</li> <li>• 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</li> <li>• You have a new dependent via your marriage, your child's birth/adoption/ placement for adoption with you</li> </ul>	<ul style="list-style-type: none"> <li>• You have 60 days from the date of the event to enroll yourself and/or your eligible dependents in one of the Retiree Medical Benefit Options offered to you. You cannot change Retiree Medical Benefit Options at this time if you are already enrolled.</li> <li>• <b>This event allows you to add retiree medical coverage only.</b></li> </ul>

## Special Life Event Considerations

The following section explains special circumstances that may happen in your life and how these changes affect your benefits. You must take all of the steps described below for your special Life Event within 60 days of the date it occurs.

**Special dependent:** To cover a special dependent (foster child or child for whom you become the legal guardian), you must complete a [Statement of Eligibility for Special Dependent](#) and return it to HR Services, regardless of the retiree medical option you select, along with a copy of the court decree or guardianship papers. For detailed criteria regarding coverage for a special dependent, see “[Dependent Eligibility](#)” in the Retiree Eligibility section.

**Stepchild:** You may add coverage for a stepchild if the child lives with you and if you — the retiree — either jointly or individually claim the stepchild as a dependent on your federal income tax return. See “Determining a Child’s Eligibility” under “[Dependent Eligibility](#)” in the Retiree Eligibility section.

**Stepchild of your Company-recognized Domestic Partner:** You may add coverage for the stepchild of your Company-recognized Domestic Partner if the child lives with you and your Company-recognized Domestic Partner claims the child on his or her federal income tax return and the tax return indicates the same address as yours.

**Birth or adoption of a child:** To add a natural child to coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth. You should not wait to receive the baby’s Social Security Number or official birth certificate to add the child to your coverage. 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 benefits coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective with the date the child is placed with you for adoption and is not retroactive to the child’s date of birth.

**Relocation:** If you are enrolled in the Retiree Value Plus Option or Retiree HMO Option (RHMO) (if you reside in Puerto Rico) and you move to a location where Retiree Value Plus or RHMO is available, you will stay enrolled in Retiree Value Plus or RHMO. If the Retiree Value Plus or RHMO is not available, you must choose the RSM Option. However, if you change Retiree Medical Benefit options, your deductibles and out-of-pocket maximums may not transfer to the new option. If you are enrolled in the RSM Option, you stay in this option.

Contact HR Services and a representative will assist you with your selection. If you are enrolled in the Retiree Value Plus Option and you do not process your relocation Life Event within 60 days of your move, you will automatically be enrolled in the RSM Option and will receive a confirmation statement indicating your new coverage. If you want to process a Relocation or Move Life Event within the last two months of the year, you must contact HR Services so they can help you ensure that you make appropriate changes for the remainder of this current year and for next year.

## Benefits Not Affected by Life Events

The following benefits are not affected by Life Events, except as noted:

- **Retiree Medical Options:** Once you elect your Retiree Medical Benefit Option for the year (either at initial enrollment or at annual enrollment), you must remain in your elected Option for the entire plan year — you are not allowed to change your Retiree Medical Benefit Option outside the annual enrollment period, even if you experience a recognized Life Event.
- **Important note:** Relocation is the only event that enables you to change your Retiree Medical Benefit Option outside the annual enrollment period as follows: If you are enrolled in the Retiree Value Plus Option and you move to a location where Retiree Value Plus is available, you will stay enrolled in Retiree Value Plus. If Retiree Value Plus is not available, you must choose the RSM Option. However, if you change Retiree Medical Benefit Options, your deductibles and out-of-pocket maximums do not transfer to the new option. If you are enrolled in the RSM Option, you may stay in that option or elect Retiree Value Plus Option.



## When Coverage Ends

Coverage will end in the Retiree Medical Benefit in the following situations:

- Coverage for Agents, Representatives, Planners who retire on or after January 1, 2011 and Officer, Management/Specialist or Support Staff retirees age 65 or over ends when you reach age 65. Coverage ends for your spouse or Company-recognized Domestic Partner when you reach age 65 or when he or she reaches age 65, whichever occurs first.
- Coverage for Agents, Representatives, Planners who retire on or after January 1, 2011 and Officer, Management/Specialist or Support Staff retirees under age 65, will end when you elect to discontinue payments, fail to make payments or when a payment is returned unpaid for insufficient funds (this is the same as discontinuing payment) or when your payment is not made timely (this means that the payment is not postmarked by the due date or before the end of the 30-day grace period allowed for payment).
- Coverage for a retiree or a dependent ends when he or she exhausts his or her individual medical maximum benefit.
- Coverage for your dependent children ends when you die. However, your surviving spouse may keep Retiree Medical Benefit coverage for a period of time after your death. If your Company-recognized Domestic Partner is covered under the Retiree Medical Benefit at the time of your death, coverage will continue for the 90 days immediately following your death. At the end of the 90-day period, your Company-recognized Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months. The 90 days of coverage are included in the 36 months. Dependent children of your Company-recognized Domestic Partner are eligible for COBRA for up to 36 months but do not receive the 90 days of coverage immediately following your death.
- Coverage for your dependent children ends when you reach age 65.
- Coverage for a dependent ends if the dependent no longer meets the eligibility requirements. See "[When Coverage Ends](#)" in the Additional Rules section for more information.

# ***Retiree Medical Benefit Options Overview***

You may choose one of the following Retiree Medical Benefit options:

- Retiree Standard Medical Option
  - Pre-65
  - Age 65 or over
- Retiree Value Plus Option (Pre-65)
- Retiree HMO (if you are Pre-65 and live in Puerto Rico)

The RSM and Retiree Value Plus Options are administered by United Healthcare (UHC), Aetna and Blue Cross and Blue Shield of Texas.

The RSM Option for eligible age 65 or over retirees is solely administered by UHC.

The RHMO is fully insured and underwritten by Triple S Health Care of Puerto Rico.

You may choose from the following coverage levels:

- Retiree
- Retiree + one
- Retiree + two or more (if Pre-65)

If you are married to an AMR employee, see “[AA Retiree Married to an AA Employee](#)” in the Retiree Eligibility section for more information.

Your dependents must be enrolled in the same medical option that you are enrolled in. You cannot enroll your dependents in a different option.

## In This Section

- Network Administrators
  - Administrator's Discretion
- Maximum Medical Benefit
  - Retiree Participants Who Elect to Move Between the RSM Option and Retiree Value Plus Option
  - Examples of Maximum Medical Benefits
  - On or Before 10/31/2012, Maximum Medical Benefit for Your Surviving Spouse of a Pilot, Flight Attendant, TWU-Represented employee or an Agent, Representative or Planner (who retired on or before December 31, 2010) Retiree
  - Maximum Medical Benefit for Your Surviving Spouse of an Agent, Representative or Planner (who retired on or after January 1, 2011 but on or before October 31, 2012) Retiree or Officer, Management/Specialist or Support Staff Retiree
  - Age 65 and Older Medicare-Eligible Retirees — Pilots, Flight Attendants, TWU Represented Retirees and Agents, Representatives or Planners (who retired on or before December 31, 2010) Retirees
  - Medicare-Eligible Retirees — Agent, Representative or Planner (who retired on or after January 1, 2011) Retirees and Officer, Management/Specialist and Support Staff Retirees
  - Article 30 Provision (Applies to Flight Attendants Only)
  - If You Are Rehired
  - When You Return to Retirement
- Retiree Medical Benefit Options Comparison
  - Retiree Medical Benefit Options Comparison — Pilot, Flight Attendant and TWU Represented Retirees On or Before 10/31/12
  - Retiree Medical Benefit Options Comparison — Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees
- Mid-Year Medical Benefit Option Change: Impact on Deductibles and Out-of-Pocket Maximums
- Mental Health and Chemical Dependency Benefits
- Gender Reassignment Benefit (GRB)
- Covered Expenses
- Excluded Expenses
- CheckFirst (Pre-Determination of Benefits)
- QuickReview (Pre-Authorization) — Network Administrator
  - When to Request Approval from Your Network Administrator

## Network Administrators

The Retiree Standard Medical Option (Pre-65) and the Retiree Value Plus Option are administered by three network administrators:

- Aetna
- Blue Cross and Blue Shield of Texas (BCBS)
- UnitedHealthcare (UHC)

A network administrator is the health plan administrator that processes health care claims and manages a network of health care providers and care facilities.

Each state has a designated preferred network administrator. Your state is determined by the ZIP code of your Jetnet alternate address on record. Jetnet allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence). Since many employees maintain more than one residence, you may list both addresses in Jetnet; however, your alternate address determines your network administrator. If you do not have an alternate address listed in Jetnet, your network administrator is based on your permanent address.

The Retiree Standard Medical Option (age 65 and over) is administered by UnitedHealthcare (UHC).

See the [Retiree Value Plus Option](#) section and the [Retiree Standard Medical Option](#) section for more information on network administrators and your medical option.

## Administrator's Discretion

The Plan Administrator may, at its sole discretion, pay benefits for services and supplies not specifically stated under the Plans. If this service or supply you've received is more expensive when a less expensive alternative is available, the Plan(s) pays benefits based on the less expensive service or supply that is consistent with generally accepted standards of appropriate medical, dental or other professional health care.

## Maximum Medical Benefit

Maximum medical benefit amounts for retirees and eligible dependents are based on your age, your date of retirement, your workgroup, the Retiree Medical Benefit Option you select, and your prior use of the group health plan.

Your retiree maximum medical benefit is determined at the time you enter a new medical benefit option. If you move between RSM Option and Retiree Value Plus, the amount you have used as a retiree will accumulate from both the RSM Option and Retiree Value Plus (or other company-sponsored retiree medical benefit, should other such benefits be created) toward a common retiree maximum medical benefit. For more information and examples, see the paragraphs immediately following this chart:

Retiree Standard Medical Option – Maximum Medical Benefit			
If you were...	And You are Pre-65...		And You are Age 65 or Older
	And You Retired Before 1/1/98	And You Retired On or After 1/1/98	
A Pilot or Flight Engineer	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, reduced by benefits you used under the active medical benefit.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, or the remainder of your maximum medical benefit under the active medical benefit, whichever is less.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>You and your covered spouse each have a maximum benefit of \$50,000 or the remainder of your maximum medical benefit before age 65, if less.</li> <li>You are not eligible for annual restoration.</li> </ul>
An Agent, Representative or Planner	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, reduced by benefits you used under the active medical benefit.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, or the remainder of your maximum medical benefit under the active medical benefit, whichever is less.</li> <li>Automatic annual restoration applies.</li> </ul>	<p><b>For Agents, Representative and Planners who retired on or before December 31, 2010:</b></p> <ul style="list-style-type: none"> <li>If you retired before January 1, 1990, you and your covered spouse each have a maximum benefit of \$50,000 or the remainder of your maximum medical benefit before age 65, if less.</li> </ul>

Retiree Standard Medical Option – Maximum Medical Benefit			
If you were...	And You are Pre-65...		And You are Age 65 or Older
	And You Retired Before 1/1/98	And You Retired On or After 1/1/98	
<b>CONTINUED</b> An Agent, Representative or Planner			<ul style="list-style-type: none"> <li>• If you retired between January 1, 1990, and April 30, 2003, and you contributed to prefunding, you and your covered spouse each have a maximum medical benefit of \$50,000.</li> <li>• If you retired on or after January 1, 1969, but before November 1, 1980, you have a maximum medical benefit of \$50,000 at age 65.</li> <li>• You are not eligible for annual restoration.</li> </ul> <b>For Agents, Representative and Planners who retired on or after January 1, 2011:</b> <ul style="list-style-type: none"> <li>• Effective 1/1/11 there is no coverage for age 65 or over retirees in the Agent, Representative and Planner workgroup.</li> </ul>

Retiree Standard Medical Option – Maximum Medical Benefit			
If you were...	And You are Pre-65...		And You are Age 65 or Older
	And You Retired Before 1/1/98	And You Retired On or After 1/1/98	
A TWU-Represented Employee	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, reduced by benefits you used under the active medical benefit.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, or the remainder of your maximum medical benefit under the active medical benefit, whichever is less.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>If you retired before January 1, 1990, you and your covered spouse each have a maximum benefit of \$50,000 or the remainder of your maximum medical benefit before age 65, if less.</li> <li>If you retired on or after January 1, 1990, and you contributed to prefunding, you and your covered spouse each have a maximum medical benefit of \$50,000.</li> <li>You are not eligible for annual restoration.</li> </ul>
An Officer, Management / Specialist or Support Staff Employee	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, reduced by benefits you used under the active medical benefit.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, or the remainder of your maximum medical benefit under the active medical benefit, whichever is less.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>Effective 1/1/10 there is no coverage for age 65 or over retirees in the Officer, Management / Specialist and Support Staff workgroup.</li> </ul>



Retiree Standard Medical Option – Maximum Medical Benefit			
If you were...	And You are Pre-65...		And You are Age 65 or Older
	And You Retired Before 1/1/98	And You Retired On or After 1/1/98	
A Flight Attendant	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, reduced by benefits you used under the active medical benefit.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$300,000, or the remainder of your maximum medical benefit under the active medical benefit, whichever is less.</li> <li>Automatic annual restoration applies.</li> </ul>	<ul style="list-style-type: none"> <li>If you retired before 1/1/02, you and your covered spouse each have a medical maximum of \$50,000 or the remainder of your maximum medical benefit before age 65, if less.</li> <li>If you retired on or after January 1, 2002, and contributed to prefunding, you and your covered spouse each have a maximum medical benefit of \$50,000.</li> <li>You are not eligible for annual restoration.</li> </ul>
A Flight Attendant Who Terminated Under Article 30	For those who took Article 30 prior to September 12, 2012: <ul style="list-style-type: none"> <li>You and your dependents each have a maximum medical benefit of \$20,000.</li> <li>You are not eligible for annual restoration.</li> <li>Flight Attendants terminating under Article 30 on or after September 12, 2012, are not eligible for Retiree Medical Benefits.</li> <li>If you are terminating under Article 30, you must provide written notice to your supervisor and People Services at least 60 days prior to your termination.</li> </ul>		

Retiree Value Plus Option – Maximum Medical Benefit		
If you voluntarily elected the Retiree Value Plus Option and you are a retired...	You are Pre-65	You are Age 65 or Older
<ul style="list-style-type: none"> <li>• Pilot</li> <li>• Flight Engineer</li> <li>• Flight Attendant</li> <li>• TWU-Represented Employee</li> <li>• Agent/Representative/Planner (who retired on or before December 31, 2010)</li> <li>• Management/Specialist, Officer and Support Staff (who retired on or before December 31, 2009)</li> </ul>	<p>Before 11/1/12:</p> <ul style="list-style-type: none"> <li>• You and your dependents each have a maximum medical benefit of \$1,000,000.</li> <li>• You are not eligible for annual restoration.</li> </ul> <p>On or after 1/1/13:</p> <ul style="list-style-type: none"> <li>• You and your dependents each have a maximum medical benefit of \$1,000,000.</li> <li>• You not eligible for annual restoration.</li> </ul>	<ul style="list-style-type: none"> <li>• When you become age 65 that coverage terminates and you revert to RSM.</li> <li>• Your Retiree Value Plus Option coverage terminates, and your medical coverage reverts to the RSM Option, with the maximum medical benefit applicable to the RSM Option coverage.</li> <li>• You are not eligible for annual restoration.</li> </ul>
Management/Specialist, Officer and Support Staff (who retire on or after January 1, 2010)	<p>Before 1/1/13:</p> <ul style="list-style-type: none"> <li>• You and your dependents each have a maximum medical benefit of \$1,000,000.</li> <li>• You are not eligible for annual restoration.</li> </ul> <p>After 1/1/13:</p> <ul style="list-style-type: none"> <li>• You and your dependents each have a maximum medical benefit of \$1,000,000.</li> <li>• No annual restoration</li> </ul>	<ul style="list-style-type: none"> <li>• Your Retiree Value Plus Option coverage terminates, and you are no longer eligible for any American Airlines-sponsored retiree medical benefit coverage</li> </ul>

## Retiree Participants Who Elect to Move Between the RSM Option and Retiree Value Plus Option

Maximum Medical Benefits are based on your annual election. However, if you move between the RSM Option and the Retiree Value Plus Option, your benefits will accumulate on a combined basis. This means that if you move from the RSM Option to the Retiree Value Plus Option, any benefits paid to you under the RSM Option shall apply to the Maximum Medical Benefit of the Retiree Value Plus Option. If you move from the Retiree Value Plus Option to the RSM Option, any benefits paid to you under the Retiree Value Plus Option shall apply to the Maximum Medical Benefit of the RSM Option.

### Examples of Maximum Medical Benefits

#### A participant in the Retiree Value Plus Option

Example 1: A new under-65 retiree elects the Retiree Value Plus Option upon retirement. When he was an active employee he used \$4,800,000 of active coverage. Under the Retiree Value Plus, the Maximum Medical Benefit is \$1,000,000. Now that he is a retiree, his available Maximum Medical Benefit under the Retiree Value Plus Option is \$1,000,000.

Example 2: A new under-65 retiree elects the Retiree Value Plus Option upon retirement. When he was an active employee he used \$300,000 of active coverage. Under the Retiree Value Plus Option, the Maximum Medical Benefit is \$1,000,000. Now that he is a retiree, his available Maximum Medical Benefit under the Retiree Value Plus Option is \$1,000,000.

#### A participant in the RSM Option

Example 1: A new under-65 retiree elects the RSM Option upon retirement. When he was an active employee he used \$200,000 of active benefits paid. Under the RSM Option, the Maximum Medical Benefit is \$300,000, or the amount remaining under his active coverage, whichever is less. This means that now that he is a retiree, his available Maximum Medical Benefit is \$300,000.

Example 2: A new under-65 retiree elects the RSM Option upon retirement. When he was an active employee he used \$4,800,000 of active benefits paid. Under the RSM Option, the Maximum Medical Benefit is \$300,000, or the amount remaining under his active coverage, whichever is less. This means that now that he is a retiree his available Maximum Medical Benefit under the RSM Option is \$300,000.

#### A participant transitioning from RSM Option to Retiree Value Plus Option

Example 1: An existing under-65 retiree first entered the RSM Option with a \$300,000 Maximum Medical Benefit. He used \$100,000 of this \$300,000 amount and then transitions to the Retiree Value Plus Option. His available Retiree Value Plus Option Maximum Medical Benefit is \$900,000 (\$1,000,000 minus the amount previously paid under the RSM Option).

Example 2: An existing under-65 retiree first entered RSM Option with a \$300,000 Maximum Medical Benefit. He used his entire \$300,000 amount and attempts to transition to the Retiree Value Plus Option. However, because his Maximum Medical Benefit has been exhausted before the desired transition, he is not permitted to become a Retiree Value Plus Option participant and no longer has medical coverage under the Retiree Medical Benefit.

### **A participant transitioning from the Retiree Value Plus Option to the RSM Option**

Example: An existing under-65 retiree first entered the Retiree Value Plus Option with a \$1,000,000 Maximum Medical Benefit. He used \$100,000 of this amount and then transitioned to the RSM Option. Under the RSM Option, the Maximum Medical Benefit is \$300,000. His available RSM Option Maximum Medical Benefit is \$200,000 (\$300,000 minus the amount previously paid under Retiree Value Plus).

### **A participant transitioning from the RSM Option to the Retiree Value Plus Option back to the RSM Option**

Example: An existing under-65 retiree first entered the RSM Option with a \$300,000 Maximum Medical Benefit. He used \$100,000 of this amount and transitioned to the Retiree Value Plus Option with an available \$900,000 Maximum Medical Benefit. He used \$100,000 of this amount (or \$200,000 in total) and then transitions back to RSM Option. Now his available RSM Option Maximum Medical Benefit is \$100,000.

## **On or Before 10/31/2012, Maximum Medical Benefit for Your Surviving Spouse of a Pilot, Flight Attendant, TWU-Represented employee or an Agent, Representative or Planner (who retired on or before December 31, 2010) Retiree**

If you are Pre-65 at the time of your death, the maximum medical benefit for your surviving spouse is as follows:

- If you prefunded or you are paying required ongoing contributions for your Retiree Medical Benefit in retirement, your surviving spouse will have a maximum medical benefit of \$50,000. Your spouse is not eligible for annual restoration.
- If you were not required to prefund, your surviving spouse will have a maximum medical benefit of \$50,000 or the remainder of his or her maximum medical benefit before your death, whichever is less. Your spouse is not eligible for annual restoration.
- At the time of your death, your spouse may elect to purchase continuation of coverage under COBRA for up to 36 months. If he or she is also enrolled in Medicare at that time and elects COBRA coverage, Medicare will be the primary coverage and the continuation of the Retiree Medical Benefit through COBRA will be secondary. If your spouse takes COBRA and later enrolls in Medicare, his or her COBRA coverage will cease.

- If your Company-recognized Domestic Partner is covered under the Retiree Medical Benefit at the time of your death, coverage will continue for the 90 days immediately following your death. At the end of the 90-day period, your Company-recognized Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months. The 90 days of free coverage are included in the 36 months. Dependent children of your Company-recognized Domestic Partner are eligible for COBRA for up to 36 months but do not receive the 90 days of free coverage immediately following your death.

If you are age 65 or over at the time of your death, your surviving spouse's maximum medical benefit will not be affected, because it was reduced when you turned 65.

## **Maximum Medical Benefit for Your Surviving Spouse of an Agent, Representative or Planner (who retired on or after January 1, 2011 but on or before October 31, 2012) Retiree or Officer, Management/Specialist or Support Staff Retiree**

If you are Pre-65 at the time of your death and your spouse is also Pre-65 at the time of your death, the maximum medical benefit for your surviving spouse is as follows:

- Because you are paying required ongoing contributions for your Retiree Medical Benefit in retirement, your surviving spouse will have a maximum medical benefit of \$50,000, as long your surviving spouse is eligible for coverage. Once your spouse reaches age 65 or remarries, he or she is no longer eligible for coverage under the Retiree Medical Benefit Option.
- At the time of your death, your spouse may elect to purchase continuation of coverage under COBRA for up to 36 months or until the time he or she turns 65, whichever comes first. If he or she is also enrolled in Medicare at that time and elects COBRA coverage, Medicare will be the primary coverage and the continuation of the Retiree Medical Benefit through COBRA will be secondary. If your spouse takes COBRA and later enrolls in Medicare, his or her COBRA coverage will cease.
- If your Company-recognized Domestic Partner is covered under the Retiree Medical Benefit at the time of your death, coverage will continue for the 90 days immediately following your death. At the end of the 90-day period, your Company-recognized Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months. The 90 days of free coverage are included in the 36 months. Dependent children of your Company-recognized Domestic Partner are eligible for COBRA for up to 36 months but do not receive the 90 days of free coverage immediately following your death.

If you are age 65 or over at the time of your death, you are no longer eligible for coverage under the Retiree Medical Benefit Option and your surviving spouse is no longer eligible as well.

## **Age 65 and Older Medicare-Eligible Retirees — Pilots, Flight Attendants, TWU-Represented Retirees and Agents, Representatives or Planners (who retired on or before December 31, 2010) Retirees**

If you are eligible for Medicare, Medicare is your primary coverage and the Retiree Medical Benefit is your secondary coverage.

Your spouse's medical maximum benefit reduces at the time you turn 65, regardless of his or her age.

If you are age 65 or over and your spouse is Pre-65 at the time you retire, your spouse can elect to purchase coverage under COBRA to continue to be eligible for the higher medical maximum benefit under the active coverage. At the end of the COBRA continuation period, you can add your spouse as a dependent under your Retiree Medical Benefit coverage. To make this change you must process a Life Event change within 60 days of the event. If you miss the 60-day deadline, you will not be able to make a Life Event change until the next Annual Benefits Enrollment period. Contact HR Services to process this change.

In the event of your death, if you have Retiree Medical Benefit coverage for yourself and your spouse, the length of time your spouse's coverage will continue depends on your spouse's age at the time of your death. If your Company-recognized Domestic Partner is covered under the Retiree Medical Benefit at the time of your death, coverage will continue at no cost for the 90 days immediately following your death. At the end of the 90-day period, your Company-recognized Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months. The 90 days of coverage are included in the 36 months. Dependent children of your Company-recognized Domestic Partner are eligible for COBRA coverage for up to 36 months but do not receive the 90 days of coverage immediately following your death at no cost.

- If your spouse is Pre-65, coverage continues until your spouse reaches age 65, becomes eligible for Medicare or remarries, whichever comes first.
- If your spouse is age 65 or over, coverage continues for six months.



## Medicare-Eligible Retirees — Agent, Representative or Planner (who retired on or after January 1, 2011) Retirees and Officer, Management/Specialist and Support Staff Retirees

If you are Pre-65 and eligible for Medicare, Medicare is your primary coverage and the Retiree Medical Benefit is your secondary coverage.

If you are 65 or over, Medicare is your primary coverage. You are not eligible for American Airlines-sponsored retiree medical coverage.

If you are age 65 or over and your spouse is Pre-65 at the time you retire, your spouse can elect to purchase active coverage under COBRA.

In the event of your death, if you have Retiree Medical Benefit coverage for yourself and your spouse, the length of time your spouse's coverage will continue depends on the date you would have reached age 65 or your spouse reaches age 65, whichever occurs first. If your Company-recognized Domestic Partner is covered under the Retiree Medical Benefit at the time of your death, coverage will continue at no cost for the 90 days immediately following your death. At the end of the 90-day period, your Company-recognized Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months. The 90 days of coverage are included in the 36 months. Dependent children of your Company-recognized Domestic Partner are eligible for COBRA coverage for up to 36 months but do not receive the 90 days of coverage immediately following your death at no cost.

- If your spouse is Pre-65, coverage continues until you would have reached age 65, your spouse reaches age 65, becomes eligible for Medicare or remarries, whichever comes first.
- If your spouse is age 65 or over, he or she is no longer eligible for coverage in the Retiree Medical Benefit Option.

## Article 30 Provision (Applies to Flight Attendants Only)

For Flight Attendants who took Article 30 prior to September 12, 2012, if you terminate employment after you reach age 45, but before age 55 and you have at least twenty (20) years of Company seniority, you are eligible for Article 30 early resignation, which provides limited Retiree Standard Medical (RSM) Option and Retiree Life Insurance Benefit coverage.

If you terminate employment under Article 30, you and your eligible dependents are covered under the RSM Option (you are not eligible for coverage under the Retiree Value Plus Option or the RHMO Option [if you are Pre-65 and reside in Puerto Rico]). In general, your benefits are the same as those described, with the following exceptions:

- The medical maximum benefit for each covered family member is \$20,000. Annual restoration does not apply.
- The annual deductible is currently \$200 per individual (\$600 per family).
- Coverage ends upon your death or when your surviving spouse becomes eligible for Medicare, if later.
- **For Flight Attendants who took Article 30 on or after September 12, 2012,** you are not eligible for Retiree Medical benefits.



## If You Are Rehired

This section does not apply to retirees who work at American Airlines as temporary workers. This only applies to retirees who are rehired as active regular employees.

American Airlines may, from time-to-time, offer active, employment to retirees. If you retire from American Airlines and are later rehired by American you are referred to as a “retiree-to-rehire” employee. Retiree-to-rehire employees move from retiree to active benefit status. When your retiree-to-rehire employment with American ends, you will return to retiree benefit status based on your original retirement date - that is, if you originally retired on or prior to October 31, 2012, you will return to the same benefits that were in force at the time you originally retired.

In order for this situation to occur, the retiree-to-rehire employee must have the ability to accept employment and later return to the retiree plan.

As a retiree-to-rehire employee, you will be eligible for the same health and welfare benefits available to other eligible active employees in your workgroup and will pay the same rates.

If you are rehired into a workgroup eligible for limited benefit plans (Home-Based Representatives and Level 84 Premium Services Representatives) you will be eligible for these health/life benefits; furthermore, your coverage limits will be in accordance with the provisions of these limited benefit plans.

### If You Prefunded

If you are returning to a workgroup that has prefunding, you will not prefund, as your Retiree Medical Benefit was already prefunded during your first active employment period.

When you return to retirement, you will automatically return to the same retiree coverage you participated in immediately prior to your most recent rehire, subject to any changes made to the coverage since you left the plan. Your claims will accumulate towards your Maximum Medical Benefit under the Retiree Medical Benefit.

### If You Did Not Prefund — Agent, Representative and Planner (who retired on or after January 1, 2011) Retirees

If you are returning to a workgroup that does not have prefunding, you will be required to continue to make timely contributions to retain your Retiree Medical Benefit coverage.

If you are Pre-65 when you initially accept active employment as a retiree-to-rehire employee, upon your subsequent retirement, if you are over 65, you are considered post-funded. You will be required to continue to make timely contributions to retain your Retiree Medical Benefit coverage.

## When You Return to Retirement

When you return to retirement, you will automatically return to the same retiree coverage you participated in immediately prior to your most recent rehire, subject to any changes made to the coverage since you left the plan. Your claims will accumulate towards your Maximum Medical Benefit under the Retiree Medical Benefit. You may re-enter the Retiree Medical Benefit when you return to retirement by resuming payment of your coverage contributions (if applicable). Your rates will be those in effect at the time of your return to retirement. Your rates will not be retroactive.

Upon your return to retirement, should you need to make any changes to your benefits, contact HR Services (see “[Contact Information](#)” in the Reference Information section).

# Retiree Medical Benefit Options Comparison

Effective January 1, 2013, Home-Based Representatives and Level 84 Premium Service Representatives are eligible for Retiree Medical benefits.

The following tables provide a summary of features under the Retiree Standard Medical (RSM) and Retiree Value Plus Options. Benefits are available for eligible expenses that are medically necessary.

- With respect to out-of-network expenses incurred under the RSM Option, eligible expenses must also fall within the usual and prevailing fee limits.
- With respect to out-of-network expenses incurred under the Retiree Value Plus Option, eligible expenses must also fall within 140% of MNRP limits.

The tables show the amount or percentage you pay for eligible expenses. You pay any amounts not covered by the options.

As you review the following Retiree Medical Benefit Options comparison tables, please keep the following points in mind:

- The out-of-pocket maximum applies to co-insurance amounts you pay under the RSM Option and to in-network services under the Retiree Value Plus Option (i.e., for hospital services, including inpatient and outpatient care and surgery). The out-of-pocket maximum does not include deductibles or co-payment amounts, amounts not covered, amounts exceeding the usual and prevailing fee limits or services covered at 50% (RSM Option) or amounts exceeding 140% of MNRP limits (Retiree Value Plus Option).
- Under the RSM Option, the retail prescription drug charges apply to the medical deductible, co-insurance and annual out-of-pocket amounts.
- Mail order prescription drug co-payments/co-insurance amounts do not apply to the out-of-pocket maximum (for both the RSM and Retiree Value Plus Options).
- Your network administrator uses your 5-digit ZIP code of your Alternate Address in Jetnet (or if you have no Alternate Address listed, from your Permanent Address in Jetnet) — your network administrator's standard access requirements — to determine eligibility for the Retiree Value Plus Option. Employees living outside your network administrator's access area are not eligible for the Retiree Value Plus Option and must select the RSM Option (or the RHMO, if you live in Puerto Rico and are Pre-65. See the [Retiree HMO section](#) for more information).
- Visit your network administrator's website to determine if your physician is an in-network provider.
  - **If you are a Pilot, Flight Engineer, Flight Attendant or TWU-Represented retiree:** If you are covered under the RSM Option or you use out-of-network services or in-network hospital-based services under the Retiree Value Plus Option, you must satisfy any individual annual deductibles before the Retiree Medical Option pays benefits for eligible expenses.

- **If you are an Agent/Representative/Planner or Officer, Management/Specialist or Support Staff retiree:** If you use out-of-network services or in-network hospital-based services under the RSM or Retiree Value Plus Option, you must satisfy any individual annual deductibles before the Retiree Medical Option pays benefits for eligible expenses.

For information regarding eligible medical expenses and expenses that are excluded from coverage, refer to “[Covered Expenses](#)” and “[Excluded Expenses](#)”.

If you reside in Puerto Rico and are Pre-65, you are eligible to enroll in the Retiree HMO. See the [Retiree HMO section](#) for more information.

## Retiree Medical Benefit Options Comparison — Pilot, Flight Attendant and TWU-Represented Retirees

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
<b>Individual Annual Deductible</b> <ul style="list-style-type: none"> <li>For most covered services with a co-insurance component, the deductible must be met before benefits are payable</li> <li>Co-pays are not subject to the deductible</li> </ul>	\$150	\$250	\$750
<b>Family Annual Deductible</b> <ul style="list-style-type: none"> <li>For most covered services with a co-insurance component, the deductible must be met before benefits are payable</li> <li>Covered expenses from any and all covered persons can be used to meet the family annual deductible</li> <li>Co-pays are not subject to the deductible</li> </ul>	\$400	N/A	N/A

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
<b>Individual Annual Out-of-Pocket Max</b> <ul style="list-style-type: none"><li>Only each individual's portion of covered expenses can be used to meet the individual annual out-of-pocket maximum</li><li>Co-pays and deductibles cannot be used to meet the individual annual out-of-pocket maximum</li></ul>	\$1,000	\$1,750 per person for services that require you pay 15%	N/A
<b>Maximum Medical Benefit</b>	\$300,000 per retiree and per covered family member less benefits used under active medical coverage	\$1,000,000 per retiree and per covered family member, less benefits used under the RSM Option	
	See " <a href="#">Retiree Participants Who Elect to Move Between the RSM Option and Retiree Value Plus Option</a> "		
<b>Preventive Care</b>			
<b>Annual Routine Physical Exams</b>	Not Covered	No Cost	Not Covered
<b>Well-child care</b>	Not Covered	No Cost	35% For Children up to age 2, Initial hospitalization following birth, All immunizations, Up to 7 well-child care visits
<b>Medical Services</b>			
<b>Physician Office Visit</b> (including X-ray and lab work)	20%	\$30 co-pay per visit to Primary Care Physician (PCP)	35%
<b>Specialist Office Visit</b> (including X-ray and lab work)	20%	\$40 co-pay per visit	35%
<b>Urgent/Immediate Care Clinic</b>	20%	\$40 co-pay per visit	35%

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
<b>Gynecological care</b>	20% preventive care not covered (except for mammogram, as listed below)	\$30 per visit to an OB/GYN (Same as a visit to a Primary Care Physician, whether the OB/GYN is treating you in the capacity of a specialist or a Primary Care Physician)  (OB/GYN visits related to care during pregnancy are subject to the \$150 copayment)	35% if medically necessary; preventive care not covered (except for mammograms, as listed below)
<b>Pap tests</b>	20% if medically necessary; routine pap tests are not covered	No cost if part of office visit	35% if medically necessary; routine pap tests are not covered
<b>Mammograms – routine preventive</b>	20% if medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in Covered Expenses for detailed information.	No cost, based on age guidelines, regardless of facility	35% if medically necessary; routine mammograms are covered beginning at age 35

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
<b>Mammograms – diagnostic</b> (test performed because of symptoms/ problem)	20% if medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in Covered Expenses for detailed information.	No cost if part of an office visit or at an independent facility  15% if hospital outpatient	35% if medically necessary
<b>Pregnancy</b>	20%	\$150 per pregnancy includes pre- and post-natal visits and delivery.  This includes physician's charges only; hospital charges are the same as for any hospitalization	35%
<b>Second surgical opinions</b> (No cost if ordered by the plan or claims processor)	20% if elected by participant	\$40 if elected by participant	35% if elected by participant
<b>Chiropractic care</b>	20% if medically necessary	\$40 per visit Maximum 20 chiropractic visits per person per year combined in-network and out-of-network	35% Maximum 20 chiropractic visits per person per year combined in-network and out-of-network
<b>Speech, physical, occupational, restorative and rehabilitative therapy</b> if medically necessary	20%	\$40 per visit	35%



Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
Allergy Care			
Physician’s office visit	20%	PCP - \$30 per visit Specialist - \$40 per visit	35%
Allergy testing, shots or serum	20%	No cost if administered in physician’s office \$30 copay for PCP \$40 copay for specialist visit	35%
Outpatient Services			
Diagnostic X-ray and lab At a hospital	20%	15%	35%
Diagnostic X-ray and lab At an independent in-network lab or at a physician’s office	20%	No Cost	35%
Outpatient surgery in physician’s office (pre-authorization is recommended to ensure medical necessity; see “ <a href="#">CheckFirst (Pre-Determination of Benefits)</a> ”)	20% See special outpatient surgery benefit for Pilot, Flight Engineer and Flight Attendant retirees for certain procedures.	\$30 per PCP visit \$40 per specialist visit	35%
Outpatient surgery in a hospital or independent surgical facility (pre-authorization is recommended to ensure medical necessity; see “ <a href="#">CheckFirst (Pre-Determination of Benefits)</a> ”)	20% See special outpatient surgery benefit for Pilot, Flight Engineer and Flight Attendant retirees for certain procedures.	15%	35%
Pre-admission testing at a hospital	20%	15%	35%
Pre-admission testing at an independent in-network lab or a doctor’s office	20%	No Cost	35%

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
Hospital Services			
<b>Inpatient room and board, including intensive care unit or special care unit</b>  Pre-authorization required	20% after annual deductible is met.  For Pilot, Flight Engineer, Flight Attendant and TWU-Represented retirees, see Inpatient Hospital Expenses.	15%	35%
<b>Ancillary services, including radiology, pathology, operating room and supplies</b>  Pre-authorization required	20% after annual deductible is met.  For Pilot, Flight Engineer, Flight Attendant and TWU-Represented retirees, see Inpatient Hospital Expenses.	15%	35%
<b>Newborn nursery care</b> Treatment of the newborn’s illness or injury is considered under the baby’s coverage, not the mother’s.  <b>IMPORTANT NOTE:</b> Within 60 days of the birth, you must process a Life Event change online through Jetnet to enroll your baby in your health coverage.  If you do not, you must wait until the next Annual Benefits Enrollment period to enroll your baby in coverage. Payment of maternity claims does not automatically enroll your baby.	20% if hospitalization for newborn’s illness or injury.  Routine well-newborn care is not covered — you pay the full cost.  Pre-authorization required.	15%	35%
<b>Surgery and related expenses</b> (such as anesthesia and medically necessary assistant surgeon)	20%	15%	35%
<b>Blood transfusions</b>	20%	15%	35%

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
Blood transfusions — physician's office	20%	No Cost	35%
Organ transplants	20%	15%	35%
Emergency ambulance	20%	No Cost	No Cost
Emergency room	20% Accidents are covered at no cost and with no deductible for the first \$250 in covered expenses. If two or more family members are injured in the same accident, only one deductible applies	15% for emergency room care	35%
Out of Hospital Care			
Convalescent and skilled nursing facilities following hospitalization	50% maximum of 60 days per illness or injury	15% Maximum of 60 days per illness for in-network and out-of-network combined	35% Maximum of 60 days per illness for in-network and out-of-network combined
Home health care	20%	No Cost when approved by your network administrator	35%
Hospice care	20%	15%	35%
Other Services			
Tubal ligation or vasectomy (reversals are not covered)	20%	\$40 copay in physician's Office 15% in hospital	35%
Infertility treatment, including in-vitro fertilization	Not covered	Not covered	Not covered
Radiation therapy and chemotherapy at a physician's office	20%	No Cost	35%
Radiation therapy and chemotherapy at a hospital or freestanding facility	20%	15%	35%

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
<b>Kidney dialysis at a physician's office</b> (If the dialysis continues more than 12 months, participant must apply for Medicare)	20%	No Cost	35%
<b>Kidney dialysis at a hospital or freestanding facility</b> (If the dialysis continues more than 12 months, participant must apply for Medicare)	20%	15%	35%
<b>Supplies, equipment and durable medical equipment (DME)</b>	20%	15%, regardless of where the device is purchased	35%
<b>Mental Health Benefits - No Treatment Limits</b>			
<b>Inpatient mental health Care</b>	20%	15%	35%
<b>Alternative mental health care center – residential treatment</b>	20%	15%	35%
<b>Alternative mental health care center – intensive outpatient and partial hospitalization</b>	20%	15%	35%
<b>Outpatient mental health Care</b>	20%	15% \$30 PCP Visit \$40 Specialist Visit	35%
<b>Marriage counseling</b>	Not Covered		
<b>Chemical Dependency Benefits</b> No Treatment Limits and EAP Approval is Not Required			
<b>Detoxification</b>	20%	15%	35%
<b>Inpatient chemical dependency rehabilitation</b>	20%	15%	35%
<b>Outpatient chemical dependency rehabilitation</b>	20%	15% \$30 PCP Visit \$40 Specialist Visit	35%

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
<b>Gender Reassignment Benefit</b> (Cumulative benefit for surgery is \$75,000. The cumulative benefit for travel is \$10,000)			
<b>Surgery</b> <ul style="list-style-type: none"><li>• <b>One bilateral mastectomy or bilateral Augmentation mammoplasty</b></li><li>• <b>One genital revision surgery</b></li></ul>	Not Covered	15%	Not Covered
<b>Travel Expenses</b>	Not Covered	Up to \$10,000	Not Covered
<b>Non-Surgical Treatments</b> <ul style="list-style-type: none"><li>• Physician’s visits</li><li>• Specialist visits</li><li>• Outpatient mental health care</li><li>• X-rays and lab work</li><li>• Retail prescription drugs</li><li>• Mail order prescription drugs</li></ul>	Not Covered	Covered as any other illness or injury under the Plan	Not Covered
<b>Prescription Medication</b>			
<b>Retail pharmacies</b> (typically up to a 30-day supply)	20% for most prescription drugs  Express Scripts network pharmacies offer discounts on prescriptions.	<ul style="list-style-type: none"><li>• <b>Generic Drugs:</b> \$10 co-pay</li><li>• <b>Formulary Drugs:</b> 30% (\$20 min/\$75 max)*</li><li>• <b>Non-Formulary Drugs:</b> 50% (\$35 min/\$90 max)*</li></ul> * If you select a brand name drug (Formulary or Non-Formulary) when a generic is available, you will pay the \$10 generic co-pay, plus the cost difference between generic and brand prices. Maximums do not apply.	

Retiree Medical Benefit Options Comparison Pilots, Flight Attendants and TWU-Represented Retirees			
Features	What You Pay Under the Retiree Standard Medical (RSM) Option	What You Pay Under the Retiree Value Plus Plan	
		In-Network	Out-of-Network
<b>Mail order benefit – coverage only for Pre-65 retirees and their covered dependents</b> (up to a 30-day supply — see <a href="#">“Excluded Expenses”</a> )	<ul style="list-style-type: none"> <li>Generic Drugs: \$25 copay for generic</li> <li>Brand Name Drugs: 25% when no generic is available, up to \$150 maximum</li> <li>Brand Name Drugs when generic is Available: \$25 per prescription or refill, plus the cost difference between brand and generic prices</li> </ul>	<ul style="list-style-type: none"> <li>Generic Drugs: 20% (no min/\$80 max)</li> <li>Formulary Drugs: 30% (\$40 min/\$150 max)*</li> <li>Non-Formulary Drugs: 50% (\$70 min/\$180 max)*</li> </ul>	<ul style="list-style-type: none"> <li>Generic Drugs: 20% (no min/\$80 max)</li> <li>Formulary Drugs: 30% (\$40 min/\$150 max)*</li> <li>Non-Formulary Drugs: 50% (\$70 min/\$180 max)*</li> </ul>
<b>Oral contraceptives</b>	Not covered, unless prescribed as medically necessary treatment of a diagnosed illness or injury. (Oral contraceptives used for family planning or birth control are not covered but are offered at a discounted price. See Mail Order Prescription Drug Benefit.)		
<b>Fertility (infertility) medications</b>	Medications used to treat infertility or to promote fertility are never covered.		
<b>Over-the-counter medication (OTC)</b>	Over-the-counter medications are not covered under the retiree medical options.		

## Retiree Medical Benefit Options Comparison — Agent, Representative and Planner, and Officer, Management/ Specialist and Support Staff Retirees

Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
Features	What You Pay Under the Retiree Standard Medical (RSM) Option		What You Pay Under the Retiree Value Plus Option	
	In-Network	Out-of-Network	In-Network	Out-of-Network
<b>Individual Annual Deductible</b> <ul style="list-style-type: none"><li>For most covered services with a co-insurance component, the deductible must be met before benefits are payable</li><li>Co-pays are not subject to the deductible</li></ul>	\$150		\$250	\$750
<b>Family Annual Deductible</b> <ul style="list-style-type: none"><li>For most covered services with a co-insurance component, the deductible must be met before benefits are payable</li><li>Covered expenses from any and all covered persons can be used to meet the family annual deductible</li><li>Co-pays are not subject to the deductible</li></ul>	\$400		N/A	N/A
<b>Individual Annual Out-of-Pocket Max</b> <ul style="list-style-type: none"><li>Only each individual's portion of covered expenses can be used to meet the individual annual out-of-pocket maximum</li><li>Co-pays and deductibles cannot be used to meet the individual annual out-of-pocket maximum</li></ul>	\$1,000	\$1,000	\$1,750 per person for services that require you pay 15%	N/A
<b>Maximum Medical Benefit</b>	\$300,000 per retiree and per covered family member less benefits used under active medical coverage		\$1,000,000 per retiree and per covered family member, less benefits used under the RSM Option	
	See “ <a href="#">Retiree Participants Who Elect to Move Between the RSM Option and Retiree Value Plus Option</a> ”			



Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
Preventive Care				
Annual Routine Physical Exams	Not Covered		No Cost	Not Covered
Well-child care	Not Covered		No Cost	35% For Children up to age 2, Initial hospitalization following birth, All immunizations , Up to 7 well-child care visits
Medical Services				
Physician Office Visit (including X-ray and lab work)	20%	40%	\$30 co-pay per visit to Primary Care Physician (PCP)	35%
Specialist Office Visit (including X-ray and lab work)	20%	40%	\$40 co-pay per visit	35%
Urgent/Immediate Care Clinic	20%	40%	\$40 co-pay per visit	35%

Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
<b>Gynecological care</b>	20%  Preventive care not covered (except for mammogram, as listed below)	40%  Preventive care not covered (except for mammogram, as listed below)	\$30 per visit to an OB/GYN  (Same as a visit to a Primary Care Physician, whether the OB/GYN is treating you in the capacity of a specialist or a Primary Care Physician)  (OB/GYN visits related to care during pregnancy are subject to the \$150 copayment)	35%  if medically necessary; preventive care not covered (except for mammograms, as listed below)
<b>Pap tests</b>	20%  if medically necessary; routine pap tests are not covered	40%  if medically necessary; routine pap tests are not covered	No cost if part of office visit	35%  if medically necessary; routine pap tests are not covered

Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
<b>Mammograms – routine preventive</b>	20%  If medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in Covered Expenses for detailed information	40%  If medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in Covered Expenses for detailed information	Covered 100% according to age guidelines, regardless of facility	35%  if medically necessary; routine mammograms are covered beginning at age 35
<b>Mammograms – diagnostic</b> (test performed because of symptoms/ problem)	20%  If medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in Covered Expenses for detailed information	40%  If medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in Covered Expenses for detailed information	15% if hospital outpatient	35%  if medically necessary

Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
<b>Pregnancy</b>	20%	40%	\$150 per pregnancy includes pre- and post-natal visits and delivery.  This includes physician's charges only; hospital charges are the same as for any hospitalization	35%
<b>Second surgical opinions</b> (No cost if ordered by the plan or claims processor)	20%	40%	\$40 per visit	35% If elected by participant
<b>Chiropractic care</b>	20% if medically necessary	40% if medically necessary	\$40 per visit  Maximum 20 chiropractic visits per person per year combined in-network and out-of-network	35% Maximum 20 chiropractic visits per person per year combined in-network and out-of-network
<b>Speech, physical, occupational, restorative and rehabilitative therapy</b> if medically necessary	20% if medically necessary	40% if medically necessary	\$40 per visit	35%
<b>Allergy Care</b>				
<b>Physician's office visit</b>	20%	40%	PCP - \$30 per visit Specialist - \$40 per visit	35%
<b>Allergy testing, shots or serum</b>	20%	40%	No cost if administered in physician's office \$30 copay for PCP \$40 copay for specialist visit	35%

Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
Outpatient Services				
<b>Diagnostic X-ray and lab At a hospital</b>	20%	40%	15%	35%
<b>Diagnostic X-ray and lab At an independent in-network lab or at a physician's office</b>	20%	40%	No Cost	35%
<b>Outpatient surgery in physician's office</b> (pre-authorization is recommended to ensure medical necessity; see " <a href="#">CheckFirst (Pre-Determination of Benefits)</a> ")	Special outpatient surgery benefit	Special outpatient surgery benefit	\$30 per PCP visit \$40 per specialist visit	35%
<b>Outpatient surgery in a hospital or independent surgical facility</b> (pre-authorization is recommended to ensure medical necessity; see " <a href="#">CheckFirst (Pre-Determination of Benefits)</a> ")	Special outpatient surgery benefit	Special outpatient surgery benefit	15%	35%
<b>Pre-admission testing at a hospital</b>	20%	40%	15%	35%
<b>Pre-admission testing at an independent in-network lab or a doctor's office</b>	20%	40%	No Cost	35%
Hospital Services				
<b>Inpatient room and board, including intensive care unit or special care unit</b> Pre-authorization required	20%	40%	15%	35%
<b>Ancillary services, including radiology, pathology, operating room and supplies</b> Pre-authorization required	20%	40%	15%	35%

Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
<b>Newborn nursery care</b> Treatment of the newborn’s illness or injury is considered under the baby’s coverage, not the mother’s.  <b>IMPORTANT NOTE:</b> Within 60 days of the birth, you must process a Life Event change online through Jetnet to enroll your baby in your health coverage. If you do not, you must wait until the next Annual Benefits Enrollment period to enroll your baby in coverage. Payment of maternity claims does not automatically enroll your baby.	20%	40%	15%	35%
	If hospitalization for newborn’s illness or injury.  Routine well-newborn care is not covered — you pay the full cost.  Pre-authorization required.			
<b>Surgery and related expenses</b> (such as anesthesia and medically necessary assistant surgeon)	20%	40%	15%	35%
<b>Blood transfusions</b>	20%	40%	15%	35%
<b>Blood transfusions — physician’s office</b>	20%	40%	No Cost	35%
<b>Organ transplants</b>	20%	40%	15%	35%
<b>Emergency ambulance</b>	20%	40%	No Cost	No Cost
<b>Emergency room</b>	20%	40%	15% for emergency room care	35%
	Accidents are covered at no cost and with no deductible for the first \$250 in covered expenses. If two or more family members are injured in the same accident, only one deductible applies			
<b>Out of Hospital Care</b>				
<b>Convalescent and skilled nursing facilities following hospitalization</b>	50% maximum of 60 days per illness or injury	50% maximum of 60 days per illness or injury	15% Maximum of 60 days per illness for in-network and out-of-network combined	35% Maximum of 60 days per illness for in-network and out-of-network combined

Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
Home health care	20%	40%	No Cost when approved by your network administrator	35%
Hospice care	20%	40%	15%	35%
Other Services				
Tubal ligation or vasectomy (reversals are not covered)	20%	40%	\$40 copay in physician's Office 15% in hospital	35%
Infertility treatment, including in-vitro fertilization	Not covered			
Radiation therapy and chemotherapy at a physician's office	20%	40%	No Cost	35%
Radiation therapy and chemotherapy at a hospital or freestanding facility	20%	40%	15%	35%
Kidney dialysis at a physician's office (If the dialysis continues more than 12 months, participant must apply for Medicare)	20%	40%	No Cost	35%
Kidney dialysis at a hospital or freestanding facility (If the dialysis continues more than 12 months, participant must apply for Medicare)	20%	40%	15%	35%
Supplies, equipment and durable medical equipment (DME)	20%	40%	15%, regardless of where the device is purchased	35%



Retiree Medical Benefit Options Comparison Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees				
Mental Health Benefits - No Treatment Limits				
Inpatient mental health Care	20%	40%	15%	35%
Alternative mental health care center – residential treatment	20%	40%	15%	35%
Alternative mental health care center – intensive outpatient and partial hospitalization	20%	40%	15%	35%
Outpatient mental health Care	20%	40%	15% \$30 PCP Visit \$40 Specialist Visit	35%
Chemical Dependency Benefits				
Detoxification	20%	40%	15%	35%
Treatment Limits	No inpatient or outpatient rehabilitation limits			
Inpatient chemical dependency rehabilitation	20%	40%	15%	35%
Outpatient chemical dependency rehabilitation	20%	40%	15% \$30 PCP Visit \$40 Specialist Visit	35%
Gender Reassignment Benefit (Cumulative benefit for surgery is \$75,000. The cumulative benefit for travel is \$10,000)				
<b>Surgery</b> <ul style="list-style-type: none"> <li>One bilateral mastectomy or bilateral Augmentation mammoplasty</li> <li>One genital revision surgery</li> </ul>	Not Covered		15%	Not Covered
Travel Expenses	Not Covered		Up to \$10,000	Not Covered
<b>Non-Surgical Treatments</b> <ul style="list-style-type: none"> <li>Physician's visits</li> <li>Specialist visits</li> <li>Outpatient mental health care</li> <li>X-rays and lab work</li> <li>Retail prescription drugs</li> <li>Mail order prescription drugs</li> </ul>	Not Covered		Covered as any other illness or injury under the Plan	Not Covered

<b>Retiree Medical Benefit Options Comparison</b> <b>Agent, Representative and Planner, and Officer, Management/Specialist and Support Staff Retirees</b>			
Prescription Drug Benefit			
<b>Retail pharmacies</b> (typically up to a 30-day supply)	20% for most prescription drugs  Express Scripts network pharmacies offer discounts on prescriptions	40% for most prescription drugs  Express Scripts network pharmacies offer discounts on prescriptions	<ul style="list-style-type: none"> <li>• <b>Generic Drugs:</b> \$10 co-pay</li> <li>• <b>Formulary Drugs:</b> 30% (\$20 min/\$75 max)*</li> <li>• <b>Non-Formulary Drugs:</b> 50% (\$35 min/\$90 max)*</li> </ul> * If you select a brand name drug (Formulary or Non-Formulary) when a generic is available, you will pay the \$10 generic co-pay, plus the cost difference between generic and brand prices. Maximums do not apply.
<b>Mail order benefit – coverage only for Pre-65 retirees and their covered dependents</b> (up to a 30-day supply — see <a href="#">“Excluded Expenses”</a> )	<ul style="list-style-type: none"> <li>• Generic Drugs: \$25 co-payment for generic</li> <li>• Brand Name Drugs: 25% coinsurance for brands when no generic is available</li> <li>• Brand Name Drugs when generic is Available: \$25 per prescription or refill, plus the cost difference between the brand and generic prices.</li> </ul>		<ul style="list-style-type: none"> <li>• Generic Drugs: 20% (no min/\$80 max)</li> <li>• Formulary Drugs: 30% (\$40 min/\$150 max)*</li> <li>• Non-Formulary Drugs: 50% (\$70 min/\$180 max)*</li> </ul> * If you select a brand name drug (Formulary or Non-Formulary) when a generic is available, you will pay the 20% generic co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.
<b>Oral contraceptives</b>	Not covered, unless prescribed as medically necessary treatment of a diagnosed illness or injury. (Oral contraceptives used for family planning or birth control are not covered but are offered at a discounted price. See Mail Order Prescription Drug Benefit.)		
<b>Fertility (infertility) medications</b>	Medications used to treat infertility or to promote fertility are never covered.		
<b>Over-the-counter medication (OTC)</b>	Over-the-counter medications are not covered under the retiree medical options.		

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

During the year you may experience one of the following mid-year changes:

- You move from Active coverage to Retiree coverage, or
- You move from Pre-65 Retiree coverage to Age 65 and Over Retiree coverage.

When you experience one of these changes, you may have to select a different Medical Benefit option. The Medical Benefit options offered vary depending on your age and retiree status.

If you experience one of these mid-year changes and as a result you select a different Medical Benefit option, your deductibles and out-of-pocket maximums may or may not carryover to your new Medical Benefit option. These are the general guidelines. Note: They may differ based on your individual situation.

If...	Your Deductible and Out-of-Pocket Maximum...
You retire and move from Active coverage to Retiree coverage	will not carryover
You move from Pre-65 Retiree coverage to Age 65 and Over Retiree coverage	will not carryover

In the event you experience a mid-year change, you must contact HR Services to determine if your deductibles and out-of-pocket maximums will carryover and if you need to provide information to your network administrator.

# Mental Health and Chemical Dependency Benefits

In addition to covered medical expenses, the RSM Option and the Retiree Value Plus Option cover the following medically necessary mental health and chemical dependency care:

## Mental Health Care

Covered expenses include medically necessary inpatient care (in a psychiatric hospital, acute care hospital or an alternative mental health care center) and outpatient care for a mental health disorder.

- **Inpatient mental health care**

Under the RSM Option when you are hospitalized in a psychiatric hospital for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses, up to Retiree Medical Option maximums. (See “inpatient room and board expenses” under “[Covered Expenses](#)”)

Under Retiree Value Plus Option when you use in-network providers, when you are hospitalized in a psychiatric hospital for a mental health disorder, during the period of hospitalization are covered the same as inpatient hospital expenses (See “inpatient room and board expenses” under “[Covered Expenses](#)”), up to Retiree Medical Option maximums. To receive in-network mental health care benefits, you or your covered dependent should call your network administrator for an authorization or referral.

- **Alternative mental health care center – residential treatment**

Under the RSM Option, such treatment is covered at 80% for Pilots, Flight Attendants and TWU-Represented retirees. Such treatment is covered at 80% in-network and 60% out-of-network for Agent, Representative and Planner and Officer, Management/Specialist and Support Staff retirees.

Under the Retiree Value Plus Option, such treatment is covered at 85% when you use in-network providers and at 65% when you use out-of-network providers.

- **Alternative mental health care center – intensive outpatient and partial hospitalization**

Under the RSM Option, such treatment is covered at 80% for Pilots, Flight Attendants and TWU-Represented retirees. Such treatment is covered at 80% in-network and 60% out-of-network for Agent, Representative and Planner and Officer, Management/Specialist and Support Staff retirees. Under the Retiree Value Plus Option, such treatment is covered at 85% when you use in-network providers and at 65% when you use out-of-network providers.

- **Outpatient mental health care**

Under the RSM Option, such treatment is covered at 80% for Pilots, Flight Attendants and TWU-Represented retirees. Such treatment is covered at 80% in-network and 60% out-of-network for Agent, Representative and Planner and Officer, Management/Specialist and Support Staff retirees.

Under the Retiree Value Plus Option, for outpatient mental health care through an in-network provider, the co-pay is \$30 per PCP visit and \$40 per specialist visit. Such treatment is covered at 65% when you use out-of-network providers.

## Chemical Dependency Care

- **Chemical dependency rehabilitation:**

Medically necessary chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient, or a combination. There are no limits on the number of chemical dependency rehabilitation programs a participant may attend (regardless of whether the program is inpatient or outpatient). The Plan does not cover expenses for a family member to accompany the patient being treated, although many chemical dependency treatment centers include family care at no additional cost.

Under the RSM Option, such treatment is covered at 80% for Pilots, Flight Attendants and TWU-Represented retirees. Such treatment is covered at 80% in-network and 60% out-of-network for Agent, Representative and Planner and Officer, Management/Specialist and Support Staff retirees.

Under the Retiree Value Plus Option, inpatient treatment is covered at 85% when you use in-network providers and at 65% when you use out-of-network providers. For outpatient treatment through an in-network provider under the Retiree Value Plus Option, the co-pay is \$30 per PCP visit and \$40 per specialist visit. Outpatient treatment is covered at 65% when you use out-of-network providers.

- **Detoxification**

Under the RSM Option, such treatment is covered at 80% for Pilots, Flight Attendants and TWU-Represented retirees. Such treatment is covered at 80% in-network and 60% out-of-network for Agent, Representative and Planner and Officer, Management/Specialist and Support Staff retirees.

This is a medical benefit, not a mental health care benefit. Under the Retiree Value Plus Option, such treatment is covered at 85% when you use in-network providers and at 65% when you use out-of-network providers.

## Gender Reassignment Benefit (GRB)

Effective June 1, 2011, the Gender Reassignment Benefit (GRB) provides coverage for gender reassignment. The GRB is a limited, one-time benefit for the entire time the employee is covered under the Plan. The GRB only offers benefits on an in-network basis. There are no GRB benefits offered out-of-network. The GRB offers a \$75,000 surgical benefit and a \$10,000 for travel reimbursement.

This benefit applies only to employees or retirees. This benefit is not available to spouses, Company-recognized Domestic Partners and other eligible dependents.

The GRB is offered under Retiree Value Plus Option. The GRB is not offered under the Retiree Standard Medical Option or the Retiree HMO (if you are Pre-65 and reside in Puerto Rico).

Coverage for surgical benefits under the GRB is limited to \$75,000, regardless of your network administrator, even if you change administrators. Any co-insurance amounts you pay apply to the \$75,000 limit. This \$75,000 GRB is available to the employee or retiree only one time during the entire time the employee or retiree is covered under the Plan.

An employee who receives the full benefit amount under the GRB for active employees cannot receive any additional benefits under the GRB for retirees. However, if you did not receive the maximum GRB under the Medical Plan for active employees, you may receive a balance GRB under the Retiree Medical Plan, not to exceed a combined benefit of \$75,000 for surgical benefits and \$10,000 for travel reimbursement.

The GRB is not offered out-of-network. All medical visits and prescription drugs incurred from out-of-network providers are excluded from coverage. This includes any doctor's or specialist visits, therapy, and retail or mail order prescription drugs.

### 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.
- Genital revision surgery and bilateral mastectomy or 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 for the entire time the employee is covered under the Plan. Subsequent surgical revisions, modifications or reversals are excluded from coverage. Coverage is limited to treatment performed by in-network providers.

Consideration for benefits is guided by the most current standards of care as published by the World Professional Association for Transgender Health (WPATH) and by the provisions, limitations and exclusions as set forth by the Plan.

Any co-insurance or co-payment amounts for in-network medical visits and prescription drugs do not accumulate towards the \$75,000. 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

Gender reassignment surgery is 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 surgery because it is not offered in your immediate home area, travel to an in-network surgery provider and lodging expenses will be reimbursed up to a maximum of \$10,000, regardless of your network administrator, even if you change administrators. To be eligible for reimbursement, travel must be over 100 miles away from your home and must be by air, rail, bus or car. The \$10,000 covers you and one caretaker to travel with you for in-network surgery only. You are only allowed to travel in-network within the 48 contiguous United States. Lodging expenses include hotel or motel room, car rental, tips and cost of meals while you are not hospitalized and for your caretaker. Itemized receipts will be required by your network administrator. Contact your network administrator for instructions on receiving reimbursement for your expenses.

### Preauthorization for the GRB

- **You must have approval from the network administrator both at the time you begin your treatment and at the time you are admitted for surgery.** Your failure to obtain preauthorization both at the time you begin treatment and at the time you are admitted for surgery will result in denial of your claims.
- See “[CheckFirst \(Pre-Determination of Benefits\)](#)” and “[QuickReview \(Pre-Authorization\) — Network Administrator](#)”.



## Covered Expenses

This section contains descriptions of the eligible medical expenses (listed alphabetically) that are covered under the RSM Option and the Retiree Value Plus Medical Option when medically necessary. Benefits for some of these eligible expenses vary depending on the retiree medical option you have selected and whether or not you use in-network providers. See the Retiree Medical Benefit Options tables under the “[Retiree Medical Benefit Options Comparison](#)” section beginning for information on how most services are covered.

For a list of items that are excluded from coverage, refer to “[Excluded Expenses](#)”.

**Acupuncture:** Medically necessary treatment for illness or injury when performed by a Certified Acupuncturist for diagnosed illnesses or injury, only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury. Coverage does not include acupuncture treatment for conditions in which the treatment has not been proven safe and effective, such as glaucoma, hypertension, acute low back pain, infectious disease, allergy and the like.

**Allergy care:** Charges for medically necessary physician’s office visits, allergy testing, shots and serum are covered. (See “[Excluded Expenses](#)” for allergy care not covered under the Retiree Medical Benefit.)

**Ambulance:** Medically necessary professional ambulance services and air ambulance once per illness or injury to and from:

- The nearest hospital qualified to provide necessary treatment in the event of an emergency,
- The nearest hospital or convalescent or skilled nursing facility for inpatient care, or
- An in-network hospital if you are covered under the Retiree Value Plus Option and your network administrator authorizes the transfer.

Air ambulance services are covered when medically necessary services cannot be safely and adequately performed in a local facility and the patient’s medical condition requires immediate medical attention for which ground ambulance services might compromise the patient’s life. Ambulance services are only covered in an emergency and only when care is required en route to or from the hospital.

**Ancillary charges:** Ancillary charges including charges for hospital services, supplies and operating room use. See Inpatient Hospital Expenses in this section.

**Anesthesia expenses:** Anesthetics and administration of anesthetics. Expenses are not covered for an anesthesiologist to remain available when not directly attending to the care of a patient.

**Assistant surgeon:** The Retiree Medical Benefit covers assistant surgeon’s fees when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst predetermination procedure.

**Blood:** Coverage includes blood, blood plasma and expanders. Benefits are paid only to the extent there is an actual expense to the participant.

**Chiropractic care:** Coverage includes medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license.

In addition, under the Retiree Value Plus Option, you are limited to 20 visits per year for combined in-network and out-of-network chiropractic care.

**Convalescent or skilled nursing facilities:** These facilities are covered at 50% of the most common semiprivate room rate in that geographic area for inpatient hospital expenses for up to 60 days per illness or injury (for the same or related causes) after you are discharged from the hospital for a covered inpatient hospital confinement of at least three consecutive days.

To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital and be recommended by your physician for the condition that caused the hospitalization.

In addition, under the Retiree Value Plus Option, these facilities are covered the same as hospitalization, except there is a combined maximum stay of 60 days per illness or injury for in-network and out-of-network facilities.

Eligible expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement and your network administrator must approve your stay. Custodial care is not covered.

**Cosmetic surgery and treatment:** Medically necessary expenses for cosmetic surgery only if they are incurred under either of the following conditions:

- As a result of a non-work related injury, or
- For replacement of diseased tissue surgically removed.

Other cosmetic surgery is not covered because it is not medically necessary.

**Dental care:** Dental expenses for medically necessary dental examination, diagnosis, care and treatment of one or more teeth, the tissue around them, the alveolar process or the gums, only when care is rendered for:

- Accidental injury(ies) to sound natural teeth, in which both the cause and the result are accidental, due to an outside and unforeseen traumatic force
- Fractures and/or dislocations of the jaw, or
- Cutting procedures in the mouth (this does not include extractions, dental implants, repair or care of the teeth and gums, etc., unless required as the result of accidental injury, as set forth in the first bullet above).

**Detoxification:** This is a medical benefit, not a mental health care benefit. Under the Retiree Value Plus Option, such treatment is covered at 85% when you use in-network providers and at 65% when you use out-of-network providers.

Under the RSM Option, such treatment is covered at 80% for Pilots, Flight Attendants and TWU-Represented retirees. Such treatment is covered at 80% in-network and 60% out-of-network for Agent, Representative and Planner and Officer, Management/Specialist and Support Staff retirees.

**Durable medical equipment (DME):** Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME resulting from normal wear and tear is not covered.

Examples of DME are items such as CPAP or BiPAP machines, wheelchairs, hospital beds, nebulizers, oxygen concentrators, TENS units, passive range of motion devices, joint cooling devices, bone stimulators, etc.

**Eyeglasses and contacts:** Coverage includes the initial purchase of eyeglasses or contact lenses required because of cataract surgery.

**Emergency room:** Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. You must call your network administrator within 48 hours of an emergency resulting in admission to the hospital.

**Facility charges:** Charges for the use of an outpatient surgical facility, when the facility is either an outpatient surgical center affiliated with a hospital or a freestanding surgical facility.

**Gender reassignment/sex changes:** Covered under the Gender Reassignment Benefit (GRB) in the following medical benefit option:

- Retiree Value Plus Option
- The GRB is not offered under the Retiree Standard Medical Option.

**Hearing care:** Covered expenses include medically necessary hearing exams and up to one hearing aid for each ear per year. Coverage for hearing aids is limited to basic hearing aids. Cochlear implants and osseointegrated hearing implant systems (such as BAHAs) are covered if medically necessary.

**Hemodialysis:** Removal of certain elements from the blood through selective diffusion for treatment of kidney failure.

**Home health care:** Home health care, when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. Custodial care is not covered.

If you are Pre-65, you should call your network administrator to be sure home health care is considered medically necessary.

**Hospice care:** Eligible expenses medically necessary for the care and treatment of a terminally ill covered person. Expenses in connection with hospice care include both facility and outpatient care. Hospice care is covered when approved by your network administrator.

**Inpatient hospital expenses:** Under the RSM Option, hospital room and board charges are covered at the applicable co-insurance percentages outlined below, up to the most common semiprivate room rate in that geographic area plus \$4. If the hospital does not have semiprivate rooms, the RSM Option considers the eligible expense to be 90% of the hospital's lowest private room rate plus \$4. Hospital ancillary charges are covered at the applicable co-insurance percentages outlined below:

- For Officer, Management/Specialist, Agent/Representative/Planner and Support Staff retirees (and their covered eligible dependents), the RSM Option pays 80% of inpatient hospital eligible expenses after you or your dependents meet the annual deductible, until you or your dependents reach the annual out-of-pocket maximum. Thereafter, further inpatient hospital eligible expenses are paid at 100% for the remainder of the calendar year.
- For Pilot, Flight Engineer, Flight Attendant and TWU-Represented retirees (and their covered eligible dependents), the RSM Option pays 100% of the first \$5,000 of inpatient hospital eligible expenses after you/your dependents meet the annual deductible. Thereafter, further inpatient hospital eligible expenses are paid at 80% until you or your dependents reach the annual out-of-pocket maximum. Thereafter, further inpatient hospital eligible expenses are paid at 100% for the remainder of the calendar year.

The Retiree Value Plus Option covers and pays inpatient hospital expenses based upon the negotiated rates with that particular in-network hospital. Out-of-network hospital expenses are subject to the out-of-network annual deductible and out-of-network co-insurance percentages under the Retiree Value Plus Option.

This inpatient hospital expense benefit (for retirees of all workgroups, whether RSM Option or Retiree Value Plus Option) applies to all inpatient hospital admissions, including hospitalization for mental health and chemical dependency care facility confinements. Physicians' charges are separate from inpatient hospital expenses, subject to the annual deductible and annual out-of-pocket maximums according to the Retiree Medical Benefit option you are enrolled in.

**Intensive care, coronary care or special care units (including isolation units):** Coverage includes room and board and medically necessary services and supplies.

**Mammograms:** Medically necessary diagnostic mammograms, regardless of age.

Under the Retiree Value Plus Option in-network coverage, there are no limits on the number of mammograms covered in-network. Coverage under the RSM Option and out-of-network under the Retiree Value Plus Option for routine mammograms for female retirees and female dependents is based on the following guidelines:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared
- Once every year beginning at age 40

Coverage under the RSM Option for routine mammograms for female retirees and female dependents is based on the following guidelines:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared
- Once every year beginning at age 40

**Mastectomy:** Certain reconstructive and related services are covered following a medically necessary mastectomy, including:

- Reconstruction of the breast on which surgery was performed,
- Reconstruction of the other breast to produce asymmetrical appearance,
- Prostheses, and
- Services in connection with complications resulting from a mastectomy, including lymphedemas.

**Medical supplies:** Covered medical supplies include, but are not limited to:

- Oxygen, blood and plasma
- Sterile items including sterile surgical trays, gloves and dressings
- Needles and syringes
- Colostomy bags
- The initial purchase of eyeglasses or contact lenses required because of cataract surgery
- Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered.

**Multiple surgical procedures:** Reimbursement for multiple surgical procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery.

- To determine the amount of coverage under the RSM Option, and to be sure the charges are within the usual and prevailing fee limits, use the CheckFirst predetermination program.
- The Retiree Value Plus Option pays benefits based on the negotiated rate with the participating in-network surgeon. Out-of-network fees under the Retiree Value Plus Option is based on the MGRP fee limits.

**Newborn nursery care:** Under Retiree Value Plus Option, hospital and medical expenses for a newborn baby's illness or injury are considered under the baby's coverage, not the mother's. The Retiree Value Plus Option covers hospital and medical expenses for a healthy newborn.

Under the RSM Option, newborn nursery care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits.

To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. The filing or payment of a maternity claim does not automatically enroll the baby. If you miss the 60-day deadline, you will not be able to add your baby to your coverage until the next Annual Benefits Enrollment period, even if you have other children enrolled in coverage.

**Nursing care:** Coverage includes medically necessary private duty care by a licensed nurse, if it is of a type or nature not normally furnished by hospital floor nurses.

**Oral surgery:** Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process, only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the RSM Option and the Retiree Value Plus Option will pay room and board, anesthesia and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the Retiree Medical Benefit.

**Outpatient surgery:** Charges for services and supplies for a medically necessary surgical procedure performed on an outpatient basis at a hospital, freestanding surgical facility or physician's office. You should pre-authorize the surgery through QuickReview to ensure the procedure is medically necessary.

Officer, Management/Specialist, Agent/Representative/Planner, Support Staff and TWU-Represented retirees have outpatient surgery coverage under their selected Retiree Medical Option.

**Outpatient surgical procedures (special benefits under the RSM Option for Pilot, Flight Engineer and Flight Attendant retirees):** Pilot, Flight Engineer and Flight Attendant retirees are covered for 100% of the usual and prevailing surgeon's fees for the following outpatient surgical procedures after meeting the annual deductible (provided general anesthesia is not used):

- Adenoidectomy
- Arthroscopy
- Breast biopsy or excision of cyst or tumor of the breast
- Bronchoscopy
- Cataract extraction
- Cone biopsy
- Cystourethroscopy
- Dilation and curettage
- Entropion/ectropion repair (noncosmetic)
- Eye muscle operation
- Excision of hydrocele
- Herniorrhaphy
- Iridectomy
- Laparoscopy (diagnostic)
- Laryngoscopy
- Mastoidectomy
- Myelogram
- Myringotomy
- Nasal polyps
- Neurolysis
- Septal reconstruction (non-cosmetic)
- Stapedectomy
- Tonsillectomy
- Tubal ligation by laparoscopy
- Ulnar nerve repair and transplant
- Varicose vein ligation

Charges for an assistant surgeon, X-rays, laboratory services, anesthesia and take-home drugs are covered at 80% of the eligible expenses (or at 100% of the eligible expenses, if you have met the annual out-of-pocket maximum).



Facility charges for these listed procedures are covered at 100% of the eligible expenses' usual and prevailing charges with no deductible when performed at:

- A freestanding surgical facility,
- A specialized outpatient unit within a hospital,
- An operating suite within the physician's office that has characteristics similar to a freestanding surgical facility, or
- General surgical facilities within a hospital.

These special benefits apply only to the outpatient surgical procedures listed above. Surgeon's fees for other procedures are covered at 80% of the eligible expenses (or 100% of the eligible expenses if you have met the annual out-of-pocket maximum).

If any of the listed surgeries are performed under general anesthesia, they are covered as inpatient hospital expenses.

**Physical or occupational therapy:** Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a physician.

**Physician's services:** Office visits and other medical care, treatment, surgical procedures and post-operative care for medically necessary diagnosis or treatment of an illness or injury. The Retiree Value Plus Option covers office visits for certain preventive care, as explained under Preventive Care. The RSM Option does not cover preventive care, except as explained under Mammograms in this section.

**Pregnancy:** Charges in connection with pregnancy, only for female retirees, female spouses of male retirees and female Company-recognized Domestic Partners, who are not eligible for Medicare. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed or certified by the state in which he or she practices.

Within the first 16 weeks of pregnancy, you should call QuickReview to pre-authorize your hospitalization.

Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority. Prescription prenatal vitamin supplements are covered.

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 or from requiring your provider to obtain pre-authorization for a longer stay. 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.

Charges in connection with pregnancy for covered dependent children are covered only if due to certain complications of pregnancy, for example: ectopic pregnancy, hemorrhage, toxemia, placental detachment and sepsis.



**Prescription drugs:** Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition. See “Prescription Drug Benefit” in the [Retiree Value Plus Option](#) section or the [Retiree Standard Medical](#) Option section.

Specialty prescription drugs prescribed to manage certain medical conditions following must be filled at one of Accredo’s Health Group pharmacies through Medco Health for Pre-65 retirees only. See “Specialty Prescription Drugs – Pre-65 Coverage Only” in the [Retiree Value Plus Option](#) section or the [Retiree Standard Medical](#) Option section.

Prescriptions related to infertility treatment, weight control and oral contraceptives (used for family planning or birth control) are not covered. See “Excluded Expenses” for additional information regarding drugs that are excluded from coverage.

Medically necessary medications are also covered for the following special situations:

- Medications administered and entirely consumed in connection with care rendered in a physician’s office are covered as part of the office visit.
- Medications that are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy are covered as part of the facility’s ancillary charges.

**Preventive care:** The Retiree Value Plus Option covers preventive care, including well-child care, immunizations, mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages at 100%. Non-routine tests for certification, sports or insurance are not covered.

Preventive care is not covered under the RSM Option. Under the RSM Option, well-child care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits.

**Prostheses:** Prostheses (such as a leg, foot, arm, hand or breast) necessary because of illness, injury or surgery. Replacement of prosthesis is only covered when medically necessary because of a change in the patient’s condition (improvement or deterioration) or due to the natural growth of a child. Replacement of a prosthesis resulting from normal wear and tear is not covered.

**Radiology (X-ray) and laboratory expenses:** Examination and treatment by X-ray, radium or other radioactive substances, diagnostic laboratory tests and annual mammography screenings for women (see “Mammograms” for guidelines). Please note that under the Retiree Value Plus Option, your in-network coverage level depends on whether the care is received in a hospital-based setting or a physician’s office or laboratory facility.

**Reconstructive surgery:** Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears.

Under the Women's Health and Cancer Rights Act, covered reconstructive services include:

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

**Speech therapy:** Restorative and rehabilitative care and treatment for loss or impairment of speech when the treatment is medically necessary because of an illness, injury or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy.

**Surgery:** When medically necessary and performed in a hospital, freestanding surgical facility or physician's office. (See "[CheckFirst \(Pre-Determination of Benefits\)](#)") for details about hospital pre-authorization and predetermination of benefits.)

**Temporomandibular joint dysfunction (TMJD):** Eligible expenses under the medical benefits include only the following, if medically necessary:

- Injection of the joints
- Bone resection
- Application of splints, arch bars or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion
- Manipulation or heat therapy

Crowns, bridges or orthodontic procedures for treatment of TMJD are not covered.

**Transplants:** Expenses for transplants or replacement of tissue or organs if they are medically necessary and not experimental, investigational or unproven services. Benefits are payable for natural or artificial replacement materials or devices.

Donor and recipient coverage is as follows:

- If the donor and recipient are both covered under the Plan, expenses for both individuals are covered by the Plan.
- If the donor is not covered under the Plan and the recipient is covered, the donor's expenses are covered to the extent they are not covered under any other medical plan and only if they are submitted as part of the recipient's claim.
- If the donor is covered under the Plan but the recipient is not covered under the Plan, no expenses are covered for the donor or the recipient.

The total benefit paid under this Plan for the donor's and recipient's expenses will not be more than any Plan maximums applicable to the recipient.

You may arrange to have the transplant at an in-network transplant facility rather than a local in-network hospital. Although using an in-network transplant facility is not required, these centers specialize in transplant surgery and may have the most experience, the leading techniques and a highly qualified staff.

It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria — not all transplant situations will be eligible for benefits. Therefore, you must contact your network administrator as soon as possible for pre-authorization before contemplating or undergoing a proposed transplant. The following transplants are covered if they are medically necessary for the diagnosed condition and are not experimental, investigational, unproven or otherwise excluded from coverage under the Medical Options, as determined in the sole discretion of the Plan Administrator and its delegate, the claims processor:

- Artery or vein
- Bone
- Bone marrow or hematopoietic stem cell
- Cornea
- Heart
- Heart and lung
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataract surgery
- Intestine
- Kidney
- Kidney and pancreas
- Liver
- Liver and kidney
- Liver and intestine
- Pancreas
- Pancreatic islet cell (allogenic or autologous)
- Prosthetic bypass or replacement vessels
- Skin

**Transportation expenses:** Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip ticket is covered for any illness or injury and will be covered only if medical attention is required en route. For information on ambulance services, see “Ambulance”.

**Tubal ligation and vasectomy:** These procedures are covered. Reversal of these procedures is not covered.

**Urgent/immediate care:** Charges for services and supplies provided at an urgent care clinic are covered under the RSM Option and the Retiree Value Plus Option. Under the Retiree Value Plus Option, you should seek care at an urgent care clinic and then call your network administrator within 48 hours to ensure that you receive the in-network level of benefits or if you are traveling and need urgent medical care.

**Well-child care:** Under the Retiree Value Plus Option, in-network well-child care services are covered, with no age limit for such care.

The Retiree Value Plus Option covers out-of-network well-child care services for children up to age two for the initial hospitalization following birth, all immunizations and up to seven well-child care visits.

Under the RSM Option, well-child care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits.

**Wigs and hairpieces:** Retirees and eligible dependents are covered up to a \$350 lifetime maximum for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery or severe burns. This benefit is subject to the usual and prevailing fee limits, deductibles, co-payments, co-insurance and out-of-pocket limits of your selected Retiree Medical Option.

Replacement wigs or hairpieces are not covered, regardless of any change in the patient's physical condition. Hair transplants, styling, shampoo and accessories are not covered.

## Excluded Expenses

The following items are excluded from coverage under the Retiree Standard Medical (RSM) Option and the Retiree Value Plus Option, unless otherwise stated.

**Allergy testing:** Specific testing (called provocative neutralization testing or therapy), which involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

**Alternative and/or Complementary medicine:** Evaluation, testing, treatment, therapy, care and medicines that constitute alternative or complementary medicine, including but not limited to herbal, holistic and homeopathic medicine (see “Glossary” in the Reference Information section).

**Claim forms:** The Plan will not pay the cost for anyone to complete your claim form.

**Care not medically necessary:** All services and supplies considered not medically necessary.

**Cosmetic surgery and treatment:**

- Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction and sclerotherapy for varicose veins or spider veins).
- Cosmetic surgery, unless medically necessary and required as a result of accidental injury or surgical removal of diseased tissue.

**Counseling:** All forms of marriage and family counseling.

**Custodial care and custodial care items:** Custodial care and items such as incontinence briefs, liners, diapers and other items when used for custodial purposes, unless provided during an inpatient confinement in a hospital.

**Dental care:** No benefits are payable under the Retiree Medical Benefit for routine dental care or treatment of dental disease or defect, except as specifically described in [“Covered Expenses”](#).

**Developmental therapy for children:** Charges for all types of developmental therapy.

**Dietician services:** Under the RSM Option no dietician services are covered. For the Retiree Value Plus Option, contact your network administrator to determine the services that are covered.

**Drugs:**

- Drugs, medicines and supplies that do not require a physician’s prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem-strips, lancets and test tape.)
- Drugs that are not required to bear the legend “Caution – Federal Law Prohibits Dispensing Without Prescription”

- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
- Contraceptive drugs, patches or implants when used for family planning or birth control. Even though oral contraceptives are not covered, you may order these drugs through the mail order prescription program and receive a discount. (See "Prescription Drug Benefits" in either the [Retiree Standard Medical Option](#) or [Retiree Value Plus Option](#) sections.)
- Drugs requiring a prescription under state law, but not federal law
- Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy)
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Medications used primarily for the purpose of weight control
- Drugs used to treat infertility or to promote fertility
- Drugs or devices used for smoking cessation
- Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs not approved by the Food and Drug Administration (FDA) or experimental drugs, even though the individual is charged for such drugs
- Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis

**Ecological and environmental medicine:** See "Alternative and/or Complementary Medicine".

**Educational testing or training:** Testing or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded).

**Experimental, Investigational or Unproven treatment:** Medical treatment, procedures, drugs, devices or supplies that are generally regarded as experimental, investigational or unproven, including, but not limited to:

- Treatment for Epstein-Barr Syndrome
- Hormone pellet insertion
- Plasmapheresis

See the "Experimental, Investigational or Unproven Treatment" definitions in the ["Glossary"](#) in the Reference Information section.

**Eye care:** Eye exams, refractions, eyeglasses or the fitting of eyeglasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training and vision therapy.

**Foot care:** Diagnosis and treatment of weak, strained or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses or toenails. (This exclusion does not apply to the removal of nail roots.)

**Free care or treatment:** Care, treatment, services or supplies for which payment is not legally required.

**Gender reassignment/sex changes:** The GRB is not offered under the Retiree Standard Medical Option. Any expenses received from an out-of-network provider will not be payable. There is no coverage under the GRB for spouses, Company-recognized Domestic Partners or other eligible dependents.

**Government-paid care:** Care, treatment, services or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian retirees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

**Infertility treatment:** Expenses or charges for infertility treatment or testing and charges for treatment or testing for hormonal imbalances that causes male or female infertility, regardless of the primary reason for hormonal therapy.

- Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction and infertility drugs such as Clomid or Pergonal are also excluded.
- Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.

**Lenses:** No lenses are covered except the first pair of medically necessary contact lenses or eyeglasses following cataract surgery.

**Massage therapy:** All forms of massage and soft-tissue therapy, regardless of who performs the service.

**Medical Error Events:** Services or supplies charged by the health care provider that are directly associated with, resulting from, or caused by medical mistakes, medical or surgical error, medical negligence or malpractice, preventable illness, preventable injury, or certain preventable complications arising from medical or surgical treatment, as defined by the Center for Medicare and Medicaid Services and identified as “never events.” Go the [Center for Medicare and Medicaid Services website](#) for fact sheets and news releases about these “never events”.

**Medical records:** Charges for requests or production of medical records.

**Missed appointments:** If you incur a charge for missing an appointment, the Plan will not pay any portion of the charge.

**MNRP (Maximum Non-Network Reimbursement Program):** For out-of-network providers under the Retiree Value Plus Option, any portion of the fees for physicians, hospitals and other providers that exceeds 140% of MNRP value.

**Newborn nursery care:** Under the RSM Option, hospital and/or medical expenses for a healthy newborn baby.



**Nursing care:**

- Care, treatment, services or supplies received from a nurse that do not require the skill and training of a nurse
- Private duty nursing care that is not medically necessary or if medical records establish that such care is within the scope of care normally furnished by hospital floor nurses
- Certified nurse's aides

**Organ donation:** Expenses incurred as an organ donor, when the recipient is not covered under the Plan.

**Prescription drugs:** Specialty prescription drugs prescribed to manage certain medical conditions following must be filled at one of Accredo's Health Group pharmacies through Express Scripts for Pre-65 retirees only. See "Specialty Prescription Drugs – Pre-65 Coverage Only" in the [Retiree Value Plus](#) Option section or [Retiree Standard Medical](#) Option section.

**Pregnancy for dependents:** Prenatal care and delivery charges are excluded for covered dependent children unless the charges are due to certain complications. Examples of covered complications include ectopic pregnancy, hemorrhage, toxemia, placental detachment and sepsis.

**Preventive care:** Coverage for preventive care varies, depending on the Retiree Medical Option you have elected for coverage. To determine if preventive care is covered by your selected Retiree Medical Option, see "[Retiree Medical Benefit Options Comparison](#)".

**Relatives:** Coverage is not provided for treatment by a medical practitioner (including, but not limited to: a nurse, physician, physiotherapist or speech therapist) who is a close relative (spouse/Company-recognized Domestic Partner, child, brother, sister, parent or grandparent of you or your spouse/Company-recognized Domestic Partners, including adopted and step relatives).

**Sleep disorders:** Treatment of sleep disorders, unless it is considered medically necessary.

**Sex changes:** Sex change, gender reassignment/revision, treatments or transsexual and related operations, except as provided under the Gender Reassignment Benefit (GRB).

**Sexual performance treatment:** Prescription medications (including, but not limited to, Viagra, Levitra or Cialis), procedures, devices or other treatments prescribed, administered or recommended to treat erectile or other sexual dysfunction, or for the purpose of producing, restoring or enhancing sexual performance/experience.

**Speech therapy:** Except as described in [Covered Expenses](#), expenses are not covered for losses or impairments caused by conditions such as learning disabilities, developmental disorders or progressive loss due to old age. Speech therapy of an educational nature is not covered.

**TMJD:** Except as described in Covered Expenses, diagnosis or treatment of any kind for temporomandibular joint disease or disorder (TMJD) or syndrome by a similar name, including orthodontia to treat TMJD. Crowns, bridges or orthodontic procedures to treat TMJD.

**Transportation:** Transportation by regularly scheduled airline, air ambulance or train for more than one round trip per illness or injury.

**Usual and prevailing:** Applies to services rendered by out-of-network providers under the RSM Option. Any portion of fees for physicians, hospitals and other providers that exceeds the usual and prevailing fee limits.

**War-related:** Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.

**Weight reduction:** Hospitalization, surgery, treatment and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact your network administrator to determine if treatment is covered.

**Well-child care:** Under the RSM Option, well-child care is not covered, including the initial hospitalization following birth, immunizations or well-child care visits. (See [“Covered Expenses”](#) for a description of coverage for well-child care under the Retiree Value Plus Option.)

**Wellness items:** Items that promote well-being and are not medical in nature and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas and health club memberships). Also excluded are:

- Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning, and
- Services related to vocation, including but not limited to: physical or FAA exams, performance testing and work hardening programs.

If you are covered under the Retiree Value Plus Option, contact your network administrator to determine if your option covers a specific preventive service for a particular medical condition.

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

## CheckFirst (Pre-Determination of Benefits)

If you are covered by the Retiree Standard Medical (RSM) Option or the Retiree Value Plus Option, CheckFirst allows you to find out if:

- The recommended service or treatment is covered by your selected Retiree Medical Option,
- Your physician's proposed charges fall within the Plan's usual and prevailing fees (applies to RSM Option only), or
- Your physician's proposed charges fall under the MNRP fee limits (applies to Retiree Value Plus Option only). See "[MNRP](#)" in the Retiree Value Plus Option section.

If you are covered by the RSM Options and your network provider charges you negotiated rates, or if you are covered by the Retiree Value Plus Option and you are using an in-network provider, the provider's fees are not subject to usual and prevailing fee limits. However, you may want to contact your network administrator to determine if the proposed services are covered under your selected Medical Option.

To use CheckFirst under the RSM Option, you may either submit a CheckFirst Predetermination of Medical Benefits form (available on Jetnet) before your proposed treatment or you may call your network administrator to obtain a pre-determination of benefits by phone or to request the pre-determination form. If you are having surgery your network administrator (as part of your network administrator's hospital pre-authorization process) will determine the medical necessity of your proposed surgery before making a pre-determination of benefits. Your network administrator will mail you a written response.

Even if you use CheckFirst, your network administrator reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different than the information submitted for pre-determination of benefits. Claims are processed in order of receipt. Payment of claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

For your proposed surgery or treatment, CheckFirst can pre-determine the benefit coverage level available to you (such as your deductible or co-insurance amount). A pre-determination does not pre-authorize the length of a hospital stay or determine medical necessity. When you call your network administrator you must also request pre-authorization (see "[QuickReview \(Pre- Authorization\) — Network Administrator](#)").

Although you may find CheckFirst beneficial whenever you need medical treatment, there are two circumstances when you may especially benefit by using CheckFirst. Use this predetermination procedure if your physician recommends either of the following:

- **Assistant surgeon:** A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if there is a medical necessity, you must use the CheckFirst procedure.
- **Multiple surgical procedures:** If you are having multiple surgical procedures performed at the same time, any procedure that is not the primary reason for surgery is covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgeon. You must use CheckFirst to find out how the Plan reimburses the cost for any additional procedures.
- For the Gender Reassignment Benefit, you must have approval from the network administrator both at the time you begin your treatment and at the time you are admitted for surgery. See the “[Gender Reassignment Benefit \(GRB\)](#)” section for more information.

## QuickReview (Pre-Authorization) — Network Administrator

You or your provider acting on your behalf are required to request pre-authorization from your network administrator before any hospital admission, or within 48 hours (or the next business day if admitted on a weekend) following emergency care. If you do not contact your network administrator, your expenses are still subject to review and will not be covered under the Plan if they are considered not medically necessary.

- **Under the RSM Option:** Request pre-authorization by calling your network administrator.
- **Under the Retiree Value Plus Option:** Request pre-authorization by calling your network administrator.
- **If you are covered by the RHMO:** Contact the HMO for any hospitalization.

### When to Request Approval from Your Network Administrator

Any portion of a stay that has not been approved through your network administrator is considered not medically necessary and will not be covered by the option. For example, if your network administrator determines that five hospital days are medically necessary for your condition and you stay in the hospital seven days, charges for the extra two days will not be covered. Your physician should contact your network administrator to request pre-authorization for approval of any additional hospital days.

Call your network administrator in the following situations:

- Before you are admitted to the hospital for an illness, injury, surgical procedure or pregnancy
- Within 48 hours after an emergency hospital admission (or the next business day if you are admitted on a weekend)
- Before outpatient surgery to ensure that the surgery is considered medically necessary
- Before you undergo testing or treatment for sleep disorders
- Before you contemplate or undergo any organ transplant
- Before you undergo a procedure that will incur a substantial expense

The list above is not comprehensive. Contact your network administrator for more information.

Under the Retiree Value Plus Option if you are in-network, your provider will call for you. If you are in the Retiree Value Plus Option seeing out-of-network provider, you must call on your behalf.

If your physician recommends surgery or hospitalization, ask your physician for the following information before calling your network administrator for pre-authorization:

- Diagnosis and diagnosis code
- Clinical name of the procedure and the CPT code

- Description of the service
- Estimate of the charges
- Physician's name and telephone number
- Name and telephone number of the hospital or clinic where surgery is scheduled

If your illness or injury prevents you from personally contacting your network administrator, any of the following may call on your behalf:

- A family member or friend
- Your physician
- The hospital

Your network administrator will tell you:

- Whether the proposed treatment is considered medical necessity and appropriate for your condition
- The number of approved days of hospitalization

In some cases, your network administrator may refer you for a consultation before surgery or hospitalization will be authorized. To avoid any delays in surgery or hospitalization, notify your network administrator as far in advance as possible.

After you are admitted to the hospital, your network administrator program provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, your network administrator consults with your physician and hospital to verify the need for any extension of your stay. If you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness, you must contact your network administrator again to authorize any additional hospitalization.

If you are scheduled for outpatient surgery, you should call your network administrator. If you do not call, you may be subject to a retrospective review of the surgery to determine whether it was medically necessary. This means you or your physician may be asked to provide medical documentation to support the medical necessity.

- For the Gender Reassignment Benefit, you must have approval from the network administrator both at the time you begin your treatment and at the time you are admitted for surgery. See the "[Gender Reassignment Benefit \(GRB\)](#)" section for more information.

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

# Retiree Standard Medical (RSM) Option

You and your spouse/Company-recognized Domestic Partner's dependents coverage ends when your retiree coverage ends at age 65. Coverage for your spouse or Company-recognized Domestic Partner ends when you reach age 65 or when he or she reaches age 65, whichever occurs first.

## Your Network/Claims Administrator

For under age 65 retirees (RSM Option), the preferred network/claims administrator for each state will be the sole network provider of health care services for the RSM Option. Therefore, you cannot select a different network/claims administrator. The [map of the network/claims administrators by state](#) can be found on the Benefits Page of Jetnet.

## Benefit Overview

Option	Individual Annual Deductible	Family Annual Deductible	Individual Annual Out-of-Pocket Maximum	Family Annual Out-of-Pocket Maximum
RSM Option	\$150	\$400	\$1,000	\$3,000



## In This Section

- How the Retiree Standard Medical Option Works
  - If You Are Pilot, Flight Attendant, Flight Engineer or TWU-Represented Retiree
  - If You Are an Agent, Representative, Planner, Officer, Management/Specialist or Support Staff Retiree
  - Network/Claims Administrator
  - Special Provisions
    - Inpatient Hospital Benefits If You Are Not Covered by Medicare
- Covered and Excluded Expenses
- Filing Claims
  - Claims Filing Deadline
- Prescription Drug Benefits
  - Retail Drug Coverage
  - Filling In-Network Prescriptions
  - Filling Out-of-Network Prescriptions
  - Filing Claims for Prescriptions
  - Retail Prescription Clinical Programs
  - Generic Drugs
  - Prior Authorization
  - Specialty Pharmacy Services— Under Age 65 Retirees Only
  - Medco Mail Order — Under Age 65 Retirees Only
  - Mail Order Prescription Clinical Programs
  - Generic Drugs
  - Ordering Prescriptions by Mail
  - Internet Refill Option
  - Other Refill Options
  - Claims Filing Deadline
  - Maximum Medical Benefits

## How the Retiree Standard Medical Option Works

As an eligible retiree, you can enroll in the Retiree Standard Medical (RSM) Option. This Medical Option offers a preferred provider network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. You may use any qualified licensed physician you wish and the Retiree Standard Medical Option will pay your expenses at a higher level of benefit. If you choose to use an out-of-network provider, the charges will be subject to usual and prevailing fee limits and the Retiree Standard Medical Option will pay your expenses at a lower level of benefit. Contact your network/claims administrator for more information and to access a list of in-network providers. See "Negotiated Rates" under "Special Provisions" in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

- If you are a Pilot, Flight Engineer, Flight Attendant, TWU-Represented or Agent/Representative/Planner retiree (who retired on or before December 31, 2010), you will be automatically enrolled in the Retiree Standard Medical Option at the time you retire.
- If you are an Agent/Representative/Planner (who retired on or after January 1, 2011) or an Officer, Management/Specialist or Support Staff retiree under age 65, you must take action to enroll yourself in the Retiree Standard Medical Option.
- If you are an Agent/Representative/Planner (who retired on or after January 1, 2011) or an Officer, Management/Specialist or Support Staff retiree age 65 or over, you are not eligible for coverage under any Retiree Medical Benefit Option, including the RSM Option.

See Retiree Eligibility for more information on specific eligibility requirements and Enrollment, for information about enrolling in the RSM Option or a different Retiree Medical Benefit Option.

Each covered person, which includes you and any covered dependents, must satisfy an annual deductible before the option begins paying a percentage of the eligible expenses.

### If You Are Pilot, Flight Attendant, Flight Engineer or TWU-Represented Retiree

After you and your covered dependents meet the annual deductible, the RSM Option pays 80% of eligible expenses up to the negotiated rate, if you use a network provider, up to the usual and prevailing fees. You pay 20% co-insurance with the exception of Mail Order prescription drugs. After you meet the annual out-of-pocket maximum, eligible expenses are covered at 100% for the remainder of the year, with the exception of Mail Order prescription drugs.

See the "[Retiree Medical Benefit Options Comparison](#)" in the Retiree Medical Benefit Options Overview section to see a comparison of your benefits under the RSM Options.

## If You Are an Agent, Representative, Planner, Officer, Management/Specialist or Support Staff Retiree

After you and your covered dependents meet the annual deductible, the RSM Option pays 80% of in-network eligible expenses up to the negotiated rate. You pay 20% co-insurance for in-network services, with the exception of Mail Order prescription drugs. Eligible out-of-network charges are paid at 60% of usual and prevailing fees until the annual out-of-pocket maximum is met. You pay 40% co-insurance for out-of-network services. After you meet the annual out-of-pocket maximum, eligible expenses are covered at 100% for the remainder of the year, with the exception of Mail Order prescription drugs.

Go to “[Retiree Medical Benefit Options Comparison](#)” in the Retiree Medical Benefit Options Overview section to see a comparison of your benefits under the RSM Option.

## Network/Claims Administrator

The RSM Option is administered by three network/claims administrators: UnitedHealthcare (UHC), Aetna, and Blue Cross and Blue Shield of Texas. The preferred network/claims administrator for each state will be the sole network provider of health care services for the RSM Option. Therefore, you cannot select a different network/claims administrator for the RSM Option. For eligible age 65 and over retirees, the RSM Option is administered by UnitedHealthcare.

If you relocate to a new state, your network/claims administrator does not change. Your medical plan option election and contribution rates remain the same for the remainder of the plan year. For more information on how your state is determined, see “[Network Administrator](#)” under the Retiree Medical Benefit Options Overview section. The [map of the network/claims administrators by state](#) can be found on the Benefits Page of Jetnet.

## Special Provisions

The RSM Option includes the following special provisions:

### Inpatient Hospital Benefits If You Are Not Covered by Medicare:

- For Pilot, Flight Attendant, Flight Engineer or TWU-Represented retirees (and your covered eligible dependents), the RSM Option pays 100% of the first \$5,000 of inpatient hospital eligible expenses after the annual deductible is met. Thereafter, further inpatient hospital eligible expenses are paid at 80% until the annual out-of-pocket maximum is met. Any further inpatient hospital eligible expenses are paid at 100% for the remainder of the year.
- For Officer, Management/Specialist or Support Staff and Agent/Representative/Planner retirees (and your covered eligible dependents), the RSM Option pays 80% of in-network inpatient hospital eligible expenses after your deductible is met, until you reach your annual out-of-pocket maximum. Thereafter, further in-network inpatient hospital eligible expenses are paid at

100% for the remainder of the year (and 60% out-of-network inpatient hospital eligible expenses).

**Accidental Injury Benefit:** If you and/or a covered dependent are injured in a non-work related accident, the RSM Option pays 100% of the first \$250 of hospital and physician charges per person each calendar year. Treatment must be received within 24 hours of the accident. After the first \$250 of eligible expenses, you must satisfy the deductible and co-insurance provisions.

If two or more members of your family are injured in the same accident, only one individual deductible applies to all injured family members for expenses in connection with that accident during the year in which the accident occurs. Individual annual deductibles (up to the family maximum) still apply to each person for expenses not related to the accident.

**Annual Individual/Family Deductible:** Each individual must satisfy his or her own deductible. The family annual deductible is applicable if three or more family members are covered. Under the RSM Option, once the family annual deductible has been satisfied, all covered individuals are eligible for reimbursement of eligible medical expenses, regardless of whether they have satisfied individual annual deductibles.

**Annual Out-of-Pocket Maximum for Pilot, Flight Engineer, Flight Attendant or TWU-Represented retirees:** After you satisfy the annual out-of-pocket maximum for eligible expenses, the medical option pays 100% of eligible expenses for the rest of the calendar year. The covered person's co-insurance amounts apply to the annual out-of-pocket maximum, with the exception of expenses covered at 50%.

**Annual Out-of-Pocket Maximum for Officer, Management/Specialist or Support Staff or Agent/Representative/Planner retirees:** After you satisfy the annual out-of-pocket maximum for eligible expenses under the option you have selected for coverage under the option you have selected for coverage, the medical option pays 100% of eligible expenses for the rest of the calendar year (with the exception of mail order drugs)(with the exception of mail order drugs). The covered person's co-insurance amounts apply to the annual out-of-pocket maximum, with the exception of expenses covered at 50%.

**Negotiated Rates:** The Standard Medical Options offer a voluntary network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for eligible medical services. The negotiated rates may save you and the Company money when you or your covered dependent needs medical care and chooses a participating provider. The Standard Medical Options offer a voluntary network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for eligible medical services. The negotiated rates may save you and the Company money when you or your covered dependent needs medical care and chooses a participating provider.

For Pilot, Flight Engineer, Flight Attendant or TWU-Represented retirees, the RSM Option offers a voluntary preferred provider network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for

eligible medical services. You may use any qualified licensed physician you wish, but you will receive the discount if you use an in-network provider. Contact your network/claims administrator for more information and to access a list of in-network providers.

For Agent/Representative/Planner and Officer, Management/Specialist or Support Staff retirees under age 65, the RSM Option offers you access to a network of physicians and hospitals that have agreed to provide medical services to plan participants at preferred rates for eligible expenses. When you use a network provider, you pay co-insurance for most services. Medical necessity is determined by your network/claims administrator.

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

Because in-network providers may change at any time, you should confirm that your provider or facility is part of the network when you make an appointment and before you receive services.

There may be special situations when you use hospital, lab or X-ray services:

- If you go to an in-network hospital but receive services from a provider who is not an in-network provider, you will receive the in-network negotiated rate for hospital charges, but the physician's fee is not eligible for the in-network negotiated rate.
- If you use an in-network physician or hospital, charges for your lab or X-ray services may not be eligible for the in-network negotiated rate if your provider or hospital uses a lab that is not part of the network. Note, some lab and X-ray services performed in a hospital may be contracted out to an out-of-network provider.

**In all cases, the out-of-network provider fees will be subject to usual and prevailing fee limits.**

## Covered and Excluded Expenses

For a detailed explanation of the Plans' covered expenses and exclusions, see "[Covered Expenses](#)" and "[Excluded Expenses](#)" in the Retiree Medical Benefit Options Overview section.

## Filing Claims

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

- Complete a [Medical Benefit Claim Form](#).
- Submit the completed form to your network/claims administrator, along with all original itemized receipts from your physician or other health care provider. A cancelled check or credit card receipt is not acceptable.

Each bill or receipt submitted to your network/claims administrator must include the following:

- Name of patient,
- Date the treatment or service was provided,
- Diagnosis of the injury or illness for which treatment or service was given,
- Itemized description and charges for the treatment or service, and
- Provider's name, address and tax ID number.

Make copies of the original itemized bill or receipt provided by your physician, hospital or other medical service provider for your own records. All medical claims payments are sent to you with an Explanation of Benefits (EOB) explaining the amount paid, unless your physician, hospital, or other medical provider has agreed to accept assignment of benefits (see "[Assignment of Benefits](#)" in the Plan Administration section). In most cases, the EOB will be mailed to you and the payment mailed to your provider. EOBs are also available on your network/claims administrator's website.

It is very important that you fully complete the 'other coverage' section of the form. Examples of other coverage include a spouse's group health plan, Workers' Compensation, Medicare, TRICARE and no-fault motor vehicle insurance.

- If you have questions about your coverage or your claim under one of the RSM Options, contact your network/claims administrator (see "[Contact Information](#)" in the Reference Information section).

## Claims Filing Deadline

- For all claims incurred on or after 1/1/10, you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- For all claims incurred on or before 12/31/09, you must submit all health claims within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment.

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



## Prescription Drug Benefits

Express Scripts is the prescription drug vendor for the RSM Option. Drugs prescribed by a physician or dentist or dentist may be purchased either at retail pharmacies or through the Medco Mail Order Prescription Drug Benefit. Only eligible expenses for covered prescription drugs purchased at a retail pharmacy purchased at a retail pharmacy apply to your deductible or out-of-pocket maximum.

Medco has a broad network of pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the Express Scripts website.

### Retail Drug Coverage

You may have your prescriptions filled at any pharmacy. For most covered drugs you are reimbursed at 80% of the Express Scripts discounted price after satisfying your medical option deductible. You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted medication rates. If you do not present your Express Scripts prescription drug card at the time of purchase, you will pay the non-discounted price at that time and reimbursement from the plan will be based on the discounted price. This means you pay the difference between the non-discounted and the discounted price, in addition to paying the 20% co-insurance (after your deductible has been met).

Here is an example:

If you:	The cost of your prescription is:	The amount Express Scripts considers an eligible expense when paying your claim is:	Plan Pays:	You Pay:
Purchase your prescription showing your Express Scripts card	\$100 (the discounted amount for that particular drug)	\$100	\$80 (80% Co-insurance)	\$20 (20% Co-insurance)
Purchase your prescription without showing your Express Scripts card	\$250 (the non-discounted price for that particular drug)	\$100	\$80 (80% Co-insurance)	\$170 (20% Co-insurance Plus the \$150 difference between the non-discounted price of the drug and the discounted price)

**Note:** You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted price.

### Filling In-Network Prescriptions

To fill prescriptions at an in-network pharmacy and file for reimbursement:

- Present your Express Scripts ID card to the pharmacy every time you order your prescription from an in-network pharmacy.
- Pay the Express Scripts price for the prescription and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Express Scripts. See Filing Claims for Prescriptions for more information on how to file a claim.

### Filling Out-of-Network Prescriptions

To fill prescriptions at an out-of-network pharmacy and file for reimbursement:

- Pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Express Scripts. See Filing Claims for Prescriptions for more information on how to file a claim.
- **Note:** If you purchase prescription drugs at an out-of-network pharmacy, you will be reimbursed based on the Express Scripts discount price, not the actual retail cost of the medication.

### Filing Claims for Prescriptions

You will need to send in a completed Express Scripts claim form, along with your receipts to Express Scripts. Once you have submitted your claim to Express Scripts, your network/claims administrator will process your claim, based on the information received from Express Scripts. Express Scripts reports the claim to your network/claims administrator. Your network/claims administrator sends you an Explanation of Benefits (EOB) and applicable payment, advising you of the total charges you submitted, any amounts not covered and the reason and the amounts eligible and paid under the medical option.

If you have questions concerning your prescription drug coverage, call the Express Scripts Member Services number on your Express Scripts ID card. If you have questions about the benefit amount reflected on your EOB, call your network/claims administrator (for specialty medications see [“Specialty Pharmacy Services— Under Age 65 Retirees Only”](#) in this section).

### Retail Prescription Clinical Programs

- Express Scripts uses a number of clinical programs that help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, they are subject to change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).
- When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional

information about these clinical programs and the specific drugs subject to these programs can be obtained from Express Scripts (see “[Contact Information](#)” in the Reference Information section).

### Generic Drugs

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

### Prior Authorization

To be eligible for benefits, certain covered prescriptions require prior authorization by Express Scripts to determine medical necessity before you can obtain them at a participating pharmacy or through the Medco Mail Order Prescription Drug Benefit. Examples of medications requiring prior authorization include growth hormones and rheumatoid arthritis drugs.

Express Scripts will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

When you fill your prescription, your pharmacist will call Express Scripts. Your pharmacist and a Express Scripts pharmacist will review the request for approval. Express Scripts will send you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for up to one year. Prior authorizations must be renewed periodically. When the renewal date approaches, you should contact Express Scripts for renewal instructions.

Ask your physician to contact Express Scripts or to complete Express Scripts’ prior authorization form with the following information:

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

If the pharmacy does not fill a prescription because there is no prior authorization on file, the pharmacy’s denial will not be treated as a claim for benefits. You must submit the request for prior authorization to Express Scripts. If the prior authorization is denied, you must file a first level appeal through Express Scripts to be considered for coverage for that medication.

## Specialty Pharmacy Services— Under Age 65 Retirees Only

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

Accredo Health Group, a subsidiary of Express Scripts, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications.

Prescriptions prescribed to manage medical conditions such as the following must be filled at a retail pharmacy or one of Accredo's Health Group pharmacies through Express Scripts:

- Anemia
- Growth Hormone
- Hemophilia
- Hepatitis C
- Immune Deficiency Therapy
- Metabolic Disorders
- Multiple Sclerosis
- Oral Cancer Drugs
- Osteoporosis
- Pulmonary/Pulmonary Arterial Hypertension
- Rheumatoid Arthritis or Other Autoimmune Conditions
- Other Various Indications

Please note that other conditions are added as appropriate and as required.

Whether these prescriptions are self-administered or administered in a physician's office the prescriptions to treat the above conditions are not reimbursed through your Medical Benefit Option and must be filled at a retail pharmacy using your Express Scripts ID card or through Medco Mail Order for you to receive prescription drug benefits. Medco can ship the prescription to your home for self-administration or to your physician's office for medications which are to be administered by a physician.

The applicable deductible and co-insurance associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions.

## Medco Mail Order — Under Age 65 Retirees Only

You and your covered dependents are eligible for Medco Mail Order. You may use this mail service option to order 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 may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration. A registered pharmacist fills your prescription.

You may order up to a 90-day supply of your prescription drug (but no more than the number of days prescribed by your physician). You pay a co-pay or co-insurance (with no annual deductible) for each prescription or refill. Co-pays and co-insurance, which are subject to change, are currently:

- Generic Drugs: \$25 co-pay per prescription or refill for generic drugs (or the actual cost of the drug, if the prescription cost is less than \$25).
- Brand Name Drugs: 25% co-insurance of the cost of the drug when no generic is available, up to a \$150 maximum per prescription or refill.
- Brand Name Drug When Generic Is Available: \$25 co-pay per prescription or refill, plus the cost difference between the brand name and the generic, with no maximum cost per prescription or refill.

Although non-medically necessary oral contraceptives (for family planning or birth control) are not covered under the RSM Option, you and your covered dependents may purchase oral contraceptives through Medco Mail Order. You pay the full cost of the prescription, but it will cost less than if you purchased it at a retail pharmacy.

### Mail Order Prescription Clinical Programs

Medco uses a number of clinical programs to help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, the drugs subject to these clinical programs may change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).

When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these programs may be obtained from Medco see “[Contact Information](#)” in the Reference Information section).

### Generic Drugs

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

## Ordering Prescriptions by Mail

**Initial order:** To place your first order for a prescription through mail order, follow these steps:

- Complete the [Mail Order Form](#).
- Complete the Health Allergy, and Medical Questionnaire (found on the [Express Scripts website](#)). The questionnaire will not be necessary on refills or future orders unless your health changes significantly.
- Include the original written prescription signed by your physician.
- Indicate your method of payment on the form.
  - A major credit or debit card, or
  - Personal check or money order.

Express Scripts will bill you when your medications are delivered (up to \$100). If paying by check or money order, enclose your payment with the order. Do not send cash. For pricing information, access the [Express Scripts website](#) or call Express Scripts (see "[Contact Information](#)" in the Reference Information section).

- Mail your order to the address on the Mail Order Form.
- Generally, your order is shipped within three working days of receipt. All orders are sent by UPS or first class mail. UPS delivers to rural route boxes but not to P.O. Boxes. If you have only a P.O. Box address, your order is sent by first class mail.

## Internet Refill Option

You have access to the [Express Scripts website](#), you can order prescription drug refills, check on the status of your order, request additional forms and envelopes, or locate a network pharmacy near you.

To refill a prescription online, log on to the [Express Scripts website](#). Your prescriptions available for refill will be displayed. Allow up to 14 days for delivery of your prescription.

## Other Refill Options

If you choose not to refill your mail order prescriptions online, place your order at least two weeks before your current supply runs out in one of the following two ways:

- Call Express Scripts to request a refill. You will be asked for your Express Scripts ID number, current mailing address and Express Scripts Health Rx Services prescription number.
- Complete and mail in your [Mail Order Form](#). Attach your Medco refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

## Claims Filing Deadline

- For all claims incurred on or after 1/1/10, you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- For all claims incurred on or before 12/31/09, you must submit all health claims within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment.

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

## Maximum Medical Benefits

Express Scripts will send you a statement with each prescription. The statement includes your co-insurance and the amount the Company paid. The amount the Company pays is applied to your maximum medical benefit (see “[Maximum Medical Benefits](#)” in the Medical Benefit Options Overview section).



# Retiree Value Plus Option

This Retiree Medical Benefit Option is non-grandfathered.

As a retiree, you can choose the Retiree Value Plus Option. You can cover yourself, your spouse/Company-recognized Domestic Partner, your dependent children and/or your spouse/Company-recognized Domestic Partner's dependent children under the Retiree Value Plus Option.

- For providers' eligible expenses, the annual deductibles are:
  - \$250 for in-network services per person
  - \$750 for out-of-network services per person
- You have the choice of receiving care from in-network providers or out-of-network providers.
  - If you use an in-network physician, hospital or other medical service providers, your out-of-pocket expenses may be lower.
  - If you use out-of-network providers, your out-of-pocket expenses will be greater.

## Your Network/Claims Administrator

The Retiree Value Plus Option is administered by three network/claims administrators: UnitedHealthcare (UHC), Aetna and Blue Cross and Blue Shield of Texas. Each state has one preferred network/claims administrator. If you retired on or before October 31, 2012, you may be able to choose a different network/claims administrator, but you will pay more in contributions. The [map of the network/claims administrators by state](#) can be found on the Benefits Page of Jetnet.

Your state is determined by your alternate address. If you do not have an alternate address on file in the [Update MY Information Page](#) of Jetnet, your state will be determined by your permanent address.

## Benefit Overview

Services	Per-Person Deductible	Co-Insurance/ Co-Pay (after deductible is met)	Per-Person Annual Out-of-Pocket Maximum
In-Network	\$250	15%	\$1,750 per covered individual (for services covered at 85%)
Out-Of-Network	\$750 (applies to all services)	35% (applies to all services)	Unlimited out-of-pocket maximum

In-network and out-of-network deductibles do not apply to the out-of-pocket maximum. If you satisfy the individual annual network deductible and later in the year use out-of-network services, you must satisfy the out-of-network deductible separately.

## In This Section

- How the Retiree Value Plus Option Works
  - In-Network Services
  - Out-of-Network Services
  - Other Information
  - Network/Claims Administrator
  - Special Features of the Retiree Value Plus Option
- Covered and Excluded Expenses
- Filing Claims
- Prescription Drug Benefits
  - Filling Prescriptions and Filing Claims
  - Maximum Medical Benefits

## How the Retiree Value Plus Option Works

As an eligible retiree, you can choose the Retiree Value Plus Option, which offers you access to the network of physicians and hospitals that have agreed to provide medical services to plan participants at preferred rates. When you use a network provider, you pay only a co-pay or coinsurance for most services. Medical necessity is determined by your network/claims administrator.

If you are a Pilot, Flight Engineer, Flight Attendant, TWU-Represented, Agent, Representative or Planner retiree, or an Officer, Management/Specialist or Support Staff retiree under age 65, if you want to elect the Retiree Value Plus Option, you must take action to enroll yourself in this coverage. You will not be automatically enrolled in the Retiree Value Plus Option.

If you are an Agent, Representative or Planner retiree age 65 or over who retired on or after January 1, 2011 or an Officer, Management/Specialist or Support Staff retiree age 65 or over, you are not eligible for coverage under any Retiree Medical Benefit Option, including the Retiree Value Plus Option.

See Retiree Eligibility for more information on specific eligibility requirements and Enrollment, for information about enrolling in the Retiree Value Plus Option or a different Retiree Medical Benefit Option.

The Retiree Value Plus Option offers you access to the network of physicians and hospitals that have agreed to provide medical services to plan participants at preferred rates. When you use a network provider, you pay only a co-pay or co-insurance for most services.

### In-Network Services

Each covered person, which includes you and any covered dependents, must first satisfy an annual in-network deductible of \$250 before the option begins paying a percentage of eligible expenses. After you and your covered dependents meet the annual in-network deductible, the Retiree Value Plus Option pays 85% of in-network eligible expenses. You pay 15% co-insurance for in-network services. After you and your covered dependents meet the individual annual out-of-pocket maximum of \$1,750 for services that require you to pay 15% co-insurance, further eligible expenses are covered at 100% for the remainder of the year.

### Out-of-Network Services

Each covered person, which includes you and any covered dependents, must first satisfy an annual out-of-network deductible of \$750 before the option begins paying a percentage of eligible expenses. After you and your covered dependents meet the annual out-of-network deductible, the Retiree Value Plus Option pays 65% of out-of-network eligible expenses. You pay 35% co-insurance for out-of-network services. There is no out-of-pocket maximum.

## Other Information

You can receive in-network benefits for specialist care without a referral from a primary care physician (PCP), but you are encouraged to have a PCP to coordinate in-network services for you. Contact your network/claims administrator to review a list of in-network providers. You can also access your network/claims administrator's website to find a list of in-network providers.

After you have enrolled, you will receive a Retiree Value Plus Option ID card from your network/claims administrator indicating that you and your enrolled dependents are covered by the Retiree Value Plus Option. The ID card includes important phone numbers and should be presented each time you go to a network physician or hospital. Retiree Value Plus members will receive a Express Scripts ID card for prescription drug services.

If you relocate to a new state, your medical plan option election and contribution rates remain the same for the remainder of the plan year. Your elected network/claims administrator does not change based on your relocation. However, if the Retiree Value Plus Option is not available in your new location, you must elect another form of medical coverage.

You must wait until the next annual enrollment period to change your medical option election and your network/claims administrator, unless you experience a relocation Life Event. See "[Life Events](#)" for more information.

The Retiree Value Plus Option is offered in most locations, but if you live outside the network/claims administrator's access area, you are not eligible for the Retiree Value Plus Option and must choose the Retiree Standard Medical Option or the RHMO (if you live in Puerto Rico and are under age 65) for medical coverage.

See the "[Medical Benefit Options Comparison](#)" in the Medical Benefit Options Overview section to see a comparison of your benefits under the Retiree Value Plus Option and the Retiree Standard Medical Option.

## Network/Claims Administrator

The Retiree Value Plus Option is administered by three network/claims administrators — UnitedHealthcare (UHC), Aetna, and Blue Cross and Blue Shield of Texas.

When you enroll for the Retiree Value Plus Option, you have a choice among the three network/claims administrators. The administrator with the lowest employee contribution costs will be the preferred network/claims administrator for your state. You can choose a non-preferred network/claims administrator — called Tier 1 or Tier 2 — but you will pay more in employee contributions. The Tier 1 and Tier 2 non-preferred network/claims administrators will vary from state to state. For example, Aetna may be a Tier 1 non-preferred network/claims administrator in one state and a Tier 2 network/claims administrator in another.

Tier 1 and Tier 2 network/claims administrators reflect monthly contributions that are 25% and 50% higher than the cost of the preferred network/claims administrator, as this chart demonstrates:

	Employee	Employee + 1 Dependent	Employee + 2 or More Dependents
Preferred network/claims administrator	Preferred Rate	Preferred Rate	Preferred Rate
Tier 1 network/claims administrator	Preferred Rate + 25% Increase	Preferred Rate + 25% Increase	Preferred Rate + 25% Increase
Tier 2 network/claims administrator	Preferred Rate + 50% Increase	Preferred Rate + 50% Increase	Preferred Rate + 50% Increase

Preferred rate increases are subject to change.

The [map of the network/claims administrators by state](#) can be found on the Benefits Page of Jetnet.

## Special Features of the Retiree Value Plus Option

The Retiree Value Plus Option includes the following special provisions:

**In-network services:** In-network providers who contract with your network/claims administrator agree to provide services and supplies at contracted rates. At the in-network benefit level, you pay a fixed co-pay or co-insurance amount, a \$250 per person annual deductible.

**Out-of-Network services:** If you go to a provider who is not part of the network, you are covered for eligible medically necessary services; however, coverage reimbursement is at a lower level (out-of-network benefit level).

At the out-of-network benefit level, you pay an annual \$750 per person per year deductible and higher out-of-pocket co-insurance amounts. For most services, the Retiree Value Plus Option pays 65% and you pay the remaining 35% of covered out-of-network charges, after you satisfy the \$750 annual per person deductible. Additionally, you must pay any amount of the provider's billed fee that exceeds the Maximum Out-of-Network Reimbursement Program (MNRP) fee limits.

**Maximum Out-of-Network Reimbursement Program (MNRP) fee limits:** The Retiree Value Plus Option will determine the eligible charge amount for out-of-network expenses by using the MNRP. The eligible amount will be the actual billed fee, up to 140% of the Medicare-allowable expense (whichever is less). MNRP fee limits will apply to all medical services and supplies, for example: hospital charges, physician's fees, lab fees, radiology fees and all other covered, medically necessary out-of-network expenses.

For the following rare occurrences, the allowable expense is determined according to the following rules:

- If the claim is for care in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the Retiree Value Plus Option will allow the out-of-network provider's full billed charge as an eligible expense.
- If the claim is for care in a "network gap" (where the nearest source of appropriate medical treatment is greater than the network/claims administrator's network gap mile limit), and covered person has received prior approval from the network/claims administrator, the Retiree Value Plus Option will allow the out-of-network provider's full billed charge as an eligible expense.
- If the claim is for services for which no MNRP data exist, the Retiree Value Plus Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.

**Primary Care Physicians (PCP):** Your PCP is your partner in the services you receive under the Retiree Value Plus Option. He or she:

- Coordinates all phases of your in-network medical care, and
- Oversees, coordinates and authorizes hospitalization and surgery.

PCPs may specialize in pediatrics, family practice, general practice or internal medicine. You are encouraged to establish a relationship with a PCP.

**Preventive care:** You and each covered family member are eligible to receive benefits at 100% for in-network annual routine physical exams, including:

- Well-woman exams,
- Well-child exams provided by an in-network provider, and
- Preventive screening exams, such as mammograms, PSA tests and colonoscopies, as set forth by the U.S. Preventive Services Task Force.

**No claims to file:** In most cases, when you use network providers, the provider files your claims for you.

**Co-pays and co-insurance:** Co-pays and co-insurance are the amounts you pay for eligible covered medical services depending on where you receive these services.

- **Co-pays:** For in-network services such as office visits to your in-network provider PCP or specialist, including any tests or treatment received during the office visit, you pay a fixed dollar co-pay amount, as described in the Medical Benefit Options Comparison table.
- **Co-insurance:** For services received in-network setting, you pay 15% co-insurance (a percentage of the cost) after you satisfy the \$250 per person annual in-network deductible. For all eligible out-of-network services you pay 35% out-of-network coinsurance after you satisfy the annual \$750 per person out-of-network deductible.

**Individual in-network annual out-of-pocket maximum:** After you satisfy the annual individual in-network out-of-pocket maximum of \$1,750 per covered person, the Retiree Value Plus Option pays 100% of in-network eligible expenses for the rest of the calendar year, excluding prescription drugs.

The in-network deductible does not apply to the in-network out-of-pocket maximum. Hospital-based services include: hospital facility charges, freestanding surgical facilities, physician charges, room and board, diagnostic testing, X-ray and lab fees, anesthesia, dialysis, chemotherapy and MRIs.

Co-pays for in-network office visits, prescription drug co-pays and co-insurance, out-of-network deductibles, and other in-network co-insurance amounts (such as, expenses reimbursed at 50%) do not apply to the annual out-of-pocket maximum.

**Emergency care:** If you have a medical emergency, go directly to an emergency facility. Benefits are paid at the in-network level regardless if your provider is in-network or out-of-network. You should arrange any follow-up treatment through your PCP.

**Urgent/immediate care:** If you are in your network service area and need urgent or immediate care, but you do not have an actual emergency, contact your PCP first. He or she will direct you to the appropriate place for treatment.



In order to receive the in-network benefit level, you should contact your network provider or your network/claims administrator for authorization before seeking care at an urgent or immediate care treatment clinic, or if you are traveling and need urgent or immediate medical care. If your network/claims administrator's offices are closed, seek treatment and then call your network/claims administrator within 48 hours to ensure that you receive the in-network level of benefits.

See the definition of urgent/immediate care in the "[Glossary](#)" in the Reference Information section).

**Specialist care:** To receive the in-network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use an in-network specialist, and services must be eligible under the terms of the Plan.

If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your PCP or your network/claims administrator to determine if a referral to an out-of-network specialist is needed. In these rare instances, your out-of-network care is covered at the in-network benefit level, but only with prior approval through your network/claims administrator. Please note that not all Retiree Value Plus area networks may have in-network specialist providers within your network/claims administrator's network gap mile limit. When you enroll, you should check to see if there are specialty providers within a comfortable distance and within the network gap mile limit.

**Care while traveling:** If you have a medical emergency while traveling, get medical attention immediately. If you need urgent or immediate (not emergency) care, you should call your network/claims administrator for a list of in-network providers and urgent care facilities. If it is after hours, seek treatment and call your network/claims administrator within 48 hours. If you go to an in-network provider, you should only have to pay your copay or co-insurance and the provider should file your claim for you.

If you go to an out-of-network provider, you or a family member must call your network/claims administrator within 48 hours of your care. You must submit a claim. However, you are eligible for the in-network level of benefits if you follow these procedures. See the definition of emergency in the "[Glossary](#)" in the Reference Information section).

#### **Transition of care:**

- If your network/claims administrator changes (and you or a covered family member has a serious illness, or you or your spouse is in the 20th — or later — week of pregnancy), you can ask your new network/claims administrator to evaluate your need for transition of care. This allows you to continue with your current care provider at the Retiree Value Plus in-network benefit level for a period of time, even if that provider is not part of the Retiree Value Plus network for your new network/claims administrator. Contact your network/claims administrator for more information.
- If you are newly enrolled in the Retiree Value Plus Option (and you or a covered family member has a serious illness, or you or your spouse is in the 20th — or later — week of pregnancy), you can ask your network/claims administrator to evaluate your need for transition of care. This allows you to continue with your

current care provider at the Retiree Value Plus in-network benefit level for a period of time, even if that provider is not part of the Retiree Value Plus network. Contact your network/claims administrator for more information.

**Network and/or claim administrator:** Your network/claims administrator establishes standards for participating providers, including physicians, hospitals and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges and medical outcomes. They also periodically monitor whether participating providers continue to meet network standards. Your network/claims administrator also processes claims, negotiates fees and contracts with care providers.

**Dependents living in different cities:** If you have a dependent who lives in a different state than you (for example: commuters, children away at school, divorced families), your dependent is covered by the preferred network/claims administrator for the state where you reside, not the state where he or she resides. Your network/claims administrator has national in-network providers, providing you and your covered dependents with access to in-network providers. For example, if you live in Texas and your dependent lives in California, your dependent is covered under the network/claims administrator for Texas (your state of residence), not California. This means your dependent will use the same network of providers that you use, regardless if your dependent resides in a different state than you. When you select a network and/or plan administrator, you should carefully evaluate your choices that are available to you and your family members living elsewhere, so your entire family can maximize your in-network benefit levels.

### **Leaving the service area (moving your home address or relocating):**

- If you move to an area where the Retiree Value Plus Option is available, you remain enrolled in the Retiree Value Plus Option and retain your current network/claims administrator.
- If the Retiree Value Plus Option is not available in your new area, you may select the Retiree Standard Medical Option or the Retiree HMO (if you reside in Puerto Rico and are under age 65).
- If you move a state with a different preferred network/claims administrator, you remain enrolled in the Retiree Value Plus Option with your new network/claims administrator. However, if the Retiree Value Plus Option is not available in your new area, you may select the Retiree Standard Medical Option or the Retiree HMO (if you reside in Puerto Rico and are under age 65).
- You must contact HR Services within 60 days of the event to process a relocation Life Event (see “[Life Events](#)”). Click on the “Start a Chat” button on the top of this page. If you do not notify HR Services of your election, you will be enrolled in the Retiree Value Plus Option in your new location (if available and previously elected) or in the Retiree Standard Medical Option (if the Retiree Value Plus Option is not available). You will receive a confirmation statement indicating your new coverage.

## Covered and Excluded Expenses

For a detailed explanation of the Plans' eligible expenses and exclusions, see "[Covered Expenses](#)" and "[Excluded Expenses](#)" in the Medical Benefit Options Overview section.

## Filing Claims

If you use an in-network provider, you do not need to file a claim as the provider will file claims on your behalf.

If you used an out-of-network provider or need medical care while you are traveling, you may need to file a claim. You must submit the original itemized bill or receipt provided by your physician, hospital, pharmacy or other medical service provider, so you should make a copy for your records. Follow the procedures below:

- Complete a [Medical Benefit Claim Form](#).
- Submit the completed form to your network/claims administrator, along with all original itemized receipts from your physician or other health care provider. A cancelled check or credit card receipt is not acceptable.

Each bill or receipt submitted to your network/claims administrator must include the following:

- Name of patient,
- Date the treatment or service was provided,
- Diagnosis of the injury or illness for which treatment or service was given,
- Itemized description and charges for the treatment or service, and
- Provider's name, address and tax ID number.

Make copies of the original itemized bill or receipt provided by your physician, hospital or other medical service provider for your own records. All medical claim payments include an Explanation of Benefits (EOB) explaining the amount paid, unless your physician, hospital or other medical provider has agreed to accept assignment of benefits (see "[Assignment of Benefits](#)" in the Plan Administration section). In most cases, the EOB will be mailed to you and the payment mailed to your provider. EOBs are available online or your network/claims administrator's website.

It is very important that you fully complete the 'other coverage' section of the form. Examples of other coverage include a spouse's group health plan, Workers' Compensation, Medicare, TRICARE and no-fault motor vehicle insurance. If you have questions about your coverage or your claim under the Retiree Value Plus Option, contact your network/claims administrator (see "[Contact Information](#)" in the Reference Information section).

## Claims Filing Deadline

- For all claims incurred on or after 1/1/10, you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- For all claims incurred on or before 12/31/09, you must submit all health claims within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment.

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

## Prescription Drug Benefits

Prescription drug coverage will be based upon an incentive formulary. The amount of coinsurance paid by the Retiree Value Plus Option is based upon whether the medication is a generic drug, formulary drug or non-formulary drug.

- Generic drugs are drugs that are chemically and therapeutically equivalent to the corresponding brand name drug, but cost less.
- Formulary drugs are preferred brand name drugs. Formulary drugs are just as safe and effective as the alternatives, but cost less. The formulary list is based on safety and cost considerations.
- Non-formulary drugs are brand name drugs that are not in the formulary, but they have preferred alternatives (either generic or brand) that are in the formulary.

Express Scripts is the prescription drug vendor for the Retiree Value Plus Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Express Scripts Mail Order Prescription Drug Benefit. Only eligible prescription drug expenses are covered under this benefit.

Express Scripts has a broad network of pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the [Express Scripts website](#) or call Express Scripts at 1-800-988-4125.

## Retail Drug Coverage

You may have your prescriptions filled at any pharmacy. However, you receive greater benefits when you use a participating in-network pharmacy. Go to the [Express Scripts website](#) or call 1-800-988-4125 to locate an in-network pharmacy. You pay, for up to a 30-day supply:

- Generic Drugs: 20% co-insurance (\$10 min/\$20 max per prescription)
- Formulary Drugs: 30% co-insurance (\$30 min/\$100 max per prescription)\*
- Non-Formulary Drugs: 50% co-insurance (\$45 min/\$150 max per prescription)\*
- If you select a brand name drug (formulary or non-formulary) when a generic is available, you will pay a 20% generic co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.

## Filling Prescriptions and Filing Claims

Follow these steps to fill prescriptions:

### Network pharmacies:

- Present your Express Scripts ID card at the in-network pharmacy
- Pay your portion of the cost for the prescription
- You do not have to file a claim form because your prescription drug information is submitted directly to your network/claims administrator.

**Out-of-network pharmacies:**

At the time you purchase your prescription, you will pay the full price. However, only the Express Scripts discount price for drugs is considered an allowable expense for reimbursement. For example, if you have a prescription that costs \$250 and the Express Scripts discounted price is \$100, you will be responsible for paying the applicable co-insurance, plus the \$150 difference between the non-discounted price of the drug and the discounted price.

You will need to file a [Express Scripts Reimbursement Form](#). Follow the instructions on the claim form. Remember to attach the receipt for your prescription.

If you have questions concerning your prescription drug benefit, call the Express Scripts Member Services number on your Express Scripts ID card.

**Retail Refill Allowance — Long-Term Medications**

Beginning January 1, 2012, you and your covered dependents will pay 50% of the drug cost for Long-Term Medications at a retail pharmacy after your third purchase. Long-Term prescriptions include medications taken on an on-going basis for conditions such as high cholesterol, high blood pressure, depression, diabetes, arthritis and other conditions. To determine if your prescription medications fall within the Long-Term Medications listing, go to the [Express Scripts website](#) or call 1-800-988-4125.

Beginning with your fourth purchase of a Long-Term Medication, you should utilize Express Scripts by Mail for these refills. You can purchase up to a 90-day supply of your Long-Term Medications, which can ultimately save you money on your prescription costs. See Express Scripts Prescription Drug Mail Order in this section for more information.

Beginning with your fourth purchase, you will pay 50% of the drug cost if you continue to refill your Long-Term Medications through a retail pharmacy. Maximums do not apply to Long-Term Medications beginning with your fourth purchase.

Short-term medications should continue to be purchased at a retail pharmacy and you will pay your retail pharmacy co-payment.

**Retail Prescription Clinical Programs**

Express Scripts uses a number of clinical programs that help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, they are subject to change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period).

When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these clinical programs and the specific drugs subject to these programs can be obtained from Express Scripts (see [“Contact Information”](#) in the Reference Information section).



## Generic Drugs

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

## Prior Authorization

To be eligible for benefits, certain covered prescriptions and specialty pharmacy medications require prior authorization by Express Scripts to determine medical necessity before you can obtain them at a participating pharmacy or through the Express Scripts Mail Order Prescription Drug Benefit. Examples of medications requiring prior authorization include growth hormones and rheumatoid arthritis drugs.

Express Scripts will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

When you fill your prescription, your pharmacist will call Express Scripts. Your pharmacist and a Express Scripts pharmacist will review the request for approval. Express Scripts will send you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for up to one year. Prior authorizations must be renewed periodically. When the renewal date approaches, you should contact Express Scripts for renewal instructions.

Ask your physician to contact Express Scripts or to complete Express Scripts' prior authorization form with the following information:

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

If the pharmacy does not fill a prescription because there is no prior authorization on file, the pharmacy's denial will not be treated as a claim for benefits. You must submit the request for prior authorization to Express Scripts. If the prior authorization is denied, you must file a first level appeal through Express Scripts to be considered for coverage for that medication.



## Specialty Pharmacy Services

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

Accredo Health Group, a subsidiary of Express Scripts Health, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications.

Prescriptions prescribed to manage medical conditions such as the following must be filled at a retail pharmacy or one of Accredo's Health Group pharmacies through Express Scripts Health:

- Anemia
- Growth Hormone
- Hemophilia
- Hepatitis C
- Immune Deficiency Therapy
- Metabolic Disorders
- Multiple Sclerosis
- Oral Cancer Drugs
- Osteoporosis
- Pulmonary/Pulmonary Arterial Hypertension
- Rheumatoid Arthritis or Other Autoimmune Conditions
- Other Various Indications

Please note that other conditions are added as appropriate and as required.

Whether these prescriptions are self-administered or administered in a physician's office, the prescriptions to treat the above conditions are not reimbursed through your Medical Benefit Option and must be filled at a retail pharmacy using your Express Scripts ID card or through Express Scripts by Mail for you to receive prescription drug benefits. Express Scripts can ship the prescription to your home for self-administration or to your physician's office for medications which are to be administered by a physician.

The applicable deductible and co-insurance associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions.

## Express Scripts Prescription Drug Mail Order

You and your covered dependents are eligible for Express Scripts by Mail. You may use this option to order 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 may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration. Ordering medications on a 90-day supply basis through Express Scripts by Mail will often save you more money than if you fill your prescriptions at a retail pharmacy on a 30-day basis.

When you fill your prescriptions through mail order, you pay:

- Generic Drugs: 15% co-insurance (\$5 min/\$40 max per prescription)
  - Formulary Drugs: 30% co-insurance (\$60 min/\$200 max per prescription)\*
  - Non-Formulary Drugs: 50% co-insurance (\$90 min/\$300 max per prescription)\*
- \* If you select a brand name drug (formulary or non-formulary) when a generic is available, you will pay a 20% generic co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.

Oral contraceptives, transdermal and intravaginal contraceptives are covered by Express Scripts by Mail only. This includes both generic and brand name (formulary or non-formulary) contraceptives.

### Mail Order Prescription Clinical Programs

Express Scripts uses a number of clinical programs to help insure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, the drugs subject to these clinical programs may change. Some medications may require prior authorization (pre-approval), and some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period). When a prescription for a medication requiring prior authorization or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these programs may be obtained from the prescription drug administrator (see “[Contact Information](#)” in the Reference Information section).

### Generic Drugs

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

## Ordering Prescriptions by Mail

**Initial order:** To place your first order for a prescription through mail order, follow these steps:

- Complete the [Mail Order Form](#).
- Complete the Health Allergy, and Medical Questionnaire (found on the [Express Scripts website](#)). The questionnaire will not be necessary on refills or future orders unless your health changes significantly.
- Include the original written prescription signed by your physician.
- Indicate your method of payment on the form.
  - A major credit or debit card, or
  - Personal check or money order.
  - Express Scripts will bill you when your medications are delivered (up to \$100).

If paying by check or money order, enclose your payment with the order. Do not send cash. For pricing information, access the [Express Scripts website](#) or call Express Scripts (see "[Contact Information](#)" in the Reference Information section).

- Mail your order to the address on the [Mail Order Form](#).
- Generally, your order is shipped within three working days of receipt. All orders are sent by UPS or first class mail. UPS delivers to rural route boxes but not to P.O. Boxes. If you have only a P.O. Box address, your order is sent by first class mail.

## Internet Refill Option

You have access to the [Express Scripts website](#), you can order prescription drug refills, check on the status of your order, request additional forms and envelopes, or locate a network pharmacy near you.

To refill a prescription online, log on to the [Express Scripts website](#). Your prescriptions available for refill will be displayed. Allow up to 14 days for delivery of your prescription.

## Other Refill Options

If you choose not to refill your mail order prescriptions online, place your order at least two weeks before your current supply runs out in one of the following two ways:

- Call Express Scripts to request a refill. You will be asked for your Express Scripts ID number, current mailing address and Express Scripts Health Rx Services prescription number.
- Complete and mail in your [Mail Order Form](#). Attach your Medco refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

## Maximum Medical Benefits

Express Scripts will send you a statement with each prescription. The statement includes your co-insurance and the amount the Company paid. The amount the Company pays is applied to your maximum medical benefit (see "[Maximum Medical Benefits](#)" in the Medical Benefit Options Overview section).

# Retiree Health Maintenance Organization (RHMO)

The RHMO is a fully insured program that provides medical care through a network of physicians, hospitals and other medical service providers.

- You must live in Puerto Rico and be Pre-65 to be eligible for the RHMO.
- If you enroll in the RHMO, you will receive information from the RHMO describing the services and exclusions of the RHMO.
- Company-recognized Domestic Partners may be eligible for coverage under the RHMO. Contact the RHMO directly to learn about the eligibility rules.
- The RHMO requires you to choose a primary care physician (PCP) who coordinates your medical care.
- Expenses such as prescription drugs and mental health care may be covered by the RHMO.

## RHMO Eligibility

To be eligible for the RHMO you must live in Puerto Rico and be Pre-65. Your eligibility is determined by the postal code of your Jetnet alternate address on record. Jetnet allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence). Since many retirees maintain more than one residence, you may list both addresses in Jetnet; however, your alternate address determines your eligibility. If you do not have an alternate address listed in Jetnet, your eligibility is based on your permanent address.

If you are eligible to enroll in the RHMO, the RHMO will appear as an option in the [Benefits Service Center](#) when you enroll for benefits.

## In This Section See Page

Eligibility

Children Living Outside of the Service Area

Termination of Coverage

How the RHMO Works

Problems and Complaints

## Eligibility

You are eligible for the RHMO Option only if you reside in Puerto Rico and are Pre-65. Your eligibility is determined by the postal code of your Jetnet alternate address. Jetnet allows you to list two addresses — a Permanent Address (for tax purposes or for your permanent residence) and an Alternate Address (for a P.O. Box or street address other than your permanent residence).

Since many retirees maintain more than one residence, you may list both addresses in Jetnet; however, your Alternate Address determines your geographical eligibility for the RHMO. If you do not have an Alternate Address listed in Jetnet, your eligibility is based on your Permanent Address.

In addition to meeting all other eligibility requirements for the Retiree Medical Benefit coverage, if you voluntarily elect to participate in the RHMO, you must also meet all of the following requirements:

- Meet all other retiree eligibility requirements, as defined in the provisions of the Retiree Medical Benefits
- Be Pre-65
- Have not reached your maximum medical benefit under a Company-sponsored medical benefit
- Reside where the RHMO offers a network (your eligibility is based upon the postal code of your alternate address, as reflected in Jetnet)
- Did not terminate employment under Article 30 (this applies to Flight Attendant retirees only)
- Did not elect to waive or elect to voluntarily and permanently opt out of the Retiree Medical Benefit
- Did not retire under the 1995 SVEOP (Special Voluntary Early Out Program)
- Are not a TWA retiree

Company-recognized Domestic Partners may be eligible for coverage under the RHMO. If your Company-recognized Domestic Partner can be covered under the RHMO, you will be able to choose coverage for him or her when you enroll. The decision to offer coverage to Company-recognized Domestic Partners is made by individual HMO plan provisions, not by American Airlines.

If you are eligible to enroll in the RHMO, it will appear as an option in the [Benefits Service Center](#) when you enroll for benefits the first time. If you elect coverage under the RHMO, all your claims for benefits are solely under the RHMO contract or policy and all benefits are provided solely through the RHMO.

## Children Living Outside of the Service Area

If your child does not live with you, either because the child is a student or because you are providing the child's coverage under a Qualified Medical Child Support Order (QMCSO), you must contact the RHMO to find out if your child can be covered. If the RHMO cannot cover your child, you may be required to select the Retiree Standard Medical Option or the Retiree Value Plus Option for your entire family.

## Termination of Coverage

Your RHMO coverage terminates:

- As set forth in “[When Coverage Ends](#)” in the Retiree Enrollment section.
- **When you move out of the RHMO service area.** With the exception of Annual Benefits Enrollment, the only other time you may change your RHMO coverage election is if you move out of the RHMO’s service area. In this event you must elect another Retiree Medical Benefit Option. You have 60 days after your move to elect another Retiree Medical Benefit Option. See the Life Events: Making Changes During the Year section or call HR Services for more information (see “[Contact Information](#)” in the Reference Information section).
- **When you reach age 65.** Your RHMO coverage terminates when you reach age 65 and your coverage reverts to the Retiree Standard Medical (RSM) Option (this does not apply to Agent Representatives and Planners who retire on or after January 1, 2011 or Officer, Management/Specialist and Support Staff retirees). When you return to the RSM Option, you must timely pay the required ongoing monthly contributions to enter and maintain RSM Option coverage (this requirement does not apply to Pilot or Flight Engineer retirees, or Flight Attendant retirees who retired prior to January 1, 2002).

## How the RHMO Works

The RHMO is a fully insured program whose covered services are paid by the Triple-S HMO in Puerto Rico. The RHMO provides medical care through a network of physicians, hospitals and other medical service providers. You must use network providers to receive benefits under the RHMO. The RHMO requires you to:

- Choose a primary care physician (PCP) who coordinates all your medical care; and
- Obtain a referral from your PCP before receiving care from a specialist.

The RHMO is completely independent of the Company. The RHMO is an independent organization; the benefits, restrictions and conditions are determined by the RHMO and the Company cannot influence or dictate the coverage provided.

If you choose RHMO coverage, your RHMO coverage replaces medical coverage offered by the Retiree Standard Medical Option and the Retiree Value Plus Option. Your benefits, including prescription drugs and mental health care, are covered according to the rules of the RHMO.

## Problems and Complaints

The RHMO has a grievance procedure or policy to appeal claim denials or other issues involving the HMO. Call the RHMO for information on filing complaints or grievances. (See “[Contact Information](#)” in the Reference Information section.)



# Medicare Coverage

You are eligible for Medicare on the first of the month in which you turn age 65 if you or your spouse worked at least 10 years in Medicare-covered employment and you are either a U.S. citizen or a permanent resident. You might also qualify if you are Pre-65 and are disabled or have chronic kidney disease. The following Medicare coverage is available:

- Original Medicare (Medicare Parts A and B)
- Medicare Advantage (Medicare Part C)
- Medicare Part D (prescription drug coverage)
- When you become eligible for Medicare, it will become your primary coverage and your retiree medical coverage will become secondary.

## Information About Medicare

This summary provides some general information about Medicare Parts A and B, as well as Medicare Advantage (Medicare Part C) and Medicare Part D, but does not explain all of the program's benefits and features. If you have specific questions contact the Social Security Administration or refer to your written materials from Medicare. Medicare information is also available on the [Medicare website](#).

## In This Section See Page

About Medicare Coverage

Medicare Part A

Medicare Part B

Medicare Part D

Medicare Assignment

Medicare Advantage (Medicare Part C)

## About Medicare Coverage

If you are covered by Medicare, knowing how your Medicare coverage works will help you understand how benefits apply under the Retiree Medical Benefit. You are eligible for Medicare on the first of the month in which you turn age 65 if you or your spouse worked at least 10 years in Medicare-covered employment and you are either a U.S. citizen or a permanent resident. You might also qualify if you are Pre-65 and are disabled or have chronic kidney disease. If you attain age 65 on the first day of the month, Medicare coverage is effective on the first day of the month prior to your 65th birthday.

You may choose to be covered under Original Medicare or under a Medicare Advantage Plan. Original Medicare includes Part A-hospital coverage and Part B-medical coverage. You may also choose a Medicare prescription drug program under Medicare Part D.

### Medicare Part A

Medicare Part A helps pay for:

- Hospital care
- Skilled nursing facilities following a hospital stay
- Home health care
- Hospice care

Part A has an in-hospital deductible per spell of illness, but Medicare customarily changes this Part A deductible amount on January 1 of each year. Most people qualify for Part A without paying any premium. Both the Part A deductible and the amount you pay are subject to change each year. Visit the [Medicare website](#) for the most current information on Medicare.

### Medicare Part B

Medicare Part B helps pay for:

- Medical expenses such as doctor's charges, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests and durable medical equipment
- Clinical laboratory and X-ray services
- Home health care
- Outpatient hospital services for diagnosis and treatment of an illness or injury
- Blood
- Certain preventive services

Part B has an annual deductible, but Medicare customarily changes this Part B deductible amount on January 1 of each year. There is a monthly premium charged for this coverage. After the Part B deductible is met, Medicare pays 80% of the Medicare-approved amount for most services. Both the Part B deductible and the amount you pay are subject to change each year. Visit the [Medicare website](#) for the most current information on Medicare.

## Medicare Part D

Once you are Medicare-eligible, your primary prescription drug coverage will be Medicare Part D. It is very important that you enroll in Medicare Part D coverage as soon as you become eligible.

Medicare Part D helps pay for both brand name and generic drugs at participating pharmacies. You pay a monthly premium for this coverage, just like you do for Medicare Part B. Medicare Part D has an annual deductible that you must satisfy before Medicare will pay prescription drug benefits. After this deductible is met, you will still be responsible for paying co-insurance and/or a co-payment for your prescription drugs. Depending on the Medicare Part D plan that you choose, you may have lesser co-insurance or a co-payment for generic than brand name drugs. Some Medicare Part D plans offer mail order purchase of medications.

The [Medicare website](#) provides more information about Medicare Part D. Carefully review this information, along with the information you receive from Medicare Part D prescription drug plan providers when choosing a plan to fit your needs.

## Medicare Assignment

Always ask your doctors if they accept Medicare assignment of benefits, because assignment can save you money. If they do, they will accept the Medicare-approved charge for a particular service or supply and will not charge you more than the Medicare Part B deductible and 20% coinsurance.

Physicians who do not accept Medicare assignment may not charge you more than 115% of the Medicare-approved amount for a particular service. (This is known as the “limiting charge.”) In this case, you are responsible for paying 20% of the Medicare-approved amount, after meeting your Part B deductible, plus the additional 15%.

Doctors can choose not to participate or accept Medicare payments (to “opt out”). Medicare will not pay for any services provided by a doctor who has chosen to opt out. Doctors who opt out of Medicare must notify patients before treating them. If you have been notified and choose to continue receiving services from a doctor who has opted out of Medicare, you must pay the full cost for that doctor’s services.

## Medicare Advantage (Medicare Part C)

When you choose Medicare Advantage, your health care is coordinated through a Health Maintenance Organization (HMO), an HMO with a Point of Service (POS) option, a Preferred Provider Organization (PPO) or a Provider Sponsored Organization (PSO). Medicare Advantage also includes private Fee-for-Service plans and Medical Savings Accounts.

Medicare Advantage provides all of the same benefits as Parts A and B. Some plans may include additional benefits such as coverage for:

- Prescription drugs
- Routine physical exams
- Hearing aids and exams
- Eye exams and glasses
- Dental services
- Health education and wellness programs

You usually pay a small co-payment when you receive medical care covered under Medicare Advantage. Also, you pay the Part B premium plus any additional premium charged by Medicare Advantage. Both the Part B premium charged by Medicare and the premium charged by Medicare Advantage are subject to change each year.

# Supplemental Medical Plan

The Supplemental Medical Plan pays a percentage of eligible expenses for medically necessary care, treatment and supplies up to the usual and prevailing fee limits.

- You must enroll when you are first eligible as a retiree. You must maintain coverage as a retiree.
- There are three situations where a participant will use their Supplemental Medical Plan benefits:
  - When you or your covered spouse exhausts your maximum medical benefit under your selected Retiree Medical Benefit Option.
  - If you are the surviving spouse of a retired employee who dies while you are both covered under this Plan.
  - If you die while you and your Company-recognized Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Company-recognized Domestic Partner continues for 90 days from the date of your death, provided he or she pays the plan contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

## HealthFirst TPA

HealthFirst TPA is the administrator of the Supplemental Medical Plan. You can contact HealthFirst TPA at 1-800-711-7083.

## Supplemental Medical Plan Overview

Feature	Amount of Coverage
Maximum medical benefit	\$500,000 per Plan participant This maximum applies to the entire time a person is covered by the Plan
Annual deductible	\$250 per person
Annual out-of-pocket maximum	\$1,000 per person each calendar year This does not include expenses paid by the Plan at 50% The \$250 annual deductible does not count towards satisfaction of the annual out-of-pocket maximum

## In This Section

- How the Supplemental Medical Plan Works
  - Coverage Ending for Non-Union Retirees Age 65 and Older
- Supplemental Medical Plan Eligibility
  - Eligibility
  - Eligibility for Spouses of Retired Employees
- Paying for Supplemental Medical Plan Coverage
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  - What Happens to Your Claim
  - Who to Call with Questions
- Coordination of Benefits under the Supplemental Medical Plan
  - Other Plans
  - Which Plan Is Primary
  - When Coordination Applies

## How the Supplemental Medical Plan Works

The Supplemental Medical Plan is a medical benefit plan covering eligible retirees of participating subsidiaries of AMR Corporation (“Company”) and their eligible spouses. In this section, the Supplemental Medical Plan may also be referred to as the “Plan.”

Coverage under the Supplemental Medical Plan is available only to retirees who enroll for coverage when you first initiate your retiree medical coverage.

If you do not enroll for coverage at this designated time or do not maintain the coverage through your retirement, you are not eligible for this coverage. See “[Supplemental Medical Plan Eligibility](#)” for more information.

This is a term (year-to-year) plan. You must maintain your coverage every year.

If you elect coverage under the Supplemental Medical Plan, there are three circumstances under which this Plan would pay a benefit:

- When you or your covered spouse exhausts your maximum medical benefit under you’re the Retiree Medical Benefit Option under the Group Life and Health Benefit Plan for Retirees, Or
- If you are the surviving spouse of a retired employee who dies while you are both covered under this Plan and you have exhausted your maximum medical benefits under your selected Company-sponsored Retiree Medical Benefit Option, or
- If you die while you and your Company-recognized Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Company-recognized Domestic Partner continues for 90 days from the date of your death, provided he or she pays the plan contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

### Coverage Ending for Non-Union Retirees Age 65 and Older

Effective January 1, 2010, Supplemental Medical Plan coverage was terminated for any retiree age 65 or over of the Officer, Management/Specialist and Support Staff workgroup and the retiree’s covered spouse or Company-recognized Domestic Partner.

Effective January 1, 2011, Supplemental Medical Plan coverage was terminated for any retiree age 65 or over of the Agent, Representative and Planner workgroup and the retiree’s covered spouse or Company-recognized Domestic Partner.



## Supplemental Medical Plan Eligibility

You are eligible for the Supplemental Medical Plan if you are a retired American Airlines, Inc. employee or the spouse of a retired employee and you meet the eligibility requirements described in this section.

### Eligibility

To be eligible for coverage under the Supplemental Medical Plan, you must enroll for coverage when you first initiate your retiree medical coverage.

You and your spouse (or Company-recognized Domestic Partner) must be a retired employee and you must be eligible for and enrolled in one of the following Company-sponsored Medical Benefit Options:

- Retiree Standard Medical (RSM) Option,
- Retiree Value Plus Option, or
- Retiree HMO (RHMO) (Puerto Rico retirees under age 65 only).

The following retirees are not eligible for the Supplemental Medical Plan:

- The Supplemental Medical Plan is not available to retired pilots. Pilots have access to a union-sponsored supplemental health plan.
- Flight Attendants who selected the Article 30 option of the APFA contract are not eligible for the Supplemental Medical Plan. For information, see [Retiree Life Insurance Benefit](#) section regarding other benefits available to retired Flight Attendants who took the Article 30 option.
- Officer, Management/Specialist and Support Staff retirees age 65 and over are not eligible for the Supplemental Medical Plan as of January 1, 2010.
- Agent, Representative and Planner retirees age 65 and over who are not eligible for the Supplemental Medical Plan as of January 1, 2011.

### **Eligibility If You Are Age 65 or Over (Flight Attendant, TWU-Represented and Agent, Representative and Planner (who retired on or before December 31, 2010) Retirees)**

As long as you timely pay your contributions, you remain eligible under the Supplemental Medical Plan at age 65 and over.

### **Eligibility If You Are Age 65 or Over (Agent, Representative and Planner (who retires on or after January 1, 2011) or Officer, Management/Specialist and Support Staff Retirees)**

Agent, Representative and Planner or Officer, Management/Specialist and Support Staff retirees age 65 and over are not eligible for the Supplemental Medical Plan.

If you are already receiving benefits under the Supplemental Medical Plan when you reach age 65, your coverage will end.

## **Maintaining Eligibility in the Supplemental Medical Plan**

To remain eligible for the Supplemental Medical Plan, you must timely pay your contributions. If you do not pay your contributions, you will no longer have coverage under the Supplemental Medical Plan.

## **Eligibility for Spouses of Retired Employees**

You may elect coverage for your spouse at the time you enroll yourself in the Supplemental Medical Plan (at the time of your retirement). Your spouse is eligible only as long as you continue to be enrolled in this Plan, unless you die while you are both covered by the Plan (see “Surviving Spouses” below).

If your spouse is not enrolled in a Company-sponsored Retiree Medical Benefit Option, your spouse will not be eligible to collect benefits under this Plan. However, by covering your spouse under the Supplemental Medical Plan while you are enrolled in coverage, your spouse will remain be covered after your death, except for Company-recognized Domestic Partners, provided he or she continues to timely pay the required contributions to maintain coverage.

### **When You Die — Surviving Spouses or Company-recognized Domestic Partners of Flight Attendant, TWU-Represented and Agent, Representative and Planner Retirees (if you retired on or before December 31, 2010)**

If you die as a retired employee while you and your spouse are covered under the Supplemental Medical Plan, your surviving spouse may use this Plan as his or her primary medical coverage. If your surviving spouse has other group medical coverage, the Supplemental Medical Plan will be his or her secondary medical coverage. When your surviving spouse reaches age 65, Medicare is primary and Supplemental Medical Plan coverage is secondary. If your surviving spouse remarries, his or her Supplemental Medical Plan coverage ends.

If you die while you and your Company-recognized Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Company-recognized Domestic Partner continues for 90 days from the date of your death, provided he or she pays the plan contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

### **When You Die — Under Age 65 Surviving Spouses or Company-recognized Domestic Partners of Agent, Representative and Planner Retirees (if you retired on or after January 1, 2011) and Officer, Management/ Specialist and Support Staff Retirees**

If you die as a retired employee and your spouse is under age 65, your surviving spouse remains covered under the Supplemental Medical Plan, until your surviving spouse remarries, turns 65 or you would have turned 65 (whichever occurs first). At this time, his or her coverage under the Supplemental Medical Plan ends. If your surviving spouse remarries, his or her Supplemental Medical Plan coverage ends.

The Supplemental Medical Plan will be primary for your under age 65 surviving spouse.

If you die while you and your Company-recognized Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Company-recognized Domestic Partner continues for 90 days from the date of your death, provided he or she pays the plan contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

**When You Die — Age 65 or Over Surviving Spouses or Company-recognized Domestic Partners of Agent, Representative and Planner Retirees (if you retired on or after January 1, 2011) and Officer, Management/Specialist and Support Staff Retirees**

If you die as a retired employee and your spouse is age 65 or over, coverage ends for your age 65 or over surviving spouse.

If you die while you and your Company-recognized Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Company-recognized Domestic Partner continues for 90 days from the date of your death, provided he or she pays the plan contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

## Paying for Supplemental Medical Plan Coverage

There are two ways you pay for Supplemental Medical Plan coverage as a retiree. You make payments directly to:

- HealthFirst TPA (call HealthFirst TPA at 1-800-711-7083 between 8:00 a.m. and 5:00 p.m. Central time for instructions).
- The COBRA Administrator, if your coverage is being continued under COBRA.

## Making Changes to Your Coverage

Contact HealthFirst TPA to make changes to your coverage.

If you are retired and if you marry or declare a Company-recognized Domestic Partner and you wish to make a change in your Supplemental Medical Plan coverage, you must make the change within 60 days of the event. If you miss the 60-day deadline, you will not be able to add your spouse/Company-recognized Domestic Partner to your coverage.

If you are adding a Company-recognized Domestic Partner, you must first request a Company-recognized Domestic Partner Kit from HR Services. The kit contains instructions to add your Company-recognized Domestic Partner to your benefits coverage. Once HR Services has updated your records to reflect your Company-recognized Domestic Partner information, you must then contact HealthFirst TPA to add your partner to your Supplemental Medical Plan coverage. You must enroll your new spouse/Company-recognized Domestic Partner within 60 days of your marriage/declaration; otherwise you cannot add your spouse/Company-recognized Domestic Partner to the Supplemental Medical Plan.

To understand how the Supplemental Medical Plan coordinates with Medicare, see [“Coordination of Benefits under the Supplemental Medical Plan”](#).

## Surviving Spouses

The surviving spouse must notify HR Services and HealthFirst TPA of the retiree’s death (see [“Contact Information”](#) in the Reference Information section). If the surviving spouse was enrolled in this Plan at the time of the retiree’s death, HealthFirst TPA will send the enrolled surviving spouse information within 30 days of receipt of notification of the retiree’s death. The enrolled surviving spouse will receive an ID card, the Retiree Benefit Guide and a claim form. The enrolled surviving spouse will receive a bill for the annual contribution each year thereafter.

If the surviving spouse does not receive the enrollment information from HealthFirst TPA within 30 days of notifying HR Services of the retiree’s death, he or she should contact HealthFirst TPA (see [“Contact Information”](#) in the Reference Information section).

## Plan Features

**Eligible expenses:** The Supplemental Medical Plan covers regular, medically necessary services, supplies, care and treatment of non-work related injuries or illnesses when ordered by a licensed physician acting within the scope of his or her license.

**Usual and prevailing fee limits:** The amount of benefits paid for eligible medical expenses is based on the usual and prevailing fee limits for that service or supply in that geographic location.

**Deductible:** Under the Supplemental Medical Plan, you are required to satisfy an annual \$250 deductible per person. This \$250 deductible does not count towards the out-of-pocket maximum.

**Annual out-of-pocket maximum:** After you have paid \$1,000 for eligible expenses under the Plan (for example, the 20% co-insurance you pay when the plan covers a service at 80%), the Plan pays 100% of eligible expenses within usual and prevailing fee limits for the rest of the calendar year.

**Maximum Medical benefit:** \$500,000 is the most this Plan will pay for any participant during the entire period a person is covered by the Supplemental Medical Plan. When an individual's maximum medical benefit is reached, medical coverage terminates as of the date the expenses resulting in exhaustion of the benefit are incurred.

When the individual's maximum medical benefit is exhausted, coverage ends. If the retiree exhausts his or her maximum medical benefit but his or her covered eligible spouse has not yet exhausted his or her respective maximum medical benefits, that covered eligible spouse may remain in his or her medical coverage under the Supplemental Medical Plan (as long as he or she continues to meet eligibility requirements).

**Maximum Medical benefit rules for Surviving Spouses:** If your under age 65 surviving spouse has coverage under any other group medical plan, he or she must first file claims with that plan. The Supplemental Medical Plan will pay as the secondary plan according to Coordination of Benefits provisions. However, this Plan does not coordinate benefits with any Company-sponsored Medical Benefit Option. If your under age 65 surviving spouse does not have any other group medical plan coverage, the Supplemental Medical Plan is his or her primary coverage. Coverage for your surviving spouse ends if your spouse remarries or dies.

**CheckFirst — Predetermination of Benefits:** To determine if a proposed medical service is covered under the Plan, use CheckFirst to obtain a predetermination. Call HealthFirst TPA (see "[Contact Information](#)" in the Reference Information section) to request a predetermination by phone or to request a predetermination form. You must receive the predetermination from HealthFirst TPA before you receive the proposed medical service.

## Supplemental Medical Plan Benefits

The Supplemental Medical Plan pays a percentage of eligible expenses for medically necessary care, treatment and supplies up to the usual and prevailing fee limits, as shown in the following table.

Supplemental Medical Plan Benefits	
Feature	Amount of Coverage
<b>Maximum medical benefit</b>	\$500,000 per Plan participant This maximum applies to the entire time a person is covered by the Plan
<b>Annual deductible</b>	\$250 per person
<b>Annual out-of-pocket maximum</b>	\$1,000 per person each calendar year This does not include expenses paid by the Plan at 50% The \$250 annual deductible does not count towards satisfaction of the annual out-of-pocket maximum
<b>Illness and diagnostic services</b> <ul style="list-style-type: none"> <li>Emergency room</li> <li>Surgery (inpatient or outpatient)</li> <li>Physician's office visit</li> <li>X-ray and laboratory charges</li> <li>Prescription drugs</li> </ul>	80%
<b>Hospital care</b> <ul style="list-style-type: none"> <li>Daily hospital room allowance (based on average semiprivate room rate)</li> <li>Intensive care room allowance</li> <li>Ancillary charges</li> </ul>	80%
<b>Convalescent and skilled nursing facilities</b> (limited to 30 days confinement per illness or injury for skilled nursing facility)	50%
<b>Home health care</b>	80%
<b>Hospice care</b> (including bereavement counseling within 90 days of the death of the participant for family members [siblings, spouse and children of the patient])	80%
<b>Mental health care inpatient services</b>	80%
<b>Alternative mental health care centers</b>	Actual facility charge or 80% of the area's semiprivate room rate, whichever is less
<b>Mental health care outpatient services, including prescription drugs</b>	80%
<b>Chemical dependency care</b> <ul style="list-style-type: none"> <li>Inpatient services</li> <li>Outpatient services</li> <li>Confinement maximum</li> </ul>	<ul style="list-style-type: none"> <li>80%</li> <li>80%</li> <li>No confinement limits</li> </ul>
<b>Other covered expenses</b>	80%

If you die while you and your Company-recognized Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Company-recognized Domestic Partner continues for 90 days from the date of your death, provided he or she pays the contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.



## Covered Expenses

To be covered, an expense must be medically necessary, within usual and prevailing fee limits and an eligible/covered expense under the Plan. Only eligible expenses can be used to satisfy the annual deductible and annual out-of-pocket maximum.

### Hospital Care

**Inpatient hospital expenses:** Hospital room and board charges, based upon of the average semiprivate room rate in that geographical area. If the hospital does not have semiprivate rooms, this Plan considers the eligible expense to be 90% of the hospital's lowest private room rate.

**Intensive care unit:** The usual and prevailing fee limits for services and supplies (excluding personal items) provided while the covered person is hospitalized in the hospital's intensive care unit.

**Emergency room:** Services and supplies provided by a hospital emergency room.

**Ancillary charges:** Ancillary charges for inpatient hospital services and supplies and operating room use.

**Illness and Diagnostic Services:** In addition to hospital care, the following medically necessary services are covered:

- **Physician's office visits:** For a medically necessary diagnosis or treatment of an illness or injury.
- **X-ray (Radiology) and laboratory charges**
- **Prescription drugs**
- **Surgery:** When medically necessary and performed in a hospital, a freestanding surgical facility or a physician's office.

### Out-of-Hospital Care

**Convalescent or skilled nursing facilities:** Eligible expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility and are under the continuous care of a physician. Your physician must certify that this admission is an alternative to a hospital admission. Benefits are limited to a maximum of 30 days' confinement per illness or injury.

Room and board charges are covered at one-half the most common semiprivate room rate for inpatient hospital expenses in a geographical area. Custodial care is not covered.

**Home health care:** Covered only when the visits are medically necessary and when certified by your physician for the care and treatment of a covered illness or injury. The claims processor may require the physician to provide an approved treatment plan before paying benefits and may periodically review that treatment plan. Custodial care is not covered. The Plan does not limit the number of covered home health care visits.

**Hospice care:** Eligible expenses in connection with hospice care include hospice facility, outpatient care and bereavement counseling.

If the physician determines that the patient is terminally ill, the patient may receive hospice care for an unlimited period of time. Bereavement counseling is covered for the participant's family (the patient's spouse, children [natural, step and adopted] and siblings) (including Company-recognized Domestic Partners) for 90 days, beginning on the date of the participant's death. Bereavement counseling benefits continue even if coverage ends under this Plan.

HealthFirst TPA, the claims processor, may require the physician to provide an approved treatment plan before paying hospice benefits and may periodically review the treatment plan.

**Pregnancy:** Charges in connection with pregnancy are covered only for female retirees, female spouses of male retirees and female Company-recognized Domestic Partners. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed or certified by the state in which he or she practices.

Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority.

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 or from requiring your provider to obtain pre-authorization for a longer stay. 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.

**Mental health and chemical dependency care:** Mental health and dependency care is benefited the same as any other illness or injury covered by the Supplemental Medical Plan.

**Mental health care:** Covered expenses include inpatient care (in a psychiatric hospital or a residential treatment center) and outpatient care for a mental health disorder.

**Inpatient mental health care:** When you are hospitalized in a psychiatric hospital or a residential treatment center for a mental health disorder, expenses during the period of hospitalization are covered (the same as inpatient hospital expenses) up to Plan maximums.

**Alternative mental health care center:** Expenses for alternative mental health care are covered at 80%.

**Outpatient mental health care:** Expenses for outpatient mental health care (including prescription drugs) are covered at 80%.

**Chemical dependency care:** Covered chemical dependency care expenses can be inpatient, outpatient, or a combination. You are covered at 80% for inpatient chemical dependency rehabilitation programs or at 80% for outpatient chemical dependency. The Plan does not cover expenses for a spouse or family member to accompany the patient being treated.

## Other Covered Expenses

The following medical services are covered:

**Ambulance:** Medically necessary professional ambulance services to and from:

- The nearest hospital able to provide necessary treatment in the event of an emergency, or
- The nearest hospital or convalescent or skilled nursing facility for inpatient care.

**Anesthesia:** Medically necessary anesthesia and its administration. The Plan does not cover expenses for an anesthesiologist to remain available when not directly tending to the care of the patient.

**Assistant surgeon:** Assistant surgeon's fees only when the surgical procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst predetermination procedure.

**Chiropractic care:** Medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license.

**Cosmetic surgery or treatment:** Expenses for cosmetic surgery or treatment are only covered if they are medically necessary and incurred for either of the following:

- As the result of a non-work related injury, or
- For replacement of diseased tissue surgically removed.

**Durable medical equipment:** Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME and/or components (such as batteries or software) resulting from normal wear and tear is not covered.

Examples of DME are items such as CPAP or BiPAP machines, wheelchairs, hospital beds, nebulizers, oxygen concentrators, TENS units, passive range of motion devices, joint cooling devices, bone stimulators, etc.

**Laboratory or pathology expenses:** Coverage is provided for medically necessary diagnostic laboratory tests.

**Medical supplies:** Including, but not limited to:

- Oxygen, blood and plasma
- Sterile items, including surgical trays, gloves and dressings
- Needles and syringes
- Colostomy bags
- The initial purchase of eyeglasses or contact lenses required because of cataract surgery performed while covered. Diabetic supplies, including needles, chem-strips, lancets and test tape covered under the prescription drug benefit
- Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered.

**Nursing care:** Medically necessary private duty care by a licensed nurse, if the care is a type or nature not normally furnished by hospital floor nurses.

**Oral surgery:** Expenses in connection with teeth, gums or alveolar process are covered only for:

- Hospital expenses for necessary inpatient care
- Treatment of tumors
- Surgery to remove an impacted tooth
- Repair to sound natural teeth or other body tissue because of an accidental injury and only if the expense is incurred within 12 months of the injury.

**Physical or occupational therapy:** Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist, when ordered by a physician.

**Physicians:** Office visits, medical care and treatment by a physician, including surgical procedures and post-operative care.

**Prescription drugs:** Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition. Prescriptions related to infertility treatment, weight control and oral contraceptives are not covered. See [“Excluded Expenses”](#) for additional information.

Medications are also covered for the following special situations:

- Medications administered and entirely consumed in connection with care rendered in a physician’s office are covered as part of the office visit.
- Medications that are to be taken by or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy are covered as part of the facility’s ancillary charges.
- Radiology (X-ray): Examination and treatment by X-ray or other radioactive substances, imaging/scanning (MRI, PET, CAT, ultrasound), diagnostic laboratory tests and routine mammography screenings for women.

**Reconstructive surgery:** Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears.

Additionally, under the Women’s Health and Cancer Rights Act, covered reconstructive services include:

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

**Secondary or multiple surgical procedures:** Secondary or multiple surgical procedures will be covered at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage, use the CheckFirst predetermination procedure.

**Speech and hearing care:** The care and treatment for loss or impairment of speech or hearing are covered when the treatment is necessary because of a physical condition such as a stroke, accident or surgery. Expenses are not covered for conditions such as learning disabilities or progressive hearing loss due to the natural aging process because they are not medically necessary for the treatment of an illness.

**Transplants:** Expenses for transplants or replacements of tissue or organs, if they are medically necessary for the diagnosed illness or injury and are not experimental, investigational, unproven or otherwise excluded from coverage under the Supplemental Medical Plan, as determined at the sole discretion of the Plan Administrator and/or claims processor. Benefits are payable for natural or artificial replacement materials or devices.

Transplants include, but are not limited to, the following (listed alphabetically):

- Artery or vein
- Bone
- Bone marrow or hematopoietic stem cell
- Cornea
- Heart
- Heart and lung
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataract surgery
- Intestine
- Kidney
- Kidney and pancreas
- Liver
- Liver and kidney
- Liver and intestine
- Lung
- Pancreas
- Pancreatic islet cell (allogenic or autologous)
- Prosthetic bypass or replacement vessels
- Skin

This is not an all-inclusive list. It is subject to change.

**Donor and recipient coverage is as follows:**

- If the donor and the recipient are both covered under this Plan, expenses for both individuals are covered.
- If the donor is not covered under this Plan and the recipient is covered, the donor's expenses will be covered to the extent they are not covered under any other medical plan and only if they are submitted as part of the recipient's claim.

- If the donor is covered under this Plan but the recipient is not covered under this Plan, no expenses are covered for the donor or the recipient.

The total benefit paid under this Plan for the donor's and recipient's combined expenses will not be more than any Plan maximums applicable to the recipient.

- It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria — not all transplant situations will be eligible for benefits.

**Transportation:** Regularly scheduled commercial transportation by train or plane is covered within the continental United States and Canada when necessary for your travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip for any illness or injury is covered and only if medical attention is required en route.

**Tubal ligations and vasectomies:** These procedures are covered; however, reversal of these procedures is not covered.

## Excluded Expenses

No benefits will be paid for expenses in connection with the following items:

**Allergy testing:** Specific testing (called provocative neutralization testing or therapy) that involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

**Alternative and/or Complementary Medicine:** Evaluation, testing, treatment, therapy, care and medicines that constitute Alternative and/or Complementary Medicine, including but not limited to herbal, holistic and homeopathic medicine.

**Care not medically necessary:** All services and supplies considered not medically necessary.

**Claim forms:** The Supplemental Medical Plan will not pay for the cost of anyone to complete your claim form.

**Cosmetic treatment:**

- Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars and sclerotherapy for varicose veins or spider veins)
- Cosmetic surgery unless required and medically necessary as a result of accidental injury or illness (as explained in Other Covered Expenses).

**Counseling:** All forms of marriage and family counseling.

**Custodial care and custodial care items:** Care provided in a convalescent or skilled nursing facility or hospital and items such as incontinence briefs, liners, diapers and other items when used for custodial purposes.

**Dental treatment:** Except as described in Covered Expenses, charges for diagnosis and/or treatment of the teeth, their supporting structures, the alveolar process or the gums are not covered.

**Dietician services:** Costs of dietician services.

**Drugs:**

- Drugs, medicines and supplies that do not require a physician's prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem-strips, lancets and test tape.)
- Drugs that are not required to bear the legend "Caution-Federal Law Prohibits Dispensing Without Prescription"
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
- Contraceptive drugs, patches or implants when used exclusively for family planning or birth control. Even though oral contraceptives are not covered, you



may order these drugs through the mail service prescription program and receive a discount.

- Drugs requiring a prescription under state law, but not federal law
- Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy)
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Medications used for weight control
- Drugs used to treat infertility or to promote fertility
- Drugs labeled “Caution-Limited by Federal Law to Investigational Use,” drugs not approved by the Food and Drug Administration (FDA) or experimental drugs, even though the individual is charged for such drugs
- Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis
- Medications or products used for smoking or tobacco use cessation

**Ecological and environmental medicine:** See “Alternative and/or Complementary Medicine,” above.

**Educational testing or training:** Testing and/or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded).

**Experimental, Investigational or Unproven Treatment:** Medical treatment, drugs or supplies that are generally regarded as experimental, investigational or unproven (as such terms are defined in the Glossary), including but not limited to treatment of Epstein-Barr syndrome, hormone pellet insertion or plasmapheresis.

**Eye care:** Eye exams, refractions, eyeglasses or the fitting of eyeglasses, contact lenses, radial keratotomy or treatment/surgery to correct refractive errors, visual training and vision therapy.

**Foot care:** Services for diagnosis or treatment of weak, strained or flat feet, including corrective shoes or devices or the cutting or removal of corns, calluses or toenails. (This exclusion does not apply to the removal of nail roots.)

**Free care or treatment:** Any care, treatment, services or supplies for which payment is not legally required.

**Government-paid care:** Any care, treatment, services or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government’s civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

**Infertility treatment:** Expenses or charges for infertility treatment or testing and charges for treatment or testing for hormonal imbalances that cause male or female infertility, regardless of the primary reason for hormonal therapy.

- Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete

transfer, zygote transfer and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction and infertility drugs such as Clomid or Pergonal, are also excluded.

- Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.

**Lenses:** No lenses are covered except the first pair of medically necessary contact lenses or eyeglasses following cataract surgery.

**Massage therapy:** All forms of massage therapy and soft tissue therapy, regardless of who performs the service.

**Medical records:** Charges for requests or production of medical records.

**Missed appointments:** If you incur a charge for missing an appointment, the Supplemental Medical Plan will not pay any portion of the charge.

**Nursing care:**

- Care, treatment, services or supplies received from a nurse that does not require the skill and training of a nurse
- Private duty nursing care that is not medically necessary or if medical records establish that such care is in the scope of care normally furnished by hospital floor nurses
- Certified nurse's aides

**Organ donation:** Expenses incurred as an organ donor when the recipient is not covered under this Plan.

**Preventive care:** Unless specifically stated elsewhere in this Plan, preventive care is excluded from coverage.

**Relatives:** Coverage is not provided for treatment by a medical practitioner (including but not limited to: a nurse, physician, physical therapist or speech therapist) who is a close relative (spouse or Company-recognized Domestic Partner, child, brother, sister, parent or grandparent of you or your spouse or Company-recognized Domestic Partner, including adopted or step relatives).

**Sex changes:** Sex change, gender reassignment/revision, treatment or transsexual and related operations.

**Sleep disorders:** Treatment of sleep disorders, unless medically necessary. If you are under age 65, you should call HealthFirst TPA to request pre-authorization for any sleep disorder treatment. See "[Contact Information](#)" in the Reference Information section.

**Speech therapy:** Expenses are not covered for conditions such as learning disabilities or progressive hearing loss due to the natural aging process because they are not medically necessary for the treatment of an illness.

**TMJD:** Expenses for diagnosis and treatment of any kind for temporomandibular joint disease or disorder (TMJD) or syndrome by similar name.

**Transportation:** Transportation by regularly scheduled airline, air ambulance or train for more than one round trip per illness or injury.

**Usual and prevailing:** Expenses that exceed the usual and prevailing fee limits.

**War-related:** Services or supplies received as a result of a declared or undeclared act of war or armed aggression.

**Weight reduction:** Hospitalization, surgery, treatment and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact HealthFirst TPA to determine if treatment is covered. See “[Contact Information](#)” in the Reference Information section.

**Wellness items:** Items that promote well-being and are not specific for the illness or injury involved (including but not limited to massage therapy, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas and health club memberships). Also excluded are:

- Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning
- Services related to vocation, including but not limited to: physical or FAA exams, performance testing and work hardening programs.
- Work-related: Medical services and supplies for treatment of any work-related illness or injury sustained by you or your spouse, whether or not covered by Workers’ Compensation, occupational disease law or other similar law.

## Administrator’s Discretion

The Plan Administrator may, at its sole discretion, pay benefits for services and supplies not specifically stated under the Plans. If this service or supply you’ve received is more expensive when a less expensive alternative is available, the Plan(s) pays benefits based on the less expensive service or supply that is consistent with generally accepted standards of appropriate medical, dental, or other professional health care.

## CheckFirst for Predetermination of Benefits

CheckFirst, administered by HealthFirst TPA, allows you to find out if the recommended service or treatment is covered by the Plan. HealthFirst TPA will determine if the recommended service or treatment is covered by the Plan

### How to Use CheckFirst

To use CheckFirst, you call HealthFirst TPA for pre-authorization. See “[Contact Information](#)” in the Reference Information section. Before calling to confirm benefit coverage, you will need the following information from your physician:

- Diagnosis
- Clinical name of the procedure and the CPT code
- Description of the service
- Physician’s name and office ZIP code
- Name and ZIP code of the hospital or clinic where surgery is scheduled

If you receive predetermination of benefits over the phone, ask for written confirmation. If you have questions about your eligibility or the Plan’s coverage for a particular procedure, call HealthFirst TPA (see “[Contact Information](#)” in the Reference Information section).

Although you may find CheckFirst beneficial whenever you need medical treatment, there are two circumstances when you especially benefit by using CheckFirst. Use this predetermination procedure if your physician recommends either of the following:

- **Assistant surgeon:** A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if it is medically necessary to have an assistant surgeon present at the time of surgery, you must use the CheckFirst procedure.
- **Secondary or multiple surgical procedures:** If you are having a secondary or multiple surgical procedures at the time of scheduled surgery, the secondary or multiple procedures will be covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgery. There are further reimbursement reductions if a third procedure is involved. You must use CheckFirst to find out how the Plan reimburses the cost for the secondary surgery.

# Filing Claims

## Eligibility to File Claims

You may file claims under the Supplemental Medical Plan once you have reached the maximum medical benefits under your AA-sponsored group medical coverage — if you have elected coverage under this Supplemental Medical Plan.

**Retirees and their spouses or Company-recognized Domestic Partners:** You must file a claim under your AA-sponsored Retiree Medical Benefits Option and receive an Explanation of Benefits (EOB) showing your claim was denied due to exceeding the maximum medical benefit before you may file your first claim under this Plan.

After you have filed your initial claim under this Plan, HealthFirst TPA records will show that you are eligible to file further claims.

**Surviving spouses:** As the covered under age 65 spouse of a deceased retiree, this Plan is primary if you do not have any other group medical coverage. You will send your claim directly to HealthFirst TPA.

If you have any other medical coverage (including Medicare), you must file a claim with that coverage first. Then, attach a copy of your Explanation of Benefits (EOB) from that coverage when you file your claim under the Supplemental Medical Plan. Coordination of benefits will be calculated.

If you die while you and your Company-recognized Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Company-recognized Domestic Partner continues for 90 days, provided your Company-recognized Domestic Partner pays the contribution rate to continue coverage. At the end of 90 days, coverage ends.

## How to File a Claim

To file a claim, you must complete a Supplemental Medical Benefits Claim Form (available from HealthFirst TPA — see “[Contact Information](#)” in the Reference Information section) according to the instructions on the form. Be sure to provide all required information about your other coverage. Examples of other coverage include your Company-sponsored Medical Benefit Option, your spouse’s other group medical coverage, Workers’ Compensation, Medicare, TRICARE and no-fault motor vehicle insurance.

Attach your Explanation of Benefits (EOB) from your Company-sponsored Medical Benefit Option or other group medical coverage showing the denied claim that makes you eligible to file under this Plan. (This is not required if you are covered as a surviving spouse with no other coverage.) Along with your claim, submit an original, itemized statement of expenses from your service provider, showing the following information:

- Name and identifying information of patient
- Date of treatment
- Description of treatment and charge per treatment code
- Charge per treatment
- Diagnosis of the injury or illness for which treatment was rendered

Keep a copy of your completed claim form and any other information you are including with the claim.

Here are some other important points about filing claims:

- If you assign payment of your benefits directly to the service provider (as described under Assignment of Benefits), the claims processor will send the payment directly to your service provider. Otherwise, the payment will be sent to you.
- If your claim form is incomplete or you do not attach an itemized statement from your service provider, processing of your claim will be delayed until the information has been received.

Send your claims to:

HealthFirst TPA  
P.O. Box 130217  
Tyler, TX 75713-0217

## Claim Filing Deadline

- **For all claims incurred on or after 1/1/10**, you must submit all health claims within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment.
- **For all claims incurred on or before 12/31/09**, you must submit all health claims within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment.

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

## What Happens to Your Claim

Your claim information goes to a HealthFirst TPA claims processing unit. HealthFirst TPA is not an insurance company. It is responsible for processing claims for the Plan according to the terms of this coverage. You will receive an Explanation of Benefits (EOB) which summarizes the benefit calculation and provides documentation of any payment made or benefit denied. Normally, you will receive an EOB within three weeks after filing a properly documented claim, unless further information is required. Your claims will be processed in accordance with the Claim Processing Requirements. The claims processor will contact you or the provider to request any additional information. Your prompt response will expedite processing of your claim.

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

The claims processor, at the plan's expense, has the right to have a physician of its choice examine any Plan participant as often as reasonably necessary while a claim is pending.

## Who to Call with Questions

For claim forms, questions about the Plan or the status of your claim, contact HealthFirst TPA at 1-800-711-7083 between 8:00 a.m. and 5:00 p.m. Central time.



## Coordination of Benefits under the Supplemental Medical Plan

If you or your spouse is covered under any other medical coverage, this Plan will coordinate benefits to avoid duplication of payment. The total amount payable under both plans will not be more than 100% of the expenses eligible for reimbursement under this Plan. The benefits that are payable under this Plan will be coordinated with any other medical coverage that provides benefits for the same expenses.

### Other Plans

With respect to the Supplemental Medical Plan, the term “other medical coverage” includes any of the following:

- Government or tax-supported programs, including Medicare (Parts A and B, Medicare Advantage and Medicare Part D) or Medicaid
- Other employer-sponsored medical coverage under which the employer pays all or part of the costs or takes payroll deductions, regardless of whether the medical coverage is insured or self-funded

Note: This does not include Company-sponsored Retiree Medical Benefits under the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries.

- Property or homeowner’s insurance
- No-fault motor vehicle insurance
- Union-sponsored medical coverage

### Which Plan Is Primary

When a person is covered by more than one plan, one 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.

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 active employee. The Supplemental Medical Plan is not primary if a retiree has coverage under any other group health coverage and/or union-sponsored medical coverage.
- Any benefits payable under this Plan and Medicare will be paid according to federal regulations. In case of a conflict between Plan provisions and federal law, federal law controls.
- If none of the above conditions apply, the plan that has been covering the retiree the longest will be primary.

## When Coordination Applies

The Supplemental Medical Plan pays after all other medical coverages have paid. Coordination of benefits is required in all of the following situations:

- If a retired employee or spouse has exceeded the maximum medical benefit under a Company-sponsored Retiree Medical Benefit Option, but the covered person has coverage under the spouse's other group medical coverage
- If a retired employee, spouse or surviving spouse has Medicare coverage (after the covered person has exhausted his or her maximum medical benefit under one of the Company-sponsored Retiree Medical Benefit Option)
- If a surviving spouse has coverage through his or her employer (employer-sponsored coverage)
- If the retiree has been covered longer under another supplemental medical coverage.

## ***Employee Assistance Program (EAP)***

The Employee Assistance Program (EAP) is available for retirees to obtain support for issues related to substance abuse, mental health and family crisis. Use of the EAP is purely voluntary.

Irrespective of your use, your benefits are not adversely affected.

See “Mental Health Benefits” in the “[Retiree Medical Benefit Options Comparison](#)” chart in the Retiree Medical Benefits Option Overview section.

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

# ***Retiree Life Insurance Benefit***

For employees who retired on or prior to October 31, 2012:

Retiree Life Insurance is term life insurance that pays a benefit to your designated beneficiary at the time of your death, but has no cash value.

The amount of your Retiree Life Insurance coverage is based on some or all of the following:

- Your workgroup at the time of your retirement,
- Your date of birth,
- Your date of hire,
- Your date of retirement,
- If you have IRS-recognized spouse or dependents,
- Your preretirement monthly salary, and/or
- The number of years you have been retired.

Contact HR Services for more information.

You can designate your Retiree Life Insurance Benefits to go to your spouse, Company-recognized Domestic Partner, children, other family members, friends or your estate at the time of your death.

The Retiree Life Insurance Benefit is insured by MetLife.

## **MetLife's Role**

Your Retiree Life Insurance Benefits are insured and processed by MetLife. You pay the cost of any coverage you elect. Contact MetLife at 1-800-638-6420 for more information.

## In This Section

- Retiree Life Insurance Benefits
  - Officer, Management/Specialist, Agent/Representative/Planner, Support Staff, TWU-Represented and Flight Attendant Retirees
  - Pilots and Flight Engineer Retirees
  - If You Became Disabled While an Active Employee
- Filing a Claim
  - Method of Payment
- Additional Rules
  - Designating Beneficiaries
  - Accelerated Benefit Option
  - Conversion Rights
  - Verbal Representations
  - Assignment of Benefits
- When a Retiree Dies
  - Survivor Support Services
  - Surviving Spouse Medical Coverage
  - Coverage for Dependent Children
  - Other Benefits and Privileges

## Retiree Life Insurance Benefits

### Officer, Management/Specialist, Agent/Representative/ Planner, Support Staff, TWU-Represented and Flight Attendant Retirees

If you retired before January 1, 1976, the following table reflects the amount of your coverage:

Pre-Retirement Monthly Salary	Coverage Amounts
\$500 - \$599	\$5,000
\$600 - \$699	\$6,000
\$700 - \$799	\$8,000
\$800 - \$899	\$10,000
\$1,000 - \$2,499	\$14,000
\$2,500 or more	\$20,000

If you retired on or after January 1, 1976, the following information explains the amount of your coverage.

- Your coverage will be \$5,000, regardless of your pre-retirement salary, if you were one of the following:
  - A Flight Attendant or TWU-Represented employee hired on or after May 27, 1974
  - An Officer, Management/Specialist, Agent/Representative/Planner or Support Staff employee hired on or after November 1, 1974
  - Born in 1921 or later and, at the time of your death, you do not have a spouse or other person whom you are eligible to claim as a dependent on your federal income tax return
- If you are not in one of the three categories listed above, your coverage will be determined by one of the following tables.

If You Were Born in 1926 or Later - Under Age 50 as of January 1, 1976						
If Your Pre-Retirement Monthly Salary Was...	Your Coverage Will Be...					
	1 <sup>st</sup> year	2 <sup>nd</sup> year	3 <sup>rd</sup> year	4 <sup>th</sup> year	5 <sup>th</sup> year	6 <sup>th</sup> year and thereafter
\$600 - \$699	\$10,000	\$9,000	\$8,000	\$7,000	\$6,000	\$5,000
\$700 - \$799	\$15,000	\$13,000	\$11,000	\$9,000	\$7,000	\$5,000
\$800 - \$899	\$20,000	\$17,000	\$14,000	\$11,000	\$8,000	\$5,000
\$1,00 or over	\$30,000	\$25,000	\$20,000	\$15,000	\$10,000	\$5,000

If You Were Born Between 1921 and 1925 - Age 50 to 54 as of January 1, 1976						
If Your Pre-Retirement Monthly Salary Was...	Your Coverage Will Be...					
	1 <sup>st</sup> year	2 <sup>nd</sup> year	3 <sup>rd</sup> year	4 <sup>th</sup> year	5 <sup>th</sup> year	6 <sup>th</sup> year and thereafter
\$600 - \$699	\$10,000	\$9,000	\$8,000	\$7,000	\$7,000	\$6,000
\$700 - \$799	\$15,000	\$13,750	\$12,500	\$11,500	\$10,000	\$8,000
\$800 - \$899	\$20,000	\$17,500	\$15,000	\$12,500	\$10,000	\$10,000
\$1,00 or over	\$30,000	\$25,000	\$20,000	\$15,000	\$10,000	\$10,000

If You Were Born Before 1921 - Age 55 or Over as of January 1, 1976						
If Your Pre-Retirement Monthly Salary Was...	Your Coverage Will Be...					
	1 <sup>st</sup> year	2 <sup>nd</sup> year	3 <sup>rd</sup> year	4 <sup>th</sup> year	5 <sup>th</sup> year	6 <sup>th</sup> year and thereafter
\$600 - \$699	\$13,500	\$12,000	\$10,500	\$9,000	\$7,500	\$6,000
\$700 - \$799	\$18,000	\$16,000	\$14,000	\$12,000	\$10,000	\$8,000
\$800 - \$899	\$22,500	\$20,000	\$17,500	\$15,000	\$12,500	\$10,000
\$1,000 - \$2,499	\$31,500	\$28,000	\$24,500	\$21,000	\$17,500	\$14,000
\$2,500 or over	\$45,000	\$40,000	\$35,000	\$30,000	\$25,000	\$20,000

### Flight Attendant Article 30 Life Insurance

- If one of the following applies, your Retiree Life Insurance Benefit will be \$5,000:
  - You were hired on or after May 27, 1974.
  - At the time of your death, you do not have a spouse or other person whom you are eligible to claim as a dependent on your federal income tax return.
- If you were hired before May 27, 1974 and you have a spouse or dependent at the time of your death, your coverage is:

Years of Retirement	Your Coverage Will Be...
1 <sup>st</sup> year	\$30,000
2 <sup>nd</sup> year	\$25,000
3 <sup>rd</sup> year	\$20,000
4 <sup>th</sup> year	\$15,000
5 <sup>th</sup> year	\$10,000
6 <sup>th</sup> year and thereafter	\$5,000



## Pilots and Flight Engineer Retirees

If you were a Pilot or Flight Engineer, your Retiree Life Insurance Benefit is as follows:

Years of Retirement	If Your Pre-Retirement Monthly Salary Was...	
	Up to \$2,499	\$2,500 or more
1 <sup>st</sup> year	\$31,500	\$45,000
2 <sup>nd</sup> year	\$28,000	\$40,000
3 <sup>rd</sup> year	\$24,500	\$35,000
4 <sup>th</sup> year	\$21,000	\$30,000
5 <sup>th</sup> year	\$17,500	\$25,000
6 <sup>th</sup> year and thereafter	\$14,000*	\$20,000*

\* If you retired after April 1, 1975, and do not have a spouse or other eligible dependent on your federal income tax return, and die in the seventh year of retirement or later, coverage is reduced to \$5,000.

## If You Became Disabled While an Active Employee

### Non-Pilot Employees

During the first 12 months of an unpaid sick leave, your active Life Insurance coverage continues. Your Basic Term Life Insurance coverage is provided by the Company and your Voluntary coverage may be continued at your own expense. At the end of this 12-month period, your active coverage ends unless you have been approved by MetLife as Permanently and Totally Disabled (PTD) under the terms of your active Employee Term Life Insurance coverage.

If you are approved as PTD, your active Employee Term Life Insurance coverage (Basic and Voluntary) continues at no cost to you, provided you remain totally disabled. If you became PTD:

- On or after January 1, 1995, your active coverage continues until you elect to take your pension. When you begin your pension, your Basic coverage will be reduced to the Retiree Life Insurance Benefit level and your Voluntary coverage will end. If you are not eligible for Retiree Life Insurance, benefit coverage will end when you reach age 65.
- Before January 1, 1995, your active Employee Term Life Insurance coverage (Basic and Voluntary) will continue as long as you remain disabled.

### Pilots with Disability Beginning Prior to February 1, 2004

If you are a Pilot under age 50 who is receiving a disability pension from the Retirement Benefit Program for Pilots, your active Employee Term Life Insurance continues until you reach age 50. Your Basic and Pilot Additional coverage (if applicable) are provided by the Company. You may continue to purchase Voluntary coverage at your own expense.

When you reach age 50, your Basic coverage will be reduced to the Retiree Life Insurance level and your Voluntary coverage will end.

If you are a disabled Pilot under age 50 and approved by MetLife as Permanently and Totally Disabled (PTD) under the terms of your Employee Term Life Insurance coverage, your Voluntary coverage continues at no cost to you, provided you remain disabled. If you became PTD:

- On or after January 1, 1995, your active Employee Term Life Insurance coverage (Basic, Pilot Additional and Voluntary) will continue until you reach age 50. At age 50, your Voluntary coverage will end and your Basic coverage will be reduced to the Retiree Life Insurance level. Your Pilot Additional coverage continues as long as you remain disabled.
- Before January 1, 1995, your active coverage (Basic, Pilot Additional and Voluntary) continues as long as you remain disabled.

If you are a Pilot who becomes disabled after age 50, you will receive Retiree Life Insurance coverage only, unless you were eligible for Pilot Additional coverage at the time you became disabled.

### **Pilots with Disability Beginning On or After February 1, 2004**

If you are a Pilot receiving disability benefits from the Pilot Long Term Disability Plan, your active Employee Term Life Insurance, as well as your other active health and welfare benefits, continues for the duration of time you receive benefits from the Pilot Long Term Disability Plan — provided that you pay the required monthly contributions to maintain these active health and welfare benefits (including Life Insurance). If your disability continues to age 60, your active

Life Insurance terminates and you receive the Retiree Life Insurance Benefit at the coverage level shown in the following chart:

Years of Retirement	If Your Pre-Retirement Monthly Salary Was...	
	Up to \$2,499	\$2,500 or more
1 <sup>st</sup> year	\$31,500	\$45,000
2 <sup>nd</sup> year	\$28,000	\$40,000
3 <sup>rd</sup> year	\$24,500	\$35,000
4 <sup>th</sup> year	\$21,000	\$30,000
5 <sup>th</sup> year	\$17,500	\$25,000
6 <sup>th</sup> year and thereafter	\$14,000*	\$20,000*

\* If you retired after April 1, 1975, and do not have a spouse or other eligible dependent on your federal income tax return, and die in the seventh year of retirement or later, coverage is reduced to \$5,000.

### **Flight Engineers**

If you have been approved by MetLife as Permanently and Totally Disabled (PTD) under the terms of your active Employee Term Life Insurance coverage, your Employee Term Life Insurance coverage continues as described above for non-pilot employees.

## Filing a Claim

Upon the death of the retiree, the surviving spouse or other family member should contact HR Services to inform the Company of the death. HR Services determines your most recently named beneficiary and confirms the amount of life insurance payable. This information will be forwarded to Survivor Support Services.

Survivor Support Services sends a letter to each life insurance beneficiary approximately 10 days after the notification of death. The letter verifies the amount of life insurance benefits payable under the Retiree Life Insurance coverage. It will enclose a Beneficiary Life Insurance

Claim Statement and any other forms that your beneficiary must complete. The Company must also have an original certified death certificate in order to process this benefit. The original death certificate will not be returned because MetLife will need to retain it for its records.

When Survivor Support Services receives the completed Beneficiary Life Insurance Claim Statement and a certified copy of the death certificate, it will ensure a claim is filed with MetLife on behalf of your beneficiary.

The life insurance claim will be paid approximately four to six weeks after MetLife receives all necessary documentation.

Your beneficiary may assign a portion of his or her benefit directly to the funeral home to cover the cost of the funeral. See [“Additional Rules”](#) for more information.

## Method of Payment

The Retiree Life Insurance Benefit is an insured plan and is administered by MetLife.

Life Insurance payments of less than \$7,500 are issued in the form of a lump-sum check.

### Total Control Account

When a claim is processed, MetLife establishes a Total Control Account for each of your beneficiaries if their share is \$7,500 or more (smaller amounts are paid in a lump sum). MetLife then deposits all insurance proceeds into the account, which is an interest-bearing checking account that earns interest at competitive money market rates and is guaranteed by MetLife. MetLife sends each of your beneficiaries a personalized checkbook and they may withdraw some or all of the proceeds and interest whenever necessary. In addition, MetLife sends them a description of alternative investment options. The Total Control Account gives your beneficiaries complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

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

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

## Additional Rules

### Designating Beneficiaries

In the event of your death, Retiree Life Insurance Benefit proceeds are paid to the named beneficiaries on file with HR Services. You may change your beneficiary designation at any time by completing a new [Beneficiary Designation Form](#). For your protection, HR Services must receive the original [Beneficiary Designation Form](#) completed and signed by you. Beneficiary information cannot be changed or given out over the telephone. All requests must be made in writing.

Unless prohibited by law, your Retiree Life Insurance Benefit proceeds are distributed as indicated on your [Beneficiary Designation Form](#) on file with HR Services. For this reason, you should consider updating your beneficiary designation is up-to-date, especially if you get married, divorced, declare a Company-recognized Domestic Partner or your spouse dies.

This table provides sample wording for the most common beneficiary designations:

Type of Designation	Sample Wording (always include your beneficiary's address)
One person, related	Jane Doe, spouse
One person, not related	Jane Doe, friend
Your estate	Estate
Member of a given religious order	Mary L. Jones, known in religious life as Sister Mary Agnes, niece
Two beneficiaries with the right of survivorship	John J. Jones, father and Mary R. Jones, mother, equally or to the survivor
Three or more beneficiaries with the right of survivorship	James O. Jones, brother; Peter I. Jones, brother; Martha N. Jones, sister; equally or to the survivor(s)
Unnamed children	My children living at my death
One contingent beneficiary	Lois P. Jones, wife, if living; otherwise, Herbert I. Jones, son
Unnamed children as contingent beneficiaries	Lois P. Jones, wife, if living; otherwise, my children living at my death
Trustee (a trust agreement must be in existence)	ABC Trust Company of Newark, NJ, Michael W. Jones, Trustee, in one sum, under Trust Agreement dated (insert date)

If none of the suggested designations meets your needs, contact an attorney for assistance.

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

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

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

- Spouse or Company-recognized Domestic Partner
- Children or stepchildren (or children or stepchildren of Company-recognized Domestic Partner)
- Parents
- Brothers and sisters
- Estate

If your beneficiary does not survive you (for example, you are both killed in a common disaster) benefits are paid to your estate according to the terms of the policy.

## Accelerated Benefit Option

If you received an accelerated benefit option (ABO) as an active employee, the amount you received reduces the amount of your Retiree Life Insurance coverage. An ABO may eliminate payment of life insurance benefits to your beneficiary. You may not take an ABO under the Retiree Life Insurance Benefit.

## Conversion Rights

If Employee Term Life Insurance coverage reduces when you retire or on the anniversary of your retirement and you wish to keep it at the higher level, you can convert the amount of the reduction in coverage to a personal policy (other than term life insurance) offered by MetLife, without providing proof of good health.

To convert to a personal policy, a Conversion Notice and first payment must be received by MetLife within 31 days of the date coverage was reduced. Contact MetLife (see “[Contact Information](#)” in the Reference Information section) to discuss conversion options and request a Conversion Notice. If you apply within this 31-day period, MetLife will not require you to provide proof of good health.

If you should die during the 31-day period, whether or not the conversion policy has been applied for, MetLife will pay the appropriate beneficiary a death benefit equal to the amount of life insurance you had on the date coverage was reduced.

If you are a retiree and die within the first 31 days after your active Employee Term Life Insurance coverage terminates, your beneficiary will receive a death benefit based on the amount of Employee Term Life Insurance coverage you had as an active employee.

## Verbal Representations

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

## Assignment of Benefits

You may irrevocably assign the value of your Retiree Life Insurance Benefit. This permanently transfers all right, title, interest and incidents of ownership, both present and future, in the benefits under this insurance coverage. Anyone considering assignment of life insurance coverage should consult a legal or tax advisor before taking such action.

If you assign your benefits, you are obligated to fulfill any conditions you have agreed to with your assignee. MetLife's only obligation is to pay the Retiree Life Insurance Benefit due at your death.

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

# When a Retiree Dies

## Survivor Support Services

Upon the death of the retiree, the surviving spouse or other family member should contact HR Services to inform the Company of the death.

Survivor Support Services will return a call to the family upon request. It will coordinate all Company benefits and privileges (including Retiree Life Insurance Benefit, pension benefits and travel privileges, as applicable) for the family and continue to assist until all benefits have been processed.

## Surviving Spouse Medical Coverage

After your death, your surviving spouse continues to be eligible for coverage under the Retiree Medical Benefit for a period of time. Your spouse's medical maximum benefit after your death depends on your age at the time of your death, as explained in the "[Maximum Medical Benefit](#)" section in the Retiree Medical Benefits Options Overview section.

After coverage under the Retiree Medical Benefit ends, your spouse may be eligible to purchase Continuation of Coverage under COBRA. If your spouse is eligible for continuation of coverage, he or she will receive information from Benefit Concepts, Inc. the COBRA administrator, regarding the procedures to continue this benefit.

If your spouse is enrolled in the Company-sponsored Supplemental Medical Plan at the time of your death, he or she may continue that coverage after your death.

## Coverage for Dependent Children

When you die, coverage ends for your children under the Retiree Medical Benefit. Your children may purchase continuation of coverage under COBRA for the Retiree Medical Benefit. Contact HR Services to coordinate this continuation of coverage.

## Other Benefits and Privileges

Survivor Support Services will contact your spouse or other family member to coordinate any other benefits and privileges for which they may be eligible, including any survivor pension benefit or survivor travel privileges.



## ***Long-Term Care Insurance Plan***

MetLife fully insures the Long-Term Care Insurance Plan. MetLife has made the determination to no longer offer Long-Term Care Insurance. Individuals who are already enrolled in Long-Term Care Insurance will be able to continue their coverage through MetLife. If you are interested in applying for coverage in the Long Term Care Insurance Plan, you must contact MetLife at 1-888-526-8495 by December 3, 2012 to request an enrollment kit. To be considered for coverage, the completed form must be received by MetLife on or before January 2, 2013.

### **Met Life's Role**

MetLife insures and administers Long-Term Care Insurance. Visit the [MetLife website](#) or contact MetLife at 1-888-526-8495 for more information.

# ***Additional Rules***

The following sections, as noted, apply to the Retiree Medical Benefits and the Supplemental Medical Plan:

- Qualified Medical Child Support Order (QMCSO)
- When Coverage Ends
- Coordination of Benefits for the Retiree Medical Benefit
- COBRA Continuation of Coverage

## **In This Section**

- Qualified Medical Child Support Order (QMCSO)
  - Use of Terms
  - Procedures Upon Receipt of Medical Child Support Order or State Agency Notice
  - Review of a Medical Child Support Order or Notice
  - Procedures Upon Final Determination
  - Appeal Process
- When Coverage Ends
- Coordination of Benefits for the Retiree Medical Benefit
  - Other Plans
  - Which Plan Is Primary
  - When the Retiree Medical Benefit Plan Is Secondary
  - When Medicare Is Primary
- COBRA Continuation of Coverage
  - COBRA Continuation for Dependents
  - Additional Qualifying Event for Retirees
  - How to Elect Continuation of Coverage
  - Enrolling for Coverage
  - Processing Life Events After Continuation of Coverage Is in Effect
  - Paying for or Discontinuing COBRA Coverage
  - Refund of Premium Payments
  - When Continuation of Coverage Begins and Ends
  - Impact of Failing to Elect Continuation Coverage on Future Coverage
  - Additional Questions
  - American Recovery and Reinvestment Act of 2009 (ARRA)
- HIPAA Certificate of Creditable Coverage

## Qualified Medical Child Support Order (QMCSO)

Federal law authorizes state courts and administrative agencies to issue Qualified Medical Child Support Orders (QMCSOs). A QMCSO may require you to add your child as a dependent for health and dental benefits in some situations, typically a divorce.

The following procedures have been adopted and amended with respect to medical child support orders received by group health benefits and plans maintained for retirees of participating AMR Corporation subsidiaries. These procedures shall be effective for medical child support orders issued on or after the Consolidated Omnibus Budget Reconciliation Act of 1993 (COBRA) relating to employer-provided group health plan benefits.

These procedures are for health coverage under the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries (“the Plan”), consisting of the following options:

- Retiree Standard Medical Option (under age 65 coverage only),
- Retiree Value Plus Option (under age 65 coverage only), and
- Retiree HMO (for retirees under age 65 in Puerto Rico only).

### Use of Terms

The term “Plan” as used in these procedures refers to the options and benefits described above, except to the extent that a plan is separately identified.

The term “Participant,” as used in these procedures, refers to a Participant who is covered under the Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.

The term “Alternate Recipient,” as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The term “Order,” as used in these procedures, refers to a “medical child support order,” which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under such plan or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

The term “QMCSO” or “NMSN,” as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient’s right to or assigns to an Alternate Recipient the right to, receive

health benefits with respect to a Participant under a plan and that meets the requirements set out in these procedures or a notice from a state agency ordering the coverage of an Alternate Recipient under health benefits with respect to a Participant under a plan and which meets the requirements to be an NMSM decreed to be a QMCSO.

The term “Plan Administrator,” as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

## Procedures Upon Receipt of Medical Child Support Order or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at:

P.O. Box 619616  
MD 5146-HDQ  
DFW Airport, TX 75261-9616.

In addition, QMCSOs or NMSNs should be delivered to the same address.

Upon receipt (or within 15 days of receipt) by the Plan Administrator of a request for information on health coverage or a state agency notice to enroll a child, the Plan Administrator will send out a letter notifying the requesting party that it has received the order or notice and describing the Plan’s procedures for determining whether the order is qualified or a notice is received, whether the coverage is available under the Plan to the child and the steps to be taken by the custodial parent or agency to effectuate coverage.

Upon receipt of an Order or upon request, the Plan Administrator will advise each person or party specified in the medical child support order that, in order to be a QMCSO or NMSN, the Order must satisfy the requirements of ERISA and OBRA '93 before the Plan Administrator is obligated to comply with its terms. These requirements state that the Order:

- Must be a “medical child support order,” which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law) and relates to benefits under such plan or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

- Must relate to the provision of medical child support and create or recognize the existence of an Alternate Recipient's right to or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a Plan and that meets the requirements set out in these procedures.
- Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.
- Does not require the Plan to provide any type or form of benefit or option that is not otherwise available under the Plan.
- Must clearly specify:
  - The name and last known mailing address of the participant and the name and address of each alternate recipient covered by the Order
  - A reasonable description of the coverage that is to be provided by the Plan to each Alternate Recipient or the manner that the coverage shall be determined
  - The period to which the Order applies (if no date of commencement of coverage is provided or if the date of commencement of coverage has passed when the Order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the Order)
  - The name of each Plan to which the Order applies (or a description of the coverage to be provided)
  - A statement that the Order does not require a plan to provide any type or form of benefit or any option, not otherwise provided under the Plan (except as a condition of receiving federal assistance for Medicaid)
  - The fact that all Plan contributions with regard to the Alternate Recipient shall be deducted from the Participant's pay.

American Airlines, Inc. does not provide interim coverage to any retiree's dependent during the pendency of a QMCSO or NMSN review. A dependent's entitlement to benefits under the Plan prior to the approval of a QMCSO or an NMSN is determined by the dependent's eligibility and enrollment in the Plan in accordance with the terms of the Plan. Without a QMCSO or NMSN American cannot be held liable if a retiree's dependent is either (i) not enrolled in coverage in the Plan or (ii) is eliminated from coverage in the Plan. In addition, neither American Airlines, Inc. nor the Plan has any obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) a retiree's dependent except upon application by the retiree in accordance with the terms of the Plan or in accordance with a QMCSO or NMSN. If the requesting party needs assistance in preparing or submitting a QMCSO or NMSN, he or she may contact the Plan Administrator or go to the [Department of Labor website](#) for more information on QMCSOs and NMSNs and for sample NMSN forms or to obtain a sample [National Medical Support Notice](#).

## Review of a Medical Child Support Order or Notice

Not later than 20 business days after receipt by the Plan Administrator of a medical child support order, the Plan Administrator shall review the Order to determine if it meets the criteria to make it a QMCSO or NMSN. Under OBRA '93, a state-ordered medical child support order is not necessarily a Qualified Medical Child Support Order. Thus, before the Plan honors the Order, the Order must meet the requirements for a QMCSO or NMSN specified above.

## Procedures Upon Final Determination

The Participant, Alternate Recipient and any party specified in the medical child support order shall be notified of the acceptance of the medical child support order or national medical support notice as being qualified. Once the Order is determined to be a QMCSO or NMSN, the Plan Administrator will follow the terms of the Order and shall authorize enrollment of the Alternate Recipient as well as have any payments for such coverage deducted from the payroll of the Participant. In addition, a copy of the appropriate health benefit guide and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipient, at the issuing agency's address. If the Participant is not enrolled, the Plan Administrator shall enroll the Participant as well as the child in the coverage. Notification will occur within 40 business days of receipt of the Order or notice.

If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Participant, the Alternate Recipient, the state agency issuing the notice or any designated representative in writing of such fact within 40 business days of receipt of the Order or notice. The notification will state the reasons the Order or notice is not a QMCSO or NMSN and that the Plan Administrator shall treat the Participant's benefits as not being subject to the Order. Any subsequent determination that an Order is a QMCSO will be administered prospectively only.

## Appeal Process

If the Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he or she must file an Application for Appeal within 60 days of receiving notification of denial of the medical child support order's or medical support notice's qualification. Appeals will be reviewed by the Pension Benefits Administration Committee (PBAC) in accordance with ERISA and the terms and provisions of the Plan and notify the Participant or Alternate Recipient within 60 days of receipt of the appeal of their decision. A copy of the Plan's appeal procedures, as set forth in the Employee Benefits Guide (the formal Plan Document and Summary Plan Description) shall be provided upon request.

## When Coverage Ends

Retiree benefits for you and your spouse will automatically terminate on the earliest of:

- The date this Plan or benefit option terminates
- The last day for which your contribution has been paid (if you are required to pay ongoing contributions to maintain the Plan or benefit option coverage)
- The date you are no longer eligible for this coverage
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan or benefit option.

Your spouse's coverage will automatically terminate on the earliest of:

- The date this Plan or benefit option terminates
- The last day for which your spouse's contribution has been paid (if your spouse is required to pay ongoing contributions to maintain the Plan or benefit option coverage)
- The date he or she is no longer your spouse
- The date you are no longer eligible for this Plan or benefit option
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan or benefit option
- The date your surviving spouse remarries
- For a Company-recognized Domestic Partner, 90 days after your death.

Expenses incurred after the date your coverage (or your spouse's coverage) terminates are not eligible for reimbursement under the Plan or benefit option. Also see "[When Coverage Ends](#)" in the Retiree Enrollment section and "[When Coverage Ends](#)" in the Life Events section.



## Coordination of Benefits for the Retiree Medical Benefit

This section explains how to coordinate coverage between the Company-sponsored Retiree Medical Benefit and any other benefits/plans that provide coverage for you or your eligible dependents.

If you or any other covered dependents have primary coverage (see “Which Plan Is Primary”) under any other group medical benefits/plans, your Company-sponsored Retiree Medical Benefit will coordinate to avoid duplication of payment for the same expenses. The benefit program for Retirees 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 Retiree Medical Benefit was your only coverage.

If your dependent is covered by another benefit/plan and the Retiree Value Plus Option is his or her secondary coverage, the RPOS Option pays only up to the maximum benefit amount payable under the RPOS Option 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.

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

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

## Other Plans

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

- Employer-sponsored benefits/plans under which the employer pays all or part of the cost or takes payroll deductions, regardless of whether the plans are insured or self-funded
- Government or tax-supported programs, including Medicare (Parts A and B, Medicare+Choice and Medicare Part D) or Medicaid
- Property or homeowner’s insurance or no-fault motor vehicle coverage, except if the plan participant has purchased this coverage.
- Other individual insurance policies.

## 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:

- If you are covered by Medicare (Parts A and B, Medicare+Choice and Medicare Part D) or another government-sponsored or tax-supported program, Medicare is your primary plan unless your spouse is still working and you are covered as a dependent under a plan sponsored by your spouse's employer.

Once you are Medicare-eligible, your primary prescription drug coverage will be Medicare Part D.

Your coverage under the Retiree Standard Medical Option or Retiree Value Plus Option (if you are under age 65) will become your secondary coverage and will coordinate benefits with Medicare Part D in the same way it coordinates with Medicare Parts A and B and Medicare+Choice.

If you or your covered dependents are Medicare-eligible and you do not enroll in all or part of the Medicare program, your benefits under the Retiree Medical Benefit will be calculated as though you are enrolled in and are receiving Medicare benefits.

- 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 under two retiree plans and both plans have a coordination of benefits provision, the plan that has covered the retiree the longest is primary.
- Any benefits payable under the Retiree Medical Benefit and Medicare are paid according to federal regulations. In case of a conflict between the Retiree Medical Benefit provisions and federal law, federal law prevails.
- If the coordination of benefits is on behalf of a covered child:
  - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise (see "Qualified Medical Child Support Order (QMCSO)").

- For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. A stepchild not living in the retiree's home is not an eligible dependent under the benefit program for Retirees, regardless of any child support order.
- If the other plan has a gender rule, that plan determines which plan is primary.

The following two tables explain which plan is primary based on your working status and eligibility for Medicare and your spouse's working status and eligibility for Medicare.

Primary Coverages for Retirees		
If you are...	Your Primary Plan is...	Your Secondary Plan is...
Not eligible for Medicare AND Not covered as a dependent under your spouse's employer-sponsored health plan.	Retiree Medical Benefit	None or any other medical coverage you have
Eligible for Medicare AND Not covered as a dependent under your spouse's employer-sponsored health plan	Medicare	Retiree Medical Benefits
Married to an active employee of an AMR subsidiary AND Covered as a dependent under your spouse's Company-sponsored plan	Active employee plan (You defer Retiree Medical Benefit coverage)	Medicare or any other medical coverage you have
Eligible for Medicare AND Covered as the dependent of your spouse who is actively working for a company that is not an AMR subsidiary	Your spouse's employer-sponsored health plan	Medicare or any other medical coverage you have (including the Retiree Medical Benefit)
Eligible for Medicare AND Re-employed by an AMR subsidiary	Active employee plan (You defer Retiree Medical Benefit coverage)	Medicare or any other medical coverage you have

Primary Coverages for Spouses		
If you are...	Your Primary Plan is...	Your Secondary Plan is...
Not employed AND Have no other group medical plan (including Medicare)	Retiree Medical Benefit	None
An active employee of a participating AMR subsidiary AND Not eligible for Medicare	Active employee plan	None
Employed by another company AND Not eligible for Medicare	Spouse's employer-sponsored plan	Retiree Medical Benefit
Eligible for Medicare AND Has no other coverage	Medicare	Retiree Medical Benefit
Eligible for Medicare AND Has another retiree plan	Medicare	Spouse retiree plan-second Retiree Medical Plan-third

If you or your spouse is eligible for Medicare (including Parts A and B, Medicare+Choice and Medicare Part D), even if you do not enroll in all or part of the Medicare program, your benefits under the Retiree Medical Benefit will be calculated as though you are enrolled and receiving Medicare benefits.

## When the Retiree Medical Benefit Plan Is Secondary

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 primary plan's reasonable and customary or usual and prevailing charge). 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% of the total eligible expense.

Here is how to calculate benefits under the Retiree Medical Benefit when it is the secondary plan and the primary plan is not Medicare:

- First, the normal benefits are calculated as though the Retiree Medical Benefit is the primary plan.
- Next, the amount paid by the primary plan is subtracted from normal benefits under the Retiree Medical Benefit.
- Finally, the Retiree Medical Benefit pays the difference, if any.

## When Medicare Is Primary

If you are eligible for Medicare, it is your primary plan unless your spouse is actively working and covers you as a dependent under the plan sponsored by his or her employer. The Retiree Medical Benefit coordinates benefits with Original Medicare (Parts A and B) if you are eligible for that coverage. Coordination applies regardless of whether you are actually enrolled in Medicare coverage and regardless of whether you select Original Medicare or a Medicare+Choice Health Plan.

### Retiree Standard Medical (RSM) Option coordination with Medicare

The following example shows how the Retiree Standard Medical (RSM) Option coordinates with Medicare and how your benefit under the RSM Option is calculated. It assumes you have \$10,000 in billed charges for services covered under Part B and the Medicare-approved charge is \$7,500. Medicare limits the amount the physician can charge you to 115% of the Medicare-approved charge (\$8,625). This is known as the Medicare “limiting charge” or Medicare cap.

#### Step 1

Billed charges: Enter the amount of charges billed by your physician.

Billed charges: \$10,000

#### Step 2 (Medicare Calculations)

Medicare Cap: Assume the Medicare-approved charge for the procedure is \$7,500 and the

Medicare cap is 115% of the approved charge. Multiply the approved charge by 115%\* to determine the Medicare cap. (\* This percentage is set by federal and state law and varies from state to state.)

Approved charge:  $\$7,500 \times 115\%$   
Medicare Cap = \$8,625

#### Step 3

Write-off/Subtract the Medicare cap in Step 2 from the billed charges in Step 1 to determine the amount the physician must write off.\*\* (\*\* Federal and state laws limit the amount a provider can “balance bill” a patient after the Medicare payment. In this example, federal law does not allow the provider to bill this \$1,375.)

Billed charges: \$10,000  
Medicare Cap: - \$8,625  
Write-off: = \$1,375

**Step 4**

Medicare benefit: Subtract your Medicare Part B deductible from the Medicare-approved charge of \$7,500 and multiply the remainder by the covered percentage of 80%.

Approved charge: \$7,500  
Part B Deductible: - \$110  
= \$7,390  
Covered percent: × 80%  
Medicare benefit: = \$5,912

**Step 5**

Subtract the deductible: Subtract the deductible under the RSM Option from the Medicare cap (Step 2) to determine the remaining amount.

Medicare cap: \$8,625  
Deductible: - \$150  
Remaining amount: = \$8,475

**Step 6**

Figure primary benefit: Using the remaining amount from Step 5, calculate the benefit under the RSM Option as if it were the primary plan. Figure 80% of the first \$5,000 plus 100% of remaining \$3,475. (This calculation may vary depending on your workgroup and type of procedure.)

80% of first \$5,000: \$4,000  
100% of remaining: + \$3,475  
Primary benefit: = \$7,475

**Step 7**

Figure secondary benefit: Determine how much the RSM Option will pay as secondary benefits by subtracting the amount Medicare will pay (Step 4) from the amount the Retiree Medical Plan would have paid as the primary plan (Step 6).

Primary benefit: \$7,475  
Medicare benefit - \$5,912  
Secondary benefit: = \$1,563

**Step 8**

Your cost: Calculate the amount you are responsible for paying by subtracting the Medicare benefit (Step 4), RSM Option secondary benefit (Step 7) and the write-off (Step 3) from billed charges (Step 1). The difference is your \$1,000 out-of-pocket maximum plus the \$150 deductible.

Billed charges: \$10,000  
Medicare benefit: - \$5,912  
Secondary benefit: - \$1,563  
Write-off: - \$1,375  
Your cost: = \$1,150

### Retiree Value Plus Option coordination with Medicare

The following tables show examples of how the Retiree Value Plus Option coordinates benefits when other coverage is primary and how your benefit under the Retiree Value Plus Option is calculated. It assumes that you have used an in-network provider — thus, the Retiree Value Plus Option benefit is based on the in-network provider's contract negotiated rate with your network/claims administrator.

**Note:** The following examples assume that Retiree Value Plus Option in-network providers are utilized.

#### Example 1

<b>PCP Office Visit Charge</b>	\$100
<b>Medicare Paid</b>	\$60
<b>RVP Option Benefit Minus the \$20 Co-payment</b> (the amount payable if you had no other coverage)	\$45
<b>RVP Option Pays</b>	\$0*

\* No benefits are paid from the Retiree Value Plus (RVP) Option because Medicare paid a benefit amount greater than what would have been paid under the RVP Option if it were your only coverage.

#### Example 2

<b>PCP Office Visit Charge</b>	\$100
<b>Medicare Paid</b>	\$30
<b>RVP Option Benefit Minus the \$20 Co-payment</b> (the amount payable if you had no other coverage)	\$45
<b>RVP Option Pays</b>	\$15*

\* Because the Retiree Value Plus (RVP) Option benefit amount is greater than the amount paid by Medicare, RVP Option pays the difference, up to the amount RVP Option would have paid in the absence of other coverage

#### RVP Example 3

<b>Outpatient Surgery Charge</b>	\$1,000
<b>Medicare Paid</b>	\$600
<b>RVP Option Benefit, paid at 90% co-insurance</b> (the amount payable if you had no other coverage)	\$710
<b>RVP Option Pays</b>	\$110*

\* Because the Retiree Value Plus (RVP) Option benefit amount is greater than the amount paid by Medicare, RVP Option pays the difference, up to the amount RVP Option would have paid in the absence of other coverage.

### Coordination With Medicare+Choice Health Plans

If you participate in a Medicare HMO or another Medicare+Choice Health Plan and you incur an expense not covered by that plan, the Retiree Medical Benefit calculation follows the formula it would use to calculate the amount that would have been paid by Medicare Parts A and B. If a medical service is not covered by any part of Medicare, but it is covered by the Retiree Medical Benefit, the Retiree Medical Benefit pays its normal benefit amount.



## Medicare Crossover

The claims processor for the Retiree Medical Benefit (your network/claims administrator), offers you a way to make coordination of benefits and claim filing easier with respect to your Medicare Part B and Durable Medical Equipment (“DME”) expenses. If you wish to do so, you may authorize Your network/claims administrator to receive—directly from the Medicare processor — an electronic copy of the Explanation of Medicare Benefits (“EOMB”). Upon receipt of this EOMB, Your network/claims administrator will process the balance of your claim under the provisions of the Retiree Medical Benefit (including processing under the Coordination of Benefits provisions). This eliminates the need for you and your provider of service to make copies of the EOMB and submit a second claim to your network/claims administrator for Medicare Part B and DME expenses. To learn more or to take advantage of this Medicare Crossover Process, access the [Medicare Crossover Information and Enrollment Form](#) or contact HR Services (see “[Contact Information](#)” in the Reference Information section).

## COBRA Continuation of Coverage

The Retiree Medical Benefit and the Supplemental Medical Plan (“Plan”) provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain Qualifying Events. If your dependents have coverage at the time of the Qualifying Event, they may be eligible to elect continuation of coverage under the Plan.

The continuation coverage is identical to coverage provided under the Plan for similarly situated retirees or their dependents, including future changes.

### COBRA Continuation for Dependents

Your covered dependents may continue coverage for a maximum period of 36 months if coverage would otherwise end because of:

- Your divorce or legal separation
- Your Company-recognized Domestic Partner relationship ends
- You become entitled to (enrolled in) Medicare benefits
- Loss of eligibility because the dependent, including a child of a covered Company-recognized Domestic Partner, no longer meets the Plan’s definition of a dependent (for example, if a child reaches the Plan’s limiting age)
- Your death
- Your Company-recognized Domestic Partner’s death

Your Company-recognized Domestic Partner and his or her covered dependents will be eligible to purchase continuation of coverage if they lose benefits as a result of the termination of your Company-recognized Domestic Partner relationship, your partner’s child’s loss of eligibility under the Plan, or the death of your Company-recognized Domestic Partner or yourself.

If you experience more than one of these Qualifying Events, your maximum continuation of coverage is the number of months allowed by the event that provides the longest period of continuation.

If the Plan requires you or your eligible dependents to timely pay ongoing contributions/premiums in order to maintain coverage under the Plan, (i.e., you must pay the full amount of the required ongoing contribution by the due date or before the end of the grace period allowed for payment), your failure to pay or timely pay such required contributions/premiums, with resulting termination of coverage, is not a Qualifying Event and you/your eligible dependents are not eligible to continue coverage under COBRA.

## Additional Qualifying Event for Retirees

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Company and you are a retired employee who loses coverage under the Plan as a result of that bankruptcy, you, your surviving spouse and dependent children may be entitled to elect Continuation Coverage under the Plan. Continuation of coverage extends until:

- The date of your (the retiree's) death or the death of your surviving spouse (if you died before the bankruptcy filing and your spouse still had coverage under the Retiree Medical Benefit), or
- 36 months after the date of your (the retiree's) death, in the case of your surviving spouse or dependent child.

If the Plan requires you (and/or your eligible dependents) to timely pay ongoing contributions or premiums in order to maintain coverage under the Plan (i.e., you must pay the full amount of the required ongoing contribution or premium by the payment due date reflected on the monthly invoice or before the end of the 30-day grace period allowed for payment), your failure to pay or timely pay such required ongoing contributions or premiums, with resulting termination of coverage, is not a Qualifying Event and you (and/or your eligible dependents) are not eligible to continue coverage under COBRA.

## How to Elect Continuation of Coverage

Solicitation following a Qualifying Event: In the event of a Qualifying Event (as shown above as for your dependents only) (divorce, legal separation, the end of a Company-recognized Domestic Partner relationship, your entitlement to or enrollment in Medicare, a dependent's reaching the limiting age for coverage or your Company-recognized Domestic Partner's death), you must notify American Airlines, Inc. by processing a Life Event change within 60 days of the event. Your Company-recognized Domestic Partner and his or her covered dependents will be eligible to purchase continuation of coverage if they lose benefits as a result of the termination of your Company-recognized Domestic Partner relationship, your partner's child's loss of eligibility under the Plan, or the death of your Company-recognized Domestic Partner or yourself.

You can process most Qualifying Events that are also Life Events online through the Retiree Benefits page on Jetnet; however, in some instances, you must contact HR Services to process the change. Click on the "Start a Chat" button on the top of this page. For example, in the event of your death, your supervisor or a dependent must call HR Services to make the appropriate notification. If the Qualifying Event is also a Life Event that involves your Company-recognized Domestic Partner, you must call HR Services to process the change.

If you fail to notify the Company of a dependent's loss of eligibility within 60 days after the Life Event, the dependent will not be eligible for continuation of coverage through COBRA, and you will be responsible for reimbursing the Company for any benefits paid for the ineligible person. You are also required to repay the Company for premium amounts that were overpaid for fully insured coverages.

## Enrolling for Coverage

Following notification of any Qualifying Event (see the Life Events: Making Changes During the Year section) HR Services will advise Benefit Concepts, Inc., who in turn will notify you or your dependents of the right to continuation of coverage. When you process your Life Event, you should provide your dependent's address (if different from your own) where Benefit Concepts, Inc. can send solicitation information.

You (or your dependents) must provide written notification of your desire to purchase continuation coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage. You must elect to continue coverage within 60 days of the date postmarked on the notice, or you will lose your right to elect to continue coverage. (See "[Contact Information](#)" in the Reference Information section for Benefit Concepts, Inc.'s address for sending the written notice.)

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

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

Federal laws require the Company to provide a Certificate of Group Health Plan Coverage outlining your coverage under the Plan and showing the dates you were covered by this Plan. This certificate is sent to you by Benefit Concepts, Inc.

## Processing Life Events After Continuation of Coverage Is in Effect

If you elect continuation of coverage for yourself and later marry or declare a Company-recognized Domestic Partner, give birth or adopt a child while covered by continuation of coverage, you may elect coverage for your newly acquired dependents after the Qualifying Event. To add your dependents, contact Benefit Concepts, Inc., the COBRA administrator, at 877-902-9207, within 60 days of the marriage, Company-recognized Domestic Partner relationship, birth or adoption.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29 or 36 months, depending on the Qualifying Event). This new dependent will not have the right to continue coverage on his or her own if there is a divorce, end of Company-recognized Domestic Partner relationship or another event that causes loss of coverage. You may add a newborn child or a child newly placed for adoption to your COBRA continuation coverage. You should notify Benefit Concepts, Inc. and the Plan Administrator of the newborn or child newly placed for adoption within 60 days of the child's birth or placement for adoption.

All rules and procedures for filing and determining benefit claims under the plans for active employees also apply to continuation of coverage.

If you have questions regarding continuation of coverage, contact Benefit Concepts, Inc. (see “[Contact Information](#)” in the Reference Information section).

## Paying for or Discontinuing COBRA Coverage

To maintain COBRA continuation of coverage, you must pay the full cost of continuation of coverage on time, including any additional expenses permitted by law. Your first payment is due within 45 days after you elect continuation of coverage. Premiums for subsequent months of coverage are due on the first day of each month for that month’s coverage. If you elect continuation of coverage, you will receive payment coupons or invoices from Benefit Concepts, Inc. indicating when each payment is due.

Contributions are due even if you have not received your payment coupons. Failure to pay the required contribution on or before the due date or by the end of the grace period will result in termination of COBRA coverage, without the possibility of reinstatement. All checks shall be made payable to Benefit Concepts, Inc. (see “[Contact Information](#)” in the Reference Information section).

## Refund of Premium Payments

If you elect continuation of coverage and later discover that you do not meet the eligibility requirements for coverage, for example, if you become entitled to (enrolled in) Medicare benefits, you must contact Benefit Concepts, Inc. (see “[Contact Information](#)” in the Reference Information section) immediately, but no later than three months after you make your first COBRA premium payment in order for you to be eligible for a refund. No payments will be refunded after this three-month period, regardless of the reason.

If claims have been paid during this three-month time period, the Plan will request reimbursement from you. If the amount of your premium payments for continuation of coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the Plan receives reimbursement for your claim, the

Plan will refund your premiums. Although a Company-recognized Domestic Partner and his or her children do not have rights to COBRA coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur, with the exception that Supplemental Medical Plan is not available under COBRA to surviving Company-recognized Domestic Partners.

This time limit for refunds also applies if the Company discovers that continuation of coverage has been provided to you or your dependent in error.

## When Continuation of Coverage Begins and Ends

When continuation of coverage begins: If you or your dependents elect continuation of coverage within 60 days of receiving your election forms, the coverage becomes effective on the date your other coverage would otherwise end. Thus, the first premium for continuation of coverage includes payment for this retroactive coverage period.

When continuation of coverage ends: Continuation of coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29 or 36 months) expires.
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds (“NSF” or “bounced”) are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement.
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a preexisting condition limitation that affects the plan participant. In that event, the participant is entitled to continuation of coverage up to the maximum time period.
- The Plan participant continuing coverage becomes entitled to Medicare
- The Company no longer provides the coverage for any of its retirees or their dependents.

## Impact of Failing to Elect Continuation Coverage on Future Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63 day gap in health coverage and election of continuation coverage may help you not have such a gap.

Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your Plan coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.



## Additional Questions

If you have any additional questions on continuation of coverage under COBRA, you should contact Benefit Concepts, Inc. (see “[Contact Information](#)” in the Reference Information section).

## American Recovery and Reinvestment Act of 2009 (ARRA)

If you (the retiree) were recalled back to active employment with American Airlines, Inc. and subsequently experience (d) involuntary termination of your employment during the period beginning September 1, 2008 and ending May 31, 2010, and are eligible for COBRA continuation of coverage, you might be eligible to participate in the COBRA contribution subsidy program provided under ARRA. If you are eligible, this program pays 65 percent of the contribution amount you are required to pay for COBRA continuation coverage, and you are required to pay 35 percent. This subsidy will be paid for up to nine (9) months. Retirees whose employment was terminated between September 1, 2008 and May 31, 2010 will receive information from the COBRA administrator, advising who is eligible to receive this subsidy, how to elect this subsidy, income qualifications and other information. Not all employees whose employment was terminated during this period of time will be eligible for the COBRA subsidy; thus, read your information carefully. If you have questions, contact your COBRA administrator (see “[Contact Information](#)” in the Reference Information section). You can also find more information about this COBRA subsidy on the [U.S. Department of Labor website](#).

## HIPAA Certificate of Creditable Coverage

If you lose your coverage (or when you notify Employee Services of your dependent’s loss of coverage), you will automatically be sent a certificate of creditable coverage showing how long you had been covered under the Plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan’s pre-existing medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will receive another certificate of coverage within the 24 months after your coverage has ended. You may also request a certificate of creditable coverage within the 24 months after your coverage has ended.

To request a certificate of creditable coverage, contact HR Employee Services (see “[Contact Information](#)” in the Reference Information section), and request a HIPAA certificate of creditable coverage.



## Plan Administration

The Plans listed below are sponsored by American Airlines, Inc. as that term is defined under ERISA Section 3(16)(B) and are part of the benefit program for Retirees of participating AMR Corporation subsidiaries.

Plan Name	Plan Number
<p>The Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries</p> <p>This Plan includes:</p> <ul style="list-style-type: none"><li>• Retiree Medical Benefits<ul style="list-style-type: none"><li>○ Retiree Standard Medical Option</li><li>○ Retiree Value Plus Option</li><li>○ Retiree HMO Option (for Puerto Rico Retirees Only)</li></ul></li><li>• Retiree Life Insurance Benefit</li></ul>	515
The Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (does not apply to Pilot or Flight Engineer retirees)	503
Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries	510

## Administrative Information

American Airlines, Inc. (See below)

### Plan Administrators

#### American Airlines, Inc.

Mailing address:

Mail Drop 5141-HDQ1

P.O. Box 619616

DFW Airport, TX 75261-9616

Street address (do not mail to this address):

4333 Amon Carter Blvd.

Fort Worth, Texas 76155

#### Long Term Care Insurance ( MetLife)

Mailing address:

57 Greens Farms Road

Westport, CT 06880

### The Plan Administrator for Second Level Claim Appeals

#### Pension Benefits Administration Committee (PBAC)

American Airlines

Mail Drop 5134-HDQ1

P.O. Box 619616

DFW Airport, TX 75261-9616

#### Agent for Service of the Legal Process

Managing Director, Benefits and Productivity

American Airlines, Inc.

Mailing address:

Mail Drop 5126-HDQ1

P.O. Box 619616

DFW Airport, TX 75261-9616

Express Delivery address:

Mail Drop 5126-HDQ1

4333 Amon Carter Blvd.

Fort Worth, TX 76155

## **Network/Claim Processor**

The network/claim processors for each benefit or plan vary and are listed in Contact Information.

## **Trustee**

The Trustee for the American Airlines, Inc. Health Benefits Trusts (prefunding trusts) and the Supplemental Medical Plan Trusts is:

State Street Bank & Trust  
200 Newport Avenue  
North Quincy, Massachusetts 02171

## **Employer ID Number**

13-1502798

## **Plan Year**

January 1 through December 31

## **Participating Subsidiaries**

American Airlines, Inc.

## Plan Amendments

The Pension Benefits Administration Committee (PBAC), under the authority granted to it by the Board of Directors through the Chairman, has the sole authority to interpret, construe, determine claims and adopt and/or amend retiree benefit plans, benefits and options ("Plans"). The PBAC, in consultation with actuaries, consultants, Employee Relations, Human Resources and the Legal Department, has the discretion to adopt such rules, forms, procedures and amendments it determines are necessary for the administration of the Plans according to their terms, applicable law, regulation, collective bargaining agreements or to further the objectives of the Plans. The PBAC may take action during a meeting if at least half the members are present or by a unanimous written decision taken without a meeting and filed with the Chairman of the PBAC.

The administration of the Plans shall be under the supervision of the Plan Administrator. The Employer hereby grants the PBAC the authority to administer and interpret the terms and conditions of the Plans and the applicable legal requirements related thereto. It shall be a principal duty of the PBAC to see that the administration of the Plans is carried out in accordance with its terms, for the exclusive purpose of providing benefits to Participants and their beneficiaries in accordance with the documents and instruments governing the Plans. The PBAC will have full power to administer the Plans in all of their details, subject to the applicable requirements of law. For this purpose, the PBAC's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by the Plans:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plans, including the establishment of any claims procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information
- To interpret and construe the terms of the Plans, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plans
- To decide all questions concerning the Plans and to determine the eligibility of any person to participate in or receive benefits under the Plans and to determine if any exceptional circumstances exist to justify any extensions
- To compute the amount of benefits that will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plans and the applicable requirements of law
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plans
- To allocate and delegate its responsibilities under the Plans and to designate other persons to carry out any of its responsibilities under the Plans, any such action to be by written instrument and in accordance with ERISA Section 405
- To delegate its authority to administer claims for benefits under the Plans by written contract with a licensed third party administrator, and
- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions and reports that are furnished by accountants, counsel or other experts employed or engaged by the PBAC.

## Plan Funding

The coverage for Retiree Medical Benefits is self-funded through Company contributions, and in certain cases, employee prefunding contributions during active employment and/or retiree payment of required ongoing contributions during retirement (postfunding).

Employee prefunding contributions as plan assets are held in Voluntary Employee Beneficiary Association (VEBA) trusts established under Section 501(c)(9) of the Internal Revenue Code. There are three separate VEBA prefunding trusts — one for non-union employees, one for employees represented by the Transport Workers Union, AFL-CIO (TWU-Represented) and one for employees represented by the Association of Professional Flight Attendants (APFA). These VEBA funds are dedicated exclusively to providing benefits to retirees of these respective workgroups and their dependents and cannot be used for any purpose other than providing retiree health benefits.

Self-funded Retiree Medical Option benefits are paid from trust assets. The network/claim administrators are independent companies that provide claim payment services. They do not insure these benefits.

The coverage for the Supplemental Medical Plan is self-funded through employee and retiree contributions. Employee and retiree contributions as plan assets are held in Voluntary Employee Beneficiary Association (VEBA) trusts established under Section 501(c)(9) of the Internal Revenue Code. There are three separate VEBA Supplemental Medical Plan trusts — one for non-union employees (post-tax contributions), one for employees represented by the Transport Workers Union, AFL-CIO (TWU-Represented) and one for employees represented by the Association of Professional Flight Attendants (APFA). These VEBA funds are dedicated exclusively to providing benefits to employees and retirees (and their spouses) and cannot be used for any purpose other than providing these Supplemental Medical Plan benefits.

Self-funded Supplemental Medical Plan benefits are paid from trust assets. The network/claim administrator is an independent company that provides claim payment services. It does not insure these benefits.

Retiree Life Insurance is fully insured and premiums are paid by the Company.

The Long Term Care Insurance Plan is fully insured and premiums are paid by the retiree participants.

## Assignment of Benefits

You may request that the network/claim administrator pay your service provider directly by assigning your benefits.

You may assign Retiree Medical Benefit and Supplemental Medical Plan benefits for eligible expenses incurred for hospital care, surgery or medical treatment for illness or injury. You may only assign benefits to the person or institution that provides the services or supplies for which these benefits are payable.

For information about assigning life insurance benefits, see “[Assignment of Benefits](#)” in the “Additional Rules” section of the Retiree Life Insurance section.

## Claims — Retiree Standard Medical Option

This information regarding claims is for the above referenced grandfathered plan. This contains appeal information and requirements specific to the Retiree Standard Medical Option.

### Confidentiality of Claims

The Company and its agents (including the network and/or claims administrators) will use the information you furnish to substantiate your claim and determine benefits. The information may be forwarded to the Company medical director or other independent consultants for medical review or appropriate medical follow-up. In addition, certain individuals within the Company will have access to this information to carry out their duties to administer the coverages properly.

The Company treats your medical information as confidential and discloses it only as may be required for the administration of the Plans or as may be required by law.

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see “[Compliance with Privacy Regulations](#)”.

### Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service provider (see “[Assignment of Benefits](#)”). Benefits are paid after the network/claim administrator (or other administrator) receives satisfactory written proof of a claim. If any benefit has not been paid when you die or, if you are legally incapable of giving a valid release for any benefit, the network/claim administrator (or other administrator) may pay all or part of the benefit to:

- Your guardian,
- Your estate,
- Any institution or person (as payment for expenses in connection with the claim), or
- Any one or more persons among the following relatives: your spouse, parents, children, brothers or sisters.

Payment of a claim to anyone described above releases the Plan Administrator from all further liability for that claim.

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

The right to benefits under the Plans may not be exchanged for, or substituted for, other benefits or cash compensation.

## Right to Recovery

If claims payments are more than the amount payable under the Plans, the network/claim administrator (or other administrator) may recover the overpayment. The network/claim administrator (or other administrator) may seek recovery from one or more of the following:

- Any plan participant to or for whom benefits were paid,
- Any other self-funded plans or insurers,
- Any institution, physician or other service provider, or
- Any other organization.

The claims processor is entitled to deduct the amount of any overpayments from any future claims payable to you or your service providers.

## Subrogation

Subrogation is third-party liability. Subrogation applies if the Plans have paid any benefits for your injury or illness and someone else (including any insurance carrier) is, or may be, considered legally responsible.

The Plans have the right to collect payment from the third party (or its insurance carrier) for the medical treatment of your injury or illness. The Plans subrogate (substitute) their own rights for your rights and have a lien of first priority on any recovery you receive. This means the Plans must be paid first from any settlement or judgment you receive and the Plans shall have a lien of first priority over any recovery you receive that will not be reduced by any “make whole” or similar doctrine. The Plans may assert this right to pursue recovery independently of you.

As a condition for receiving benefits under the Plans, you agree to:

- Cooperate with the Plans to protect the Plans’ subrogation rights
- Provide the Plans with any relevant information they request
- Obtain consent of the Plans before releasing any party from liability for payment of medical expenses
- Sign and deliver documents regarding the Plans’ subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plans’ subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plans.
- The Plans’ claims and lien shall not be reduced by any “make whole” or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery.



If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plans.

The Plans will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plans will not pay your or others' legal costs associated with subrogation.

## Claim Processing Requirements

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), to be effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Airlines, Inc.- sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

### Time Frame for Initial Claim Determination

For claims for medical benefits, the processing rules vary by the type of claim. For urgent care claims and pre-service claims (claims in which the service has not yet been rendered and/or that require approval of the benefit or precertification before receiving medical care), the claims processor or benefit administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- Seventy-two hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification), or
- Fifteen days after receipt of a pre-service claim.

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

For urgent care claims, if you fail to provide the claims processor or benefit administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the claims processor or benefit administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information

needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The claims processor or benefit 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 network and/or claims administrator or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the network and/or claims administrator or benefit administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your or your authorized representative's failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the network and/or claims administrator or benefit administrator sends you an extension notification until the date you respond to the request for additional information.

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

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

### **Urgent Care Claims**

Urgent care claims are those that, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function, or
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

- An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

### **Concurrent Care Claims**

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

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

**Note:** Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

### **If You Receive an Adverse Benefit Determination on a Health/Welfare Benefit Plan Claim**

The claims processor or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request.
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim

## All Other Claims

All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the claims processor. After the claims processor has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the claims processor shall notify you within a reasonable period of time not to exceed 90 days after receipt of the acceptance or denial of the claim. The 90-day period during which a claim for benefits is reviewed may be extended by the case manager or claims processor for up to 90 days, provided the claims processor both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 90-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 90-day period provided the claims processor notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for disability benefits is denied, in whole or in part, the claims processor shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial
- Specific references to the Plan provisions on which the denial is based
- A description of any information or material necessary to perfect the claim
- An explanation of why this material is necessary
- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review, and
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request.

## Effect of Failure to Submit Required Claim Information

If the claims processor determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the claims processor's request for information or upon a demonstration to the satisfaction of the claims processor that under the circumstances the claims processor's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the claims processor, taking into consideration the cause or reason for your failure or refusal, the length of the period and other facts or circumstances the claims processor deems relevant.

## Claims — Retiree Value Plus Option

This information regarding claims is for the above referenced non-grandfathered plan. This contains appeal information and requirements specific to the Retiree Value Plus Option.

### Confidentiality of Claims

The Company and its agents (including the network and/or claims administrators) will use the information you furnish to substantiate your claim and determine benefits. The information may be forwarded to the Company medical director or other independent consultants for medical review or appropriate medical follow-up. In addition, certain individuals within the Company will have access to this information to carry out their duties to administer the coverages properly.

The Company treats your medical information as confidential and discloses it only as may be required for the administration of the Plans or as may be required by law.

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see [“Compliance with Privacy Regulations”](#).

### Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service provider (see [“Assignment of Benefits”](#)). Benefits are paid after the network/claim administrator (or other administrator) receives satisfactory written proof of a claim. If any benefit has not been paid when you die or, if you are legally incapable of giving a valid release for any benefit, the network/claim administrator (or other administrator) may pay all or part of the benefit to:

- Your guardian,
- Your estate,
- Any institution or person (as payment for expenses in connection with the claim), or
- Any one or more persons among the following relatives: your spouse, parents, children, brothers or sisters.

Payment of a claim to anyone described above releases the Plan Administrator from all further liability for that claim.

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

The right to benefits under the Plans may not be exchanged for, or substituted for, other benefits or cash compensation.

## Right to Recovery

If claims payments are more than the amount payable under the Plans, the network/claim administrator (or other administrator) may recover the overpayment. The network/claim administrator (or other administrator) may seek recovery from one or more of the following:

- Any plan participant to or for whom benefits were paid,
- Any other self-funded plans or insurers,
- Any institution, physician or other service provider, or
- Any other organization.

The claims processor is entitled to deduct the amount of any overpayments from any future claims payable to you or your service providers.

## Subrogation

Subrogation is third-party liability. Subrogation applies if the Plans have paid any benefits for your injury or illness and someone else (including any insurance carrier) is, or may be, considered legally responsible.

The Plans have the right to collect payment from the third party (or its insurance carrier) for the medical treatment of your injury or illness. The Plans subrogate (substitute) their own rights for your rights and have a lien of first priority on any recovery you receive. This means the Plans must be paid first from any settlement or judgment you receive and the Plans shall have a lien of first priority over any recovery you receive that will not be reduced by any “make whole” or similar doctrine. The Plans may assert this right to pursue recovery independently of you.

As a condition for receiving benefits under the Plans, you agree to:

- Cooperate with the Plans to protect the Plans’ subrogation rights
- Provide the Plans with any relevant information they request
- Obtain consent of the Plans before releasing any party from liability for payment of medical expenses
- Sign and deliver documents regarding the Plans’ subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plans’ subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plans.
- The Plans’ claims and lien shall not be reduced by any “make whole” or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plans.

The Plans will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plans will not pay your or others’ legal costs associated with subrogation.



## Claim Processing Requirements

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), to be effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Airlines, Inc.- sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

### Time Frame for Initial Claim Determination

For claims for medical benefits, the processing rules vary by the type of claim. For urgent care claims and pre-service claims (claims in which the service has not yet been rendered and/or that require approval of the benefit or precertification before receiving medical care), the claims processor or benefit administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- Seventy-two hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification), or
- Fifteen days after receipt of a pre-service claim.

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

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

- The claims processor or benefit 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 network and/or claims administrator or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the network and/or claims administrator or benefit administrator must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your or your authorized representative's failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the network and/or claims administrator or benefit administrator sends you an extension notification until the date you respond to the request for additional information.

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

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

### **Urgent Care Claims**

Urgent care claims are those that, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.
- An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

### Concurrent Care Claims

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

**Note:** Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

### If You Receive an Adverse Benefit Determination on a Health/Welfare Benefit Plan Claim

The claims processor or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request
- Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits
- If the adverse benefit determination concerns a claim involving urgent care, a description of the expedited review process applicable to the claim
- The network and/or claims administrator is required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale

## All Other Claims

All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the claims processor. After the claims processor has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the claims processor shall notify you within a reasonable period of time not to exceed 90 days after receipt of the acceptance or denial of the claim. The 90-day period during which a claim for benefits is reviewed may be extended by the case manager or claims processor for up to 90 days, provided the claims processor both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 90-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 90-day period provided the claims processor notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for disability benefits is denied, in whole or in part, the claims processor shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial
- Specific references to the Plan provisions on which the denial is based
- A description of any information or material necessary to perfect the claim
- An explanation of why this material is necessary
- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review, and
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request.

## Effect of Failure to Submit Required Claim Information

If the claims processor determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the claims processor's request for information or upon a demonstration to the satisfaction of the claims processor that under the circumstances the claims processor's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the claims processor, taking into consideration the cause or reason for your failure or refusal, the length of the period and other facts or circumstances the claims processor deems relevant.

## Appealing a Denial — Retiree Standard Medical Option

This information regarding appeals is for the above referenced grandfathered plan. This contains appeal information and requirements specific to the Retiree Standard Medical Option.

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), to be effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Airlines, Inc.- sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

### Important Information about Health Care Provider's Appeals

As a participant in the American Airlines, Inc.-sponsored health and welfare benefit plans, you have the right (under federal law known as ERISA) to appeal adverse benefit determinations through the American Airlines Inc. two-tiered appeal processes, as described in this section of the Guide.

However, your network health care providers, through their provider contracts with the network/claims administrators, also have the option to appeal adverse benefit determinations — to the extent that the adverse benefit determinations affect their benefit payments from the network/claims administrators. Your network health care providers may appeal directly to the network/claims administrator — with or without your knowledge and/or consent. These “provider appeals” are separate and distinct from your appeal rights under ERISA, unless the providers specify that their provider appeals are being filed with the network/claims administrator on your behalf.

If the provider specifies in its appeal that the appeal is being filed on your behalf, the appeal will be considered your ERISA First Level Appeal filed with the network/claims administrator. If the provider does not specify in its appeal that the appeal is being filed on your behalf, the provider's appeal will not be considered as your ERISA First Level Appeal. Thus, if you then decide to appeal the adverse benefit determination, you must file both the First Level and Second Level Appeals, as described in this section of the Guide (or if the appeal is an urgent care appeal, you must file under the “urgent care appeal” process, as described in this section of the Guide).

## Procedures for Appealing an Adverse Benefit Determination

American Airlines, Inc., as Sponsor and Administrator for the Company-sponsored health and welfare benefit plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the claims processor or benefit administrator that rendered the adverse benefit determination. Second Level Appeals are conducted by the Pension Benefits Administration Committee (PBAC) at American Airlines, Inc.

This two-tiered appeal process applies to adverse benefit determinations made on all self-funded benefits or plans, as follows:

- Retiree Standard Medical Option
- Retiree Value Plus Option
- Supplemental Medical Plan

and for administrative, eligibility and enrollment issues on any and all benefits or plans offered through the benefit program for Retirees.

With respect to adverse benefit determinations made on fully insured benefits, as follows:

- Retiree Life Insurance Benefit, and
- Long Term Care Insurance Plan,

the appeal process is defined by the respective insurers (thus, it might not be a two-tiered process). The PBAC cannot render a decision involving fully insured benefits (except for administrative, eligibility and enrollment issues, as stated previously). The insurers make the final appeal determinations for their respective insured coverages/benefits. Each insurer has its own appeal process and you should contact the respective insurer for information on how to file an appeal (see [“Contact Information”](#) in the Reference Information section).

This two-tier appeal process is mandatory for all claims, unless otherwise stated. The one exception to this mandatory two-tier process is an appeal for an urgent care claim. For urgent care claim appeals, only Second Level Appeals are required. No First Level Appeals are necessary.

Retirees must use both levels of appeal (or the Second Level Appeal for urgent care claims) and must exhaust all administrative remedies to resolve any claim issues.

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the claims processor or benefit administrator. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the claims processor or benefit administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination.

To file a First Level Appeal with the claims processor or benefit administrator, please complete an Application for First Level Appeal and include with the Application all comments, document, records and other information relating to the denied/withheld



benefit. (The Application for First Level Appeal provides information about what to include with your appeal. You can download and print this Application from the “Forms” site on Jetnet – Benefits or you can request the form from HR Services. Click on the “Start a Chat” button on the top of this page.

The claims processor or benefit administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing,

- For pre-service claims – within 30 days of receipt of your First Level Appeal
- For post-service claims – within 60 days of receipt of your First Level Appeal
- For urgent care claims – within 72 hours of receipt of your First Level Appeal
- For all other claims for all benefits other than medical, within 60 days of receipt of your First Level Appeal, if the claims processor or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical benefits, it may have an additional 60 to complete your First Level Appeal (the claims processor or benefits administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

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

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the Pension Benefits Administration Committee (“PBAC”) at American Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the PBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the PBAC, please complete an Application for Second Level Appeal and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal).

The PBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 30-day time period allotted for completion of both levels of appeal
- For post-service claims, within the 60-day time period allotted for completion of both levels of appeal
- For urgent care claims, within the 72-hour time period allotted for completion of both levels of appeal.

Example: A participant appeals an adverse benefit determination (post-service claim). For both levels of appeal – First and Second Levels, the combined time taken by the claims processor or benefit administrator and the PBAC to review and complete the

appeals must be no more than 60 days. If the First Level Appeal review is completed by the claims processor or benefit administrator in 15 days, then the PBAC has the remaining 45 days (for a total of 60 days) to complete its review and render its decision.

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the PBAC. Appointed officers of American Airlines, Inc. are on the PBAC. In some cases, the PBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the claims processor or benefit administrator, if appropriate, will be reviewed by the PBAC or its designee(s).

The Second Level of Appeal is mandatory for all other claims, unless otherwise stated in this Guide. American Airlines, Inc. encourages all retirees to use both levels of appeal to exhaust all avenues to resolve any claim issues in the quickest manner possible.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- 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



- In the case of a claim for urgent care, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
  - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method.

You must use and exhaust Plans' administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plans' prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

## Appealing a Denial — Retiree Value Plus Option

This information regarding appeals is for the above referenced non-grandfathered plan. This contains revised appeal information and requirements specific to the Retiree Value Plus Option.

The Patient Protection and Affordable Care Act (PPACA) has changed the rules, requirements and procedures for the processing of group health plan claims and for the reevaluation and determination of adverse benefit determinations (i.e., appeals), to be effective on July 1, 2011; however, there are other rules and provisions that the U.S. Department of Labor is currently reviewing. Those rules carry a compliance date of January 1, 2012. American Airlines, Inc.-sponsored health and welfare benefit plans are, we believe, in compliance with the U.S. Department of Labor's regulations as of their most recent interpretation and guidance.

As the U.S. Department of Labor and the U.S. Department of Health and Human Services continue to provide updated regulations, clarification and guidance on these claim procedures, American Airlines, Inc., as sponsor and administrator of its health and welfare benefit plans, will modify its claim and appeal procedures to comply with these regulations, and will incorporate those regulations in this Guide in a timely manner in compliance with the federal regulations, guidance and interpretation.

### Procedures for Appealing an Adverse Benefit Determination

As a participant in the Company-sponsored health and welfare benefit plans, you have the right to appeal adverse benefit determinations. Adverse benefit determinations include denial, withholding and reduction of benefits described in the plans, and eligibility/enrollment determinations that prevent you or your dependents from obtaining coverage under the plans. Adverse benefit determinations also include rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).

American Airlines, Inc., as Sponsor and Administrator for the Company-sponsored health and welfare benefit plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the claims processor or benefit administrator that rendered the adverse benefit determination. Second Level Appeals are conducted by the Pension Benefits Administration Committee (PBAC) at American Airlines, Inc.

This two-tiered appeal process applies to adverse benefit determinations made on all self-funded benefits or plans, as follows:

- Retiree Standard Medical Option
- Retiree Value Plus Option
- Supplemental Medical Plan

and for administrative, eligibility and enrollment issues on any and all benefits or plans offered through the benefit program for Retirees.

With respect to adverse benefit determinations made on fully insured benefits, as follows:

- Retiree Life Insurance Benefit, and
- Long Term Care Insurance Plan,

the appeal process is defined by the respective insurers (thus, it might not be a two-tiered process). The PBAC cannot render a decision involving fully insured benefits (except for administrative, eligibility and enrollment issues, as stated previously). The insurers make the final appeal determinations for their respective insured coverages/benefits. Each insurer has its own appeal process and you should contact the respective insurer for information on how to file an appeal (see “[Contact Information](#)” in the Reference Information section).

This two-tier appeal process is mandatory for all claims, unless otherwise stated. The one exception to this mandatory two-tier process is an appeal for an urgent care claim. For urgent care claim appeals, only Second Level Appeals are required. No First Level Appeals are necessary.

Retirees must use both levels of appeal (or the Second Level Appeal for urgent care claims) and must exhaust all administrative remedies to resolve any claim issues.

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the claims processor or benefit administrator. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the claims processor or benefit administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination.

To file a First Level Appeal with the claims processor or benefit administrator, please complete an Application for First Level Appeal and include with the Application all comments, document, records and other information relating to the denied/withheld benefit. (The Application for First Level Appeal provides information about what to include with your appeal).

The claims processor or benefit administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing,

- For pre-service claims – within 30 days of receipt of your First Level Appeal
- For post-service claims – within 60 days of receipt of your First Level Appeal
- For urgent care claims – within 72 hours of receipt of your First Level Appeal
- For all other claims for all benefits other than medical, within 60 days of receipt of your First Level Appeal, if the claims processor or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical benefits, it may have an additional 60 to complete your First Level Appeal (the claims processor or benefits administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

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

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the Pension Benefits Administration Committee (“PBAC”) at American Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the PBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the PBAC, please complete an Application for Second Level Appeal and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal.)

The PBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 30-day time period allotted for completion of both levels of appeal
- For post-service claims, within the 60-day time period allotted for completion of both levels of appeal
- For urgent care claims, within the 72-hour time period allotted for completion of both levels of appeal.

Example: A participant appeals an adverse benefit determination (post-service claim). For both levels of appeal – First and Second Levels, the combined time taken by the claims processor or benefit administrator and the PBAC to review and complete the appeals must be no more than 60 days. If the First Level Appeal review is completed by the claims processor or benefit administrator in 15 days, then the PBAC has the remaining 45 days (for a total of 60 days) to complete its review and render its decision.

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the PBAC. Appointed officers of American Airlines, Inc. are on the PBAC. In some cases, the PBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the claims processor or benefit administrator, if appropriate, will be reviewed by the PBAC or its designee(s).

The Second Level of Appeal is mandatory for all other claims, unless otherwise stated in this Guide. American Airlines, Inc. encourages all retirees to use both levels of appeal to exhaust all avenues to resolve any claim issues in the quickest manner possible.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as “relevant” to your claim if it:
  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
- Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
- Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- You are entitled to receive, free of charge, new or additional evidence considered, relied upon or generated by the plan or issuer in connection with your appeal; you shall be afforded a reasonable opportunity to respond to such evidence or rationale
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person’s subordinate
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for urgent care, an expedited review process in which:
  - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
  - All necessary information, including the Plan’s benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method.

You must use and exhaust Plans’ administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plans’ prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

# Compliance with Privacy Regulations

## Notice of Privacy Rights (Health Care Records)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice applies to all active and retired Plan participants of participating AMR Corporation subsidiaries.

This Notice is effective as of February 17, 2010, and applies to health information received about you by the health care components of the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (particularly, the Standard Medical Options, the Value Option, the Out-of-Area Option, the Value Plus Option, the Core Option, the HMOs, Dental Benefits, Vision Insurance Benefits, Health Care Flexible Spending Accounts Benefit, Limited Purpose Health Care Flexible Spending Account, Health Savings Account), the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, TransWorld Airlines Retiree Health and Life Benefits Plan and any other group health plan for which American Airlines, Inc. ("American") serves as Plan Administrator (collectively, the "Plan").

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations") and as amended by the Genetic Information Nondiscrimination Act ("GINA") and the American Recovery and Reinvestment Act ("ARRA"). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your PHI may be made by the Plan:

**For Payment.** Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claims for benefits are covered under the Plan and disclosures to obtain reimbursement under insurance, reinsurance or stop-loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained

by AMR Corporation and its subsidiaries for any of the purposes described above. ARRA requires disclosures for purposes of payment to meet its minimally necessary standard.



**For Treatment.** Your PHI may be used or disclosed by the Plan for purposes of treating you (for example, if your doctor requests information on what other drugs you are currently receiving).

**For the Plan's Operations.** Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances. ARRA requires disclosures for purposes of the Plan's operations to meet its minimally necessary standard. The Plan is prohibited from disclosing any of your PHI that constitutes genetic information (as defined by GINA) for underwriting purposes.

**When Required by Law.** The Plan may also be required to disclose or use your PHI for certain other purposes (for example, if certain types of wounds occur that require reporting or a disclosure to comply with a court order, a warrant, a subpoena, a summons or a grand jury subpoena).

**For Workers' Compensation.** The Plan may disclose your PHI as authorized by you or your representative and to the extent necessary to comply with laws relating to Workers' Compensation and similar programs providing benefits for work-related injuries or illnesses if either, (1) the health care provider is a member of the employer's workforce and provides health care to the individual at the request of the employer, the PHI is provided to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace and the information is required for the employer to comply with OSHA or with laws with similar purposes, or (2) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

**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 revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

**For Appointment Reminders and Health Plan Operations.** Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you, such as case management, disease management, wellness programs or retiree assistance programs.

**To the Plan Sponsor.** Information may be provided to the Sponsor of the Plan, provided that the Sponsor has certified that this information will not be used for any other benefits, retiree benefit plans or employment-related activities.



## Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family's or friend's involvement with your care or payment for that care and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.
- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. State laws may provide you with additional rights or protections.

## Rights You May Exercise

**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 is required to comply with your request not to disclose to another plan any PHI related to any claim for which you paid in full. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: Managing Director, Human Resources Delivery.

**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. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. You may also direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by you.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer:

Managing Director, Human Resources  
Delivery at American Airlines  
Mail Drop 5144-HDQ1  
P.O. Box 619616  
DFW Airport, TX 75261-9616.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

**To Amend.** You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the following officer: Managing Director, Human Resources Delivery at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. You or your personal representative will be required to complete a written form to request amendment of the PHI in your designated record set.

**To Receive an Accounting.** You have the right to receive an accounting of any disclosures of your PHI, other than those 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. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (such disclosures occurring after January 1, 2014, will be required to be included in the accounting); (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

**To Obtain a Paper Copy of This Notice.** An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Plan's Privacy Officer by calling the Managing Director, Human Resources Delivery or by writing to American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

**To Request Confidential Communication.** You have the right to request to receive 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. Such requests should be made to the following officer: Managing Director, Human Resources Delivery, American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

### **A Note About Personal Representatives**

You may exercise your rights through a personal representative (e.g., having your spouse call for you). Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public,
- a signed authorization completed by you,
- a court order of appointment of the person as the conservator or guardian of the individual, or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. 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. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

### **Minimum Necessary Standard**

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the Secretary of the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

The Plan may use or disclose "summary health information" or a limited data set on and after February 17, 2010 to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a "Limited Data Set" that may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set.

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 may file a complaint with the Plan by filing a written notice with the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, Mail Drop 5134- HDQ, P.O. Box 619616, DFW Airport, TX 75261-9616, describing when you believe the violation occurred and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. You may obtain the address of the appropriate regional office of the Office for Civil Rights from the Privacy Complaint Official. If you would like to receive further information, you should contact the Privacy Official, the Managing Director, Human Resources Delivery at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616 or the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, Mail Drop 5134-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. This notice will first be in effect on February 17, 2010. and shall remain in effect until you are notified of any changes, modifications or amendments.



# How AMR Corporation and Its Subsidiaries, Including American Airlines, May Use Your Health Information

American Airlines, Inc. (“American”), administers many aspects of the American Group Health Plans (the “Plans”), which are listed below, on behalf of AMR Corporation and its Subsidiaries, including American Airlines and American Eagle. American, as the plan sponsor and/or plan administrator of the Plans may use and disclose your personal medical information (called “Protected Health Information”) created and/or maintained by the Plans that it receives from the Plans as permitted and/or required by, and consistent with the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Regulations found at 45 CFR Part 164, Subpart A. This includes, but is not limited to, the right to use and disclose a participant’s PHI in connection with payment, treatment and health care operations.

The American Airlines Group Health Plans include the health plan components of:

- The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 515),
- The Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503)
- The Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation Subsidiaries (Plan 515)
- TransWorld Airlines, Inc. Retiree Health and Life Benefits Plan
- Any other Group Health Plan for which American serves as Plan Administrator.

## This Applies To

The information in this section applies only to health-related benefit plans that provide “medical care,” which means the diagnosis, cure, mitigation, treatment or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body, transportation primarily for and essential to medical care and insurance covering medical care. This means that, for the Plans listed above, only the health-related benefits, including medical, prescription drug and mental health, are subject to the limitations described in this section. The EAP is included only to the extent that it is involved in the administration of medical benefits.

## This Section Does Not Apply To

By law, the HIPAA Privacy rules and the information in this section, do not apply to the following benefit plans:

- Life insurance plans
- Workers’ compensation plans, which provide benefits for employment-related accidents and injuries
- Property and casualty insurance.



In addition, AMR Corporation and its subsidiaries may have personal medical information about you that is used for routine employment activities. Medical information held or used by AMR Corporation and its subsidiaries in its employment records for employment purposes is not subject to the HIPAA Privacy rules.

This includes, but is not limited to, medical information, files or records related to compliance with government occupational and safety requirements, the Americans with Disabilities Act (ADA) or other employment law requirements, occupational injury, disability insurance eligibility, sick leave requests or justifications, drug or alcohol screening results, workplace medical surveillance, fitness-for-duty test results or other medical information needed to meet Federal Aviation Administration (FAA), Department of Transportation (DOT) or other company policy or government requirements. Information used by the EAP in its role in administering employment-related programs, such as drug and alcohol testing, is not subject to the HIPAA Privacy rules.

The Plans will disclose PHI to the employer Plan Sponsor (American Airlines or other current or former AMR subsidiary) only upon receipt of a certification by the employer that the plan documents have been amended to incorporate all the required provisions as described below. To the extent that PHI is maintained by one of the Plans, American and all other participating current or former subsidiaries of AMR Corporation for which American administers the Plans have agreed to:

- Not use or further disclose the information other than as permitted or required by this
- Employee or Retiree Benefits Guide, as it may be amended by American from time-to-time or as required by law
- Ensure that any agents, including a subcontractor, to whom the Plans give PHI, agree to the same restrictions and conditions that apply to the employer Plan Sponsor with respect to such information
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or retiree benefit plan of the employer Plan Sponsor, unless that use or disclosure is permitted or required by law (for example, for Workers' Compensation programs) or unless such other benefit is part of an organized health care arrangement with the plan
- To the extent that the employer Plan Sponsor becomes aware that there is any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures, to report such improper uses or disclosures to the Plan
- Make available PHI in accordance with individual rights to review their PHI
- Make available PHI for amendment and consider incorporating any amendments to PHI consistent with the HIPAA rules
- Upon request and to the extent mandated by applicable law, make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules
- Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Plan

- Agree to the same restrictions and conditions that apply to the Plan with respect to such information and enter into Business Associate agreements that comply with the standards for such agreements in the Privacy Regulations
- Enter into limited data set use agreements when the Plan discloses data de-identified in compliance with the requirements for a limited data set as provided in the Privacy Regulations pursuant to a Limited Data Set use or disclosure agreement that meets the standards of the Privacy Regulations
- Terminate any Business Associate agreement or Limited Data Set agreement in the event the Plan becomes aware of a pattern of non-compliance with the terms of the agreement
- Provide the individual who is the subject of the PHI with the opportunity to request restrictions on the PHI's disclosure in accordance with the Plan's policy on requesting restrictions on disclosure of PHI
- Provide the individual who is the subject of the PHI with the opportunity to request confidential communication of PHI from the Plan to the individual in accordance with the Plan's policies and procedures
- Incorporate any amendments or corrections to PHI when such amendment is determined to be required by the Plan's policy on amendment of PHI
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plans
- If feasible, return or destroy all PHI received from the Plans that the employer Plan Sponsor still maintains in any form. The employer Plan Sponsor will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if the return or destruction is not feasible, but the Plans must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible, and
- Ensure that there is an adequate separation between the Plans and the employer Plan Sponsor as will be set forth below.

## Separation of AMR Corporation and Its Subsidiaries, Including American Airlines and the Group Health Plans

The following employees or classes of employees or other persons under the control of American Airlines or another AMR subsidiary shall be given access to PHI for the purposes related to the Plan:

- Health Strategy employees involved in health plan design, vendor selection and administration of the Plans and including the Plan Managers and administrative assistants, secretarial and support staff; as well as any Retirement Strategy employees involved in health plan issues
- Pension Benefits Administration Committee (PBAC), its delegated authority and PBAC Advisory Committee members, due to their role in governing health plan matters, including reviewing and approving plan design changes, rendering appeal decisions and other health plan administrative matters
- Benefits Compliance and the PBAC Appeals group personnel involved in receiving, researching and responding to health plan member appeals filed with the PBAC
- Employee Services personnel and HR Services personnel who assist with day-to-day health plan operations, including Vendor Relations personnel; Retirement Counselors, who assist with retiree medical coverage questions; employees involved in receiving, reviewing and processing Qualified Medical Child Support Orders; and all call center personnel, case coordinators and support staff who assist employees and retirees by answering questions, researching issues and resolving health plan problems, including those administering the Travel program; Leave of Absence coordinators working with health plan enrollment issues; Survivor Support counselors, who assist with health plan issues for survivors; and administrative assistants, secretarial and support staff for the employees listed
- Instructors who train Employee Services and HR Services personnel and thus have access to the call center systems
- HR Records Room personnel responsible for managing benefit plan record storage
- Certain HR Operations Support (HR Ops Support) personnel, but only those involved in investigating health plan fraud or abuse
- Executive Compensation employees, including secretarial and support staff, who assist Company executives and certain other employees with health plan enrollment and payment issues on a day-to-day basis
- Occupational Health Services/Clinical Services employees, including the Corporate Medical Director, EAP Manager, EAP nurses and support staff providing services through the Employee Assistance Program (EAP), including review and approval of mental health and substance abuse claims under the Plans, but only to the extent of their involvement with the Group Health Plans

- Legal department employees, including Employment Attorneys, ERISA counsel, Labor Attorneys and Litigation Attorneys and any other attorneys involved in health plan legal matters, and including paralegals and administrative assistants, Legal Records Room personnel who manage record storage, and Legal IT personnel
- Human Resource (HR) Quality Assurance personnel responsible for financial management of the health plans, including the HR Controller; HR Delivery Operations personnel; health plan Benefits Analysts monitoring financial trends; and their administrative assistants, secretarial and support staff
- Financial Reporting Group employees involved in audits and financial reporting for the group health plans and including the secretarial and support staff for these employees
- Employee Relations personnel, but only those involved in grievance processes or mediation/arbitration processes
- Internal Audit employees, but only for purposes of auditing administrative processes related to the group health plans and including the secretarial and support staff for these employees
- Benefits & Travel Technology personnel who maintain key human resource and benefits systems used to transmit, store or manage PHI and including the secretarial and support staff for these employees
- Information Technology Services (ITS) management personnel, including certain team leads and other designated personnel managing IT infrastructure for systems used by HR and Benefits, including administrative staff, key vendor managers and certain management personnel responsible for disaster recovery procedures
- American Eagle personnel involved in benefit plan administration for that subsidiary
- Privacy Compliance Council and HIPAA Subcommittee members, due to their role in understanding and investigating the flow of PHI for the Group Health Plans, in order to ensure compliance with HIPAA and other privacy rules; and
- On a need-to-know basis, appropriate personnel employed by the employer Plan Sponsor as independent contractors who have executed Business Associate agreements with the Plan to provide other necessary administrative services to the Plan that include, but are not limited to:
  - Insurance agents retained to provide consulting services and obtain insurance quotes
  - Actuaries retained to assess the Plan's ongoing funding obligations
  - Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities
  - Consulting firms engaged to design and administer Plan benefits
  - Financial accounting firms engaged to determine Plan costs; and
  - Claims processing companies engaged to assist the Plan Administrator in the processing of claims made against the Plan.

Access to and use of PHI by such employees and other persons described above is restricted to administration functions for the Plans performed by American or another employer Plan Sponsor, including payment and health care operations.

American and other AMR subsidiaries shall provide an effective mechanism for resolving any issues of non-compliance by such employees or persons. American Airlines' Rules of Conduct as outlined in the Employee Policy Guide, including disciplinary procedures, will apply to such issues of employee non-compliance.

### **Non-compliance Issues**

If the persons described above do not comply with the requirements included in this portion of the Plan, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for the individuals involved in the violation, which sanctions are included in the policy on sanctions for violation of the privacy policies and procedures. The Plan's Policy Regarding Sanctions for Violation of the HIPAA Privacy Policies and Procedures shall be followed along with the Group Health Plan's Policy and Procedure on Mitigation of Damages for Violative Disclosure of Protected Health Information in the event of any violation of the Plan's HIPAA Privacy Provisions in this Article.

### **Organized Health Care Arrangement**

The Plan is part of an organized health care arrangement with the following other health plans maintained by AMR Corporation and its subsidiaries.

The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries with respect to the benefits and benefit options providing health care benefits; the Group Life and Health Benefits Plan for Retirees of Participating AMR Corporation subsidiaries with respect to the benefits and benefit options providing retiree medical benefits, and the

Retiree HMO offered hereunder, the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries, the TransWorld Airlines Retiree Health and Life Benefits Plan and any other Group Health plan for which American serves as Plan Administrator. 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 for the purposes described in the regulations and in the section entitled "Notice of Privacy Rights — Health Care Records" above.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of the Plan's benefits that relate to an individual to whom health care is provided. A disclosure for payment will be limited to the minimally necessary information unless the disclosure occurs in the form of the standard for the electronic transactions. An authorization is not required to permit a disclosure or use for payment unless the disclosure involves psychotherapy notes or the use of the information for marketing.

Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, co-insurance, deductibles and co-payments as determined for an individual's claim)
- Coordination of benefits
- Adjudication of health benefit claims (including appeals and other payment disputes)
- Subrogation of health benefit claims
- Establishing retiree contributions
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Billing, collection activities and related health care data processing
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance)
- Determining medical necessity, experimental or investigational treatment or other coverage reviews or reviews of appropriateness of care or justification of charges (including hospital bill audits)
- Processing utilization review, including precertification, pre-authorization, concurrent review, retrospective review, care coordination or case management
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for such purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan), and
- Obtaining reimbursements due to the Plan.

**Health Care Operations.** A disclosure for Health Care Operations will be limited to the amount minimally necessary. Health Care Operations include, but are not limited to, the following activities:

- Quality assessment
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions
- Rating providers and plan performance, including accreditation, certification, licensing or credentialing activities
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance)



- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies
- Business management and general administrative activities of the Plan, including but not limited to:
  - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  - Participant service, including the provision of data analyses for participants or the plan sponsors
- Resolution of internal grievances, and
- The sale, transfer, merger or consolidation of all or part of the Plan with another covered entity or an entity that following such activity will become a covered entity and due diligence related to such activity.

**Treatment.** Disclosures for treatment are not limited by the minimally necessary requirement if the disclosures are made to, or the requests are made by a health care provider for the treatment of an individual. Treatment means the provision, coordination or management of health care and related services by one or more health care provider(s). Treatment includes:

- The coordination or management of health care by a health care provider and a third party,
- Consultation between health care providers about an individual patient, or
- The referral of a patient from one health care provider to another.

**Limited Data Set.** The Plan may disclose PHI in the form of a limited data set as provided in 45 CFR §164.514(e) provided that the disclosure is in accordance with such provisions.



# Your Rights Under ERISA

## Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

## 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 retiree benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

## Enforce Your Rights

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

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We believe that the Plan that has been developed is only good if you receive the benefits to which you are entitled. We encourage you to come to us if you have any questions or problems. In addition, as already noted, the Plan documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to

\$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## Assistance with Your Questions

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

### For general information contact:

HR Services  
Mail Drop 5141-HDQ1  
American Airlines, Inc.  
P.O. Box 619616  
DFW Airport, Texas 75261-9616  
1-800-447-2000  
Web Address: Jetnet

For information about your claims, contact the appropriate network/claim administrator or benefits plan administrator at the addresses and phone numbers located in the "[Contact Information](#)" in the Reference Information section.

# ***Reference Information***

This section provides useful reference materials. It includes:

- “[Contact Information](#)”
- “[Glossary](#)”
- “[Archives](#)”

## Contact Information

The following table lists the names, addresses, phone numbers and Websites (when available) for these important contacts.

Contact Information Chart		
For Information About:	Contact:	At:
<b>Health and Welfare Benefits</b> <ul style="list-style-type: none"> <li>General questions</li> <li>Eligibility criteria</li> <li>Information updates</li> </ul>	<b>HR Services</b>  American Airlines HR Services, P.O. Box 9741 Providence, RI. 02940	<b>Phone:</b> 1-800-447-2000  <b>Website:</b> <a href="http://www.jetnet.aa.com">www.jetnet.aa.com</a>  <b>Chat live with HR Services:</b> Click on the “Start a Chat” button at the top of the Benefit’s page on Jetnet. Chat hours are 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday
<b>Forms, Guides and Contact Information</b>	Jetnet (Retiree Benefits page)	<b>Website:</b> <a href="http://www.jetnet.aa.com">www.jetnet.aa.com</a>
<b>Medical and Mental Health/Chemical Dependency Coverage</b>		
<b>Network/Claims Administrator</b> <ul style="list-style-type: none"> <li>Retiree Standard Medical Option</li> <li>Retiree Value Plus Option</li> </ul>	<b>Aetna</b> P.O. Box 981106 El Paso, TX 79998-1106	<b>Phone:</b> 1-800-572-2908  <b>Website:</b> <a href="http://www.jetnet.aa.com/jetnet/go/ssoaetna.asp">www.jetnet.aa.com/jetnet/go/ssoaetna.asp</a> <b>Provider directory:</b> <a href="http://www.aetna.com/docfind/custom/americanairlines">www.aetna.com/docfind/custom/americanairlines</a>
	<b>Blue Cross and Blue Shield of Texas</b> P.O. Box 660044 Dallas, TX 75266-0044	<b>Phone:</b> 1-877-235-9258  <b>Website:</b> <a href="http://www.jetnet.aa.com/jetnet/go/ssobcbs.asp">www.jetnet.aa.com/jetnet/go/ssobcbs.asp</a> <b>Provider directory:</b> <a href="http://www.bcbstx.com/americanairlines">www.bcbstx.com/americanairlines</a>
<b>Network/Claims Administrator</b> <ul style="list-style-type: none"> <li>Retiree Standard Medical Option</li> <li>Retiree Value Plus Option</li> </ul>	<b>UnitedHealthcare</b> AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	<b>Phone:</b> 1-800-955-8095  <b>Website:</b> <a href="http://www.jetnet.aa.com/jetnet/go/ssouhc.asp">www.jetnet.aa.com/jetnet/go/ssouhc.asp</a> <b>Provider directory:</b> <a href="http://www.myuhc.com/groups/americanairlines">www.myuhc.com/groups/americanairlines</a>

Contact Information Chart		
For Information About:	Contact:	At:
Retiree HMO	Triple S, Inc. 1441 F.D. Roosevelt Ave. San Juan, PR 00920 Puerto Rico	<b>Phone:</b> 1-787-749-4777  <b>Website:</b> <a href="http://www.ssspr.com/">http://www.ssspr.com/</a>
<b>Maximum Medical Benefit Requests</b>		
<ul style="list-style-type: none"> <li>Retiree Standard Medical Option</li> </ul>	Aetna P.O. Box 981106 El Paso, TX 79998-1106	<b>Phone:</b> 1-800-572-2908
<ul style="list-style-type: none"> <li>Retiree Value Plus Option</li> </ul>	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	<b>Phone:</b> 1-877-235-9258
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	<b>Phone:</b> 1-800-955-8095
<b>Retiree Medical Benefits Billing &amp; Eligibility for Retiree Value Plus Option</b>		
Billing for: <ul style="list-style-type: none"> <li>Retiree Standard Medical Option</li> <li>Retiree Value Plus Option</li> <li>Retiree HMO</li> </ul>	PayFlex Systems USA, Inc. P.O. Box 3039 Omaha, NE 68103-3039	<b>Phone:</b> 1-800-284-4885  <b>Fax:</b> 1-402-231-4310  <b>Website:</b> <a href="http://www.jetnet.aa.com/jetnet/go/SSOHealthHub.asp">www.jetnet.aa.com/jetnet/go/SSOHealthHub.asp</a>
<b>Retiree Medical Benefits Billing &amp; Eligibility for Retiree Standard Medical Option</b>		
Retiree Medical Benefits Eligibility for Retiree Standard Medical Option	HR Services AMR Corporation MD 5141-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	<b>Phone:</b> 1-800-447-2000  <b>Website:</b> <a href="http://jetnet.aa.com/">http://jetnet.aa.com/</a>  Chat live with HR Services: Click on the “Start a Chat” button on the top of this page. Chat hours are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday.

Contact Information Chart		
For Information About:	Contact:	At:
<b>Supplemental Medical Plan</b> (Coverage pays benefits only after you have exhausted your Maximum Medical Benefit under the Retiree Medical Benefit Option)		
<b>HealthFirst TPA</b>	Claims Filing P.O. Box 130217 Tyler, TX 75713-0217	Phone: 1-800-477-2287 Fax: 1-903-509-5729
	Eligibility, Enrollment and Contributions P.O. Box 130187 Tyler, TX 75713-0187	Website: <a href="http://www.hfbenefits.com">www.hfbenefits.com</a> Email Customer Service: <a href="mailto:customerservice@hfbenefits.com">customerservice@hfbenefits.com</a>
<b>CheckFirst</b>		
<b>Predetermination of Benefits</b>	Aetna P.O. Box 981106 El Paso, TX 79998-1106	Phone: 1-800-572-2908
<ul style="list-style-type: none"> <li>Retiree Standard Medical Option</li> </ul>	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	Phone: 1-877-235-9258
<ul style="list-style-type: none"> <li>Retiree Value Plus Option</li> </ul>	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	Phone: 1-800-955-8095
<b>QuickReview</b>		
Pre-authorization for Hospitalization	Aetna P.O. Box 981106 El Paso, TX 79998-1106	Phone: 1-800-572-2908
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	Phone: 1-877-235-9258
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	Phone: 1-800-955-8095
<b>Prescription Drugs</b>		
Mail Order Pharmacy Service	Express Scripts (formerly Medco) P.O. Box 3938 Spokane, WA 99220-3938	Phone: 1-800-988-4125 Website: <a href="http://www.jetnet.aa.com/jetnet/go/ssomedco.asp">www.jetnet.aa.com/jetnet/go/ssomedco.asp</a>
Prescriptions-Prior Authorization	Express Scripts (formerly Medco)	

Contact Information Chart		
For Information About:	Contact:	At:
	8111 Royal Ridge Parkway Suite 101 Irving, TX 75063	
Prescriptions - Retail	Express Scripts (formerly Medco) Member Services Phone Inquiries	
Filing Retail Prescription Claims	Express Scripts (formerly Medco) P.O. Box 2160 Lee's Summit, MO 64063-2160	
Life Insurance		
Retiree Insurance Benefit	MetLife American Airlines Customer Unit P.O. Box 3016 Utica, NY 13504-3016	Phone: 1-800-638-6420
Long-Term Care Insurance Plan		
Long-Term Care Insurance Plan	MetLife Long-Term Care 57 Greens Farms Road Westport, CT 06880	Phone: 1-888-526-8495
Continuation of Coverage (COBRA)		
Continuation of Coverage (COBRA) Administrator	Benefit Concepts Inc. P.O. Box 246 Barrington, RI 02806-0246	Phone: 1-866-629-0274  Website: <a href="http://www.benefitconcepts.com">www.benefitconcepts.com</a>
Other Information		
Pension Benefits Administration Committee Information about appeals	PBAC American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	1-817-967-1412



# Glossary

IMPORTANT NOTICE: THIS GLOSSARY IS DESIGNED TO BE USED IN BOTH THE EMPLOYEE BENEFITS GUIDE (FOR ACTIVE EMPLOYEES) AND THE RETIREE BENEFITS GUIDE (FOR RETIRED EMPLOYEES). NOT ALL OF THE DEFINITIONS APPLY

TO BOTH ACTIVE AND RETIRED EMPLOYEES—DIFFERENCES, IF ANY, BETWEEN DEFINITIONS FOR ACTIVE EMPLOYEES AND RETIRED EMPLOYEES WILL BE NOTED IN THE GLOSSARY ITEMS.

## Accidental injury

An injury caused by an outside and unforeseen traumatic force, independent of all other causes.

## Alternative and/or Complementary medicine

Diverse medical health care systems, practices and products that are not considered to be part of conventional medicine. Alternative and/or Complementary medicine have not been proven safe and effective through formal scientific studies and scientific clinical trials conducted by the

National Institutes of Health (National Center for Complementary and Alternative Medicine) or that are not recognized in Reliable Evidence as safe and effective treatments for the illness or injury for which they are intended to be used. Alternative and/or Complementary medicine lack proof of safety and efficacy through formal, scientific studies or scientific clinical trials conducted by the National Institute of Health or similar organizations recognized by the National Institute of Health. Some examples of Complementary and/or alternative medicine are:

- Mind-body interventions (meditation, mental healing, creative outlet therapy, etc.)
- Biological therapies (herbal therapy, naturopathic or homeopathic treatment, etc.)
- Manipulative or body-based treatment (body-work, massage, rolfing, etc.)
- Energy therapies (qi-gong, magnetic therapies, etc.)

These examples are not all inclusive, as new forms of alternative and/or Complementary medicine exist and continue to develop. Other terms for Complementary and/or alternative medicine include (but are not limited to) unconventional, non-conventional, unproven and irregular medicine or health care.

## Alternative mental health care centers

These centers include residential treatment centers and psychiatric day treatment facilities (see definitions in this section).

## Ancillary charges

Charges for hospital services, other than professional services and room and board charges, to diagnose or treat a patient. Examples include fees for X-rays, lab tests, medicines, operating rooms and medical supplies.

**Assignment of benefits (medical, dental, vision coverages and other health benefits)**

You may authorize the Network/Claims Administrator to directly reimburse your medical service provider for your eligible expenses by requesting that the provider accepts assignment of benefits. When you request assignment of benefits, you avoid paying the full cost of the medical service up front, filing a claim and waiting for reimbursement. Your medical service provider generally files your medical claim for you if he or she accepts assignment. However, not all Network/Claims Administrator will accept assignments for out-of-network providers.

**Bereavement counseling**

Counseling provided by a licensed counselor (usually a certified social worker, advanced clinical practitioner or clinical psychologist) of a hospice facility to assist the family of a dying or deceased plan participant with grieving and the psychological and interpersonal aspects of adjusting to the participant's death.

**Chemical dependency treatment center**

An institution that provides a program for the treatment of alcohol or other drug dependency by means of a written treatment plan that is approved and monitored by a physician. This institution must be:

- Affiliated with a hospital under a contractual agreement with an established system for patient referral
- Accredited by the Joint Commission on Accreditation of Health Care Organizations
- Licensed, certified or approved as an alcoholism or other drug dependency treatment program or center by any state agency that has the legal authority to do so

**Chiropractic care**

Medically necessary diagnosis, treatment or care for an injury or illness when provided by a licensed chiropractor within the scope of his or her license.

**Co-insurance**

A percentage of eligible expenses. You pay a percentage of the cost of eligible expenses and the Medical Benefit Option or Retiree Medical Benefit Option pays the remaining percentage.

**Common accident** (for AD&D Insurance for active employees/dependents—not applicable to retirees)

With respect to Accidental Death and Dismemberment (AD&D) Insurance, this refers to the same accident or separate accidents that occur within one 24-hour period.

**Company**

Participating AMR Corporation subsidiaries.

**Convalescent or skilled nursing facility**

A licensed institution that:

- Mainly provides inpatient care and treatment for persons who are recuperating from illness or injury
- Provides care supervised by a physician
- Provides 24-hour nursing care by nurses who are supervised by a full-time registered nurse
- Keeps a daily clinical record of each patient
- Is not a place primarily for the aged or persons who are chemically dependent
- Is not an institution for rest, education or custodial care

**Conventional Medicine**

Medical health care systems, practices and products that are proven and commonly accepted and used throughout the general medical community of medical doctors, doctors of osteopathy and allied health professionals such as physical therapists, registered nurses and psychologists. Conventional medicine has been determined safe and effective, and has been accepted by the National Institutes of Health, United States Food and Drug Administration, Centers for Disease Control or other federally recognized or regulated health care agencies, and has been documented by Reliable Evidence as both safe and effective for the diagnosis and/or treatment of the specific medical condition. Other terms for conventional medicine include (but are not limited to) allopathy, western, mainstream, orthodox and regular medicine.

**Co-pays**

The specific dollar amount you must pay for certain covered services when you use in-network providers.

**Custodial care**

Care that assists the person in the normal activities of daily living and does not provide any therapeutic value in the treatment of an illness or injury.

**Deductible**

The amount of eligible expenses a person or family must pay before a benefit or plan will begin reimbursing eligible expenses.

**Dental**

Dental refers to the teeth, their supporting structures, the gums and/or the alveolar process.

**Detoxification**

24-hour medically directed evaluation, care and treatment of drug-and alcohol addicted patients in an inpatient setting. This care is evaluated for coverage under the Medical Benefit and Retiree Medical Benefit. The services are delivered under a defined set of physician-approved policies and procedures or clinical protocols.

**Developmental therapy**

Therapy for impaired childhood development and maturation. Examples of developmental therapy include treatments that assist a child in walking, speech proficiency (word usage, articulation and pronunciation) and socialization skills. Developmental therapy is not considered rehabilitative unless the function had been fully developed and then lost due to injury or illness.

**Durable medical equipment (DME)**

Medical equipment intended for use solely by the participant for the treatment of his or her illness or injury. DME is considered to be lasting and would have a resale value. DME must be usable only by the participant and not the family in general.

The equipment must be medically necessary and cannot be primarily for the comfort and convenience of the patient or family. A statement of medical necessity from the attending physician and a written prescription must accompany the claim. DME includes (but is not limited to): prosthetics, casts, splints, braces, crutches, oxygen administration equipment, wheelchairs, hospital beds and respirators.

**Eligible medical expenses or eligible expenses**

The benefit or plan covers the portion of regular, medically necessary services, supplies, care and treatment of non-occupational injuries or illnesses up to the usual and prevailing fee limits, when ordered by a licensed physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage.

**Emergency**

An injury or illness that happens suddenly and unexpectedly and could risk serious damage to your health or is life threatening if you do not get immediate care. Examples include poisoning, drug overdose, multiple trauma, uncontrolled bleeding, fracture of large bones, head injury, severe burns, loss of consciousness and heart attacks.

**Enter-on-duty date** (applies to active employees only)

The first date that you were on the U.S. payroll of American Airlines, Inc. as a regular employee.

**Experimental or investigational service or supply**

A service, drug, device, treatment, procedure or supply is experimental or investigational if it meets any of the following conditions:

- It cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished.
- Reliable Evidence shows that the drug, device, procedure or medical treatment is the subject of ongoing phase I, II or III clinical trials or under study (or that the consensus of opinion among experts is that further studies or clinical trials are necessary) to determine its maximum tolerated dose, toxicity, safety or efficacy,

both in diagnosis and treatment of a condition and as compared with the standard means of treatment or diagnosis.

- The drug or device, treatment or procedure has FDA approval, but is not being used for an indication or at a dosage that is accepted and approved by the FDA or the consensus of opinion among medical experts.
- Reliable Evidence shows that the medical service or supply is commonly and customarily recognized throughout the physician's profession as accepted medical protocol, but is not being utilized in accordance or in compliance with such accepted medical protocol and generally recognized standards of care.
- The drug, device, treatment or procedure that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure that is used with a patient informed consent document that was reviewed and approved (or that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function.
- A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- The treatment or procedure is less effective than conventional treatment methods.
- The language appearing in the consent form or in the treating hospital's protocol for treatment indicates that the hospital or the physician regards the treatment or procedure as experimental.

### **Explanation of benefits (EOB)**

A statement provided by the Network/Claims Administrator that shows how a service was covered by the Plan, how much is being reimbursed and what portion, if any, is not covered.

### **Flexible Benefits** (applies to active employees only)

The Company-sponsored benefits program for American Airlines, Inc. regular employees in the following workgroups:

- Management/Specialist
- Support Staff
- Agent/Representative/Planner
- TWU-Represented (retirees represented by the Transport Workers Union, AFL-CIO)

**Freestanding surgical facility**

An institution primarily engaged in medical care or treatment at the patient's expense and that is:

- Eligible to receive Medicare payments
- Supervised by a staff of physicians and provides nursing services during regularly scheduled operating hours
- Responsible for maintaining facilities on the premises for surgical procedures and treatment
- Not considered part of a hospital

**Home health care agency**

A public or private agency or organization licensed to provide home health care services in the state in which it is located.

**Home health care**

Services that are medically necessary for the care and treatment of a covered illness or injury furnished to a person at his or her residence.

**Hospice care**

A coordinated plan of care that treats the terminally ill patient and family as a family unit. It provides care to meet the special needs of the family unit during the final stages of a terminal illness. Care is provided by a team of trained medical personnel, homemakers and counselors. The hospice must meet the licensing requirements of the state or locality in which it operates.

**Incapacitated child**

A child who is incapable of self-support because of a physical or mental condition and who legally lives with you and wholly depends on you for support.

**Individual annual deductible** An annual deductible is the amount of eligible expenses you must pay each year before your medical option coverage will start reimbursing you. After you satisfy the deductible, your selected Medical Option or Retiree Medical Option pays the appropriate percentage of eligible covered medical services.

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**Infertility treatment or testing**

Includes medical services, supplies and procedures for or resulting in impregnation and testing of fertility or for hormonal imbalances that cause male or female infertility (regardless of the primary reason for the hormone therapy). Infertility treatment or testing includes, but is not limited to: all forms of in-vitro fertilizations, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversals of tubal ligations or vasectomies, drug therapy, including drug treatment for ovarian dysfunction and infertility drugs, such as Clomid, Pergonal, Lupron or Repronex.

**Inpatient or hospitalization**

Medical treatment or services provided at a hospital when a patient is admitted and confined, for which a room and board charge is incurred.

**Life event**

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

**Loss or impairment of speech or hearing**

Those communicative disorders generally treated by a speech pathologist, audiologist, or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both and that fall within the scope of his or her license or certification.

**Mammogram or mammography**

The X-ray examination of the breast using equipment dedicated specifically for mammography, including the X-ray tube filter compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views of each breast. This also includes mammography by means of digital or computer-aided (CAD) systems.

**Maximum medical benefit (applies to Retiree Medical Benefit only)**

The maximum medical benefit is the most a benefit or plan will pay for eligible expenses during the entire time a person is covered by the benefit or plan.

When you have exhausted your maximum medical benefit your retiree medical coverage terminates and you do not receive the annual restoration of benefits (if applicable). You are not eligible for any future increases in the maximum medical benefit. Even if you have exhausted your maximum medical benefit, your covered eligible dependents may continue their existing medical coverage under the benefit or plan up to their maximum medical benefit (as long as they meet the eligibility requirements). If your selected medical coverage (for both the retiree and covered eligible dependents) is one of the self-funded medical coverages and you and/or your eligible dependents exhaust the maximum medical benefit under the self-funded medical coverage, neither you nor your eligible dependent may elect other retiree medical coverage, including the Retiree HMO. If you and your covered eligible



dependents exhaust the maximum medical benefit, you may continue other coverages/benefits as applicable. The medical coverage is the only coverage that terminates for the affected individual.

**Maximum Out-of-Network Reimbursement Program (MNRP)** (applies only to the Retiree Value Plus Option)

This program is based upon federal Medicare reimbursement limits; that is Medicare-allowable (what the federal Medicare program would allow as covered expense) charge for all types of medical services and supplies. Under the Retiree Value Plus Option, the Eligible Expense for out-of-network services and supplies is not to exceed 140% of the Medicare fee allowance. Most health care facilities and medical providers accept MNRP as a valid reimbursement resource.

MNRP applies to all out-of-network medical services and supplies, including, but not limited to: hospital, physician, lab radiology, medical supply expenses and medication expenses administered, purchased or provided in a physician's office, clinic or other health care facility.

**Medical benefit**

The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of an illness or injury.

**Medical necessity or medically necessary**

A medical or dental service or supply required for the diagnosis or treatment of a non-occupational, accidental injury, illness or pregnancy. The benefit or plan determines medical necessity based on and consistent with standards approved by the Network/Claims Administrator's medical personnel. To be medically necessary, a service, supply, or hospital 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 used instead of the service, supply or treatment given
- 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. A service is not considered medically necessary if it is educational, experimental or unproven in nature. In the case of hospital confinement, the length of confinement and hospital services and supplies are considered medically necessary to the extent the Network/Claims Administrator determines them to be:

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

**Mental health disorder**

A mental or emotional disease or disorder.

**Multiple surgical procedures**

One or more surgical procedures performed at the same time as the primary surgical procedure, which are medically necessary but were not the primary reason for surgery.

**Network**

A group of physicians, hospitals, pharmacies and other medical service providers who have agreed, via contract with the Network/Claims Administrator to provide their services at negotiated rates.

**Nurse**

This term includes all of the following professional designations:

- Registered Nurse (R.N.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)

Nursing services are covered only when medically necessary and the nurse is licensed by the State Board of Nursing, and if the nurse is not living with you or related to you or your spouse.

**Original Medicare**

The term used by the Centers for Medicare and Medicaid Services (CMS) to describe the coverage available under Medicare Parts A and B.

**Outpatient**

Medical treatment or services provided at a hospital or clinic for a patient who is not admitted to the hospital for an overnight stay.

**Over-the-counter (OTC)**

Drugs, products and supplies that do not require a prescription by federal law.

**Physician**

A licensed practitioner of the healing arts acting within the scope of his or her license.

The term does not include:

- You
- Your spouse
- A parent, child, sister or brother of you or your spouse

The term physician includes the following licensed individuals:

- Audiologist
- Certified social worker or advanced clinical practitioner
- Chiropractor
- Clinical psychologist
- Doctor of Osteopathy (DO)
- Doctor of Medicine (MD)
- Nurse anesthetist
- Nurse practitioner
- Physical or occupational therapist
- Physician Assistant (PA)
- Speech pathologist or speech language pathologist or therapist

**Post-fund, post-funding, post-funded** (applies to Retiree Medical Benefits only)

A mechanism by which retirees pay for the cost of their Retiree Medical Benefit. To post-fund their Retiree Medical Benefit means that these retirees are required to pay ongoing monthly contributions during their retirement in order to obtain and maintain Retiree Medical Benefit coverage. All employees who retired on or after November 1, 2012 are required to post-fund their Retiree Medical Benefit.

**Pre-fund, pre-funding, pre-funded**

A mechanism by which employees gained eligibility for and paid for their Retiree Medical Benefit. To pre-fund your Retiree Medical Benefit means that you elected to pre-pay contributions during your active working years. When you retired, if you had met the pre-funding requirements (and the other requirements for eligibility in the Retiree Medical Benefit), you were able to enter the Retiree Standard Medical Option at no further contribution cost to you.

**Preferred Provider Organization (PPO)** (applies to the Medical Benefits and Dental Benefit for active employees, and to the Retiree Medical Benefits)

A group of physicians, hospitals and other health care providers who have agreed to provide medical services at negotiated rates.

**Pre-retirement monthly salary** (applies to Retiree Life Insurance Benefit, which is available for employees who retired on or before October 31, 2012)

Your base monthly salary in effect on your retirement date. Pre-retirement monthly salary does not include overtime pay, premium pay, shift differential, bonuses, approved expenses or other allowances. Your pre-retirement monthly salary may determine the amount of your Retiree Life Insurance coverage

**Prescriptions**

Drugs and medicines that must, by federal law, be requested by a physician's written order and dispensed only by a licensed pharmacist. Prescription drugs also include injectable insulin and prenatal vitamins during pregnancy.

**Primary care physician**

An in-network physician who specializes in family practice, general practice, internal medicine or pediatrics and who may coordinate all of the in-network medical care for a participant in the Medical Benefit Options, HMO Options, Retiree Medical Benefit Options, and Retiree HMO Option. (An OB/GYN can also be considered a PCP.)

**Primary surgical procedure**

The principal surgery prescribed based on the primary diagnosis.

**Prior authorization for prescriptions**

Authorization by the prescription drug program administrator that a prescription drug for the treatment of a specific condition or diagnosis meets all of the medical necessity criteria.

**Proof of Good Health or Statement of Health** (also referred to as Evidence of Insurability or EOI, and applies to active employee only)

Some benefit plans and coverages require you to provide proof of good health when you enroll for coverage at a later date (if you do not enroll when you are first eligible), or when you increase levels of coverage. Proof of good health (or a Statement of Health) is a form you must complete and return to the appropriate benefit Plan Administrator when you enroll in the Optional Short Term Disability Insurance (this insurance is not for Pilots), the American Airlines, Inc. Long Term Disability Plan (this plan is not for Pilots or TWU-Represented employees) or increase levels of Life Insurance for you or your spouse/DP. Life Insurance coverage amounts will not increase, nor will you be enrolled in the Optional Short Term Disability Insurance, or the American Airlines, Inc. Long Term Disability Plan until the Plan Administrator approves your Statement of Health Form and you pay the initial/additional contribution for coverage.

If a death or accident occurs before your enrollment for coverage or increase in coverage is processed, the amount of Life Insurance, Accidental Death & Dismemberment (AD&D) Insurance, or VPAI coverage that will be payable is your current amount of coverage or default coverage (if you have not enrolled following your initial period of eligibility). You may obtain a Statement of Health Form from the Plan Administrator for each benefit plan.

**Provider**

The licensed individual or institution that provides medical services or supplies. Providers include physicians, hospitals, pharmacies, surgical facilities, dentists and other covered medical or dental service and supply providers.

**Psychiatric day treatment facility**

A mental health institution that provides treatment for individuals suffering from acute mental health disorders. The institution must:

- Be clinically supervised by a physician who is certified in psychiatry by the American Board of Psychiatry and Neurology
- Be accredited by the Program of Psychiatric Facilities of the Joint Commission on the Accreditation of Health Care Organizations
- Have a structured program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the program's treatment format.

**Psychiatric hospital**

An institution licensed and operated as set forth in the laws that apply to hospitals, which:

- Is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons, either by or under the supervision of a physician
- Maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided
- Is licensed as a psychiatric hospital
- Requires that every patient be under the care of a physician
- Provides 24-hour nursing service

The term psychiatric hospital does not include an institution, or that part of an institution, used mainly for the following:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial care
- Educational care

**Qualifying event**

A change in your status that causes you to lose eligibility for Medical, Dental, Vision and Health Care Flexible Spending Account coverages (these are for active employees and their dependents)—or for Retiree Medical Benefits (for retirees and their dependents) and would qualify you to be eligible for COBRA Continuation of Coverage. Qualifying events are defined by COBRA. For examples, see [Continuation of Coverage](#) in the Additional Rules for Retiree Medical Benefits section of this Retiree Benefits Guide.

**Regular employee** (this refers to active employees only)

An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, or a Flexible Work Arrangement, depending on the business needs of the organization or the terms of the applicable labor agreement. A regular employee is eligible for the benefits and privileges that apply to his or her workgroup or as outlined in his or her applicable labor agreement.

**Reliable Evidence**

Reliable Evidence includes:

- Published reports and articles in the authoritative peer reviewed medical and scientific literature including: American Medical Association (AMA) Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Dispensing Information and National Institutes of Health, U.S. Food and Drug Administration
- Written protocols used by the treating facility studying substantially the same drug, device, medical treatment or procedure
- Written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure
- Reliable Evidence does not include articles published only on the Internet

**Residential treatment center**

A facility that offers 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The center must be licensed by the state as a psychiatric residential treatment center and accredited by the Joint Commission on the Accreditation of Health Care Organizations.

**Restoration of medical maximum benefit under the Retiree Standard Medical Option Only**

Each January 1, you are eligible to have part of your medical maximum benefit automatically restored. The amount restored will be the lesser of:

- \$3,500, or
- The amount necessary to restore your full medical maximum benefit

**Restorative and rehabilitative care**

Care that is expected to result in an improvement in the patient's condition and restore reasonable function. This is focused on a function that you had at one time and then lost, due to illness or injury. After improvement ceases, care is considered to be maintenance and is no longer covered.

**School/Educational Institution**

A school/educational institution, including a vocational or technical school, if the student is enrolled:

- In a program leading to a degree or certificate
- On a full-time basis (generally 12 credit hours at colleges and universities)

**Secondary surgical procedure**

An additional surgical procedure performed at the same time as the primary surgical procedure, which is medically necessary but was not included in the primary surgical procedure.



**Special dependent**

A foster child or child for whom you are the legal guardian.

**Summary Plan Description**

Document provided to participants outlining terms of employer sponsored group coverage. In our efforts to provide you with multimedia access to benefits information, American Airlines, Inc. has created online versions of the Summary Plan Descriptions for our benefit plans and they are included in this Guide. The Summary Plan Descriptions are also the formal legal plan documents. If there is any discrepancy between the online version and the official hard copy of this Guide, then the official hard copy, plus official notices of plan changes/updates will govern.

**Timely pay, timely payment**

This term applies to plans, benefits, or options for which you are required to pay ongoing contributions or premiums in order to maintain coverage under the plans, benefits, or options. Timely payment means payment of the full amount of contribution or premium due by the payment due date or before the end of the 30-day grace period for payment (as reflected on the invoice or payment coupon). Payments rejected due to insufficient funds (e.g., “bounced” checks) are also considered not timely paid.

**Urgent/immediate care**

Care required because of an illness or injury that is serious and requires prompt medical attention, but is not life threatening. Examples of situations that require urgent care include high fevers, flu, cuts that may require stitches or sprains.

**Unproven Service, Supply or Treatment**

Any medical or dental service, supply or treatment that has not been proven both safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications, or has not been proven both safe and effective by Reliable Evidence.

**Usual and prevailing fee limits**

The maximum amount that the Plan will consider as an eligible expense for medical or dental services and supplies. For purposes of the Plan, “usual and prevailing” shall be equivalent with the terms “usual and customary”, “reasonable and customary”, and “usual, reasonable and customary”. The primary factors considered when determining if a charge is within the usual and prevailing fee limits:

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

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](http://www.fairhealthus.org).



Information from this FairHealth database is utilized by American's medical administrators in determining the eligible expense for medical or dental services and supplies provided by nonparticipating and out-of-network providers.

Usual and prevailing 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 usual and prevailing fee determination, the Network/Claims Administrator looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (often referred to as "coding fragmentation" or "unbundling") usually results in higher physician's charges that if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

## Archives

Prior versions of your Retiree Benefits Guide are available at  
<http://www.aacareers.com/ebg/Archive/default.asp>.