

***American Airlines, Inc. Group Life and Health Benefits Plan
American Airlines, Inc. Long-Term Disability Plan
American Airlines, Inc. Long-Term Care Insurance Plan***

Employee Benefits Guide for Ground Employees

Effective January 1, 2015

2015 Employee Benefits Guide for Ground Employees

American Airlines, Inc. (the “Company”) provides you with a comprehensive benefits package designed to help you meet the health and insurance needs of you and your eligible family members.

To help you make the most of those benefits, this Guide, which serves as both the legal plan document and the summary plan description, describes the provisions of the American Airlines, Inc. Group Life and Health Benefits Plan, the American Airlines, Inc. Long-Term Disability Plan, and the American Airlines, Inc. Long-Term Care Insurance Plan (collectively, the “Plans”) effective January 1, 2015 for ground employees.

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

[General Eligibility](#) section

[General Enrollment](#) section

[Life Events](#) section

[Additional Health Benefit Rules](#) section

[Plan Administration](#) section

[Reference Information](#) section, including a [Contacts](#) list, the [Glossary](#), and the [Archives](#) of older versions of the Guide.



About This Guide

This Employee Benefits Guide (“Guide”) is for the eligible employees, as described in “Employee Eligibility” section, in the following groups (collectively referred to as “Ground Employees”):

- Agents/Representatives/Planners (ARP); including Home-Based Representatives or Level 84 Premium Services Representatives (HBR) employed by the Company
- Officers, Management/Specialists, Support Staff (OMSS) employed by the Company and US Airways, Inc.
- Transport Workers Union-represented employees (TWU) employed by the Company
- Communication Workers of America (CWA), International Association of Machinists and Aerospace Workers (IAM) and Transport Workers Union (TWU) represented employees employed by US Airways, Inc.¹

This Guide describes separate health and welfare benefit plans sponsored by American Airlines, Inc. and established under and operated pursuant to the Employee Retirement Income Security Act (ERISA) and other applicable federal laws. These health and welfare

¹ This guide serves as the Legal Plan Document and Summary Plan Description for CWA, IAM and TWU represented employees employed by US Airways, Inc. who are eligible for and/or enroll in the CORE medical option.

benefit plans are provided through a §125 cafeteria plan arrangement, as described and controlled by Internal Revenue Code, and US Treasury regulations. US Airways, Inc. is a participating employer of the plans.

This Guide serves as the legal plan documents and the summary plan description (SPD) for the following benefit program (collectively the “Plans”):

- American Airlines Inc. Group Life and Health Benefits Plan (the “Group Life and Health Plan”)
- American Airlines, Inc. Long-Term Disability Plan
- American Airlines, Inc. Long-Term Care Plan

The Company, or its authorized delegate, 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 incurred before the change.

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.

The Company believes that certain HMO Medical Options under the Group Life and Health Plan are grandfathered health plan(s), under the Patient Protection and Affordable Care Act (PPACA). The following chart specifies which medical benefit options in this plan are grandfathered, and which are not:

Medical Option	Grandfathered or Non-Grandfathered
STANDARD Medical Option	Non-Grandfathered
CORE Medical Option	Non-Grandfathered
VALUE Medical Option	Non-Grandfathered
Out-of-Area Medical Option	Non-Grandfathered
HMO Medical Options	May be either, depending upon the HMO; contact your specific HMO for this information

As permitted by the PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan or policy might not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions about non-grandfathered Medical Options can be addressed to:

American Airlines, Inc.
PO Box 619616
Mail Drop 5134, HDQ1
Dallas-Fort Worth Airport, TX 75261-9616

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections apply to non-grandfathered health plans.

Voluntary Offerings Provided by American Benefits Consulting (ABC)
<p>The Company 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, the Company facilitates the post-tax payroll deductions to pay for these voluntary offerings. The Company does not assume any plan sponsorship for the Voluntary Offerings provided by American Benefits Consulting (ABC). The details of these offerings are not included in or governed by this Guide. Please go to www.AAaddedbenefits.com or call 1-855-550-0706 to contact ABC directly for information about these benefits.</p>

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How do I determine my eligibility?

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Eligibility During Leaves of Absence and Disability

Family Medical Leave of Absence (FMLA) or Military Leave

Eligibility After Age 65

Dependent Eligibility by Benefit

Medical Coverage

Dental and Vision Coverage

Child Life Insurance and Child Accidental Death and

Dismemberment (AD&D) Insurance

Spouse Life Insurance and Spouse Accidental Death and

Dismemberment (AD&D) Insurance

Dependent Eligibility Requirements

Determining a Child's Eligibility

Dependents of Deceased Employees

Determining a Spouse (SP), Domestic Partner (DOMESTIC PARTNER (DP) or

Common Law Spouse Eligibility

Employees Married to Other Employees

Other Information

Ineligibility

This section outlines general eligibility requirements.

Employee Eligibility

This Guide applies only to employees described in the "About This Guide" section. However, the Company's Plans cover employees that are described in this Guide and other Guides. Eligibility for the Company's Plans for all active employees is set forth below.

All active, full-time or part-time employees of American Airlines, Inc. and US Airways, Inc. are eligible for the health and welfare benefits offered by the Company, but excluding (i) flight attendants employed by US Airways, Inc. and represented by Association of Professional Flight Attendants ("APFA"), (ii) mechanics and related fleet service and maintenance employees employed by US Airways, Inc. and represented by the International Association of Machinists and Aerospace Workers ("IAM"), and passenger service employees employed by US Airways, Inc. and represented by the Communications Workers of America and the International Brotherhood of Teamsters ("CWA-IBT"), and (iii) any individual or employee specifically listed as ineligible in the "Ineligibility" section below.

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

Ineligibility

The following individuals are not eligible to participate in the health and welfare benefits programs described in this Guide:

A leased employee, as defined in section 414(n) of the Internal Revenue Code.

This includes any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service, or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker; this term includes any of the following former classifications:

Temporary employee

- If a temporary worker becomes a regular employee, and meets all of the other requirements to participate in the Benefits Program without a break in service, 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 the individual to retroactive group health and welfare benefits.

- **Provisional employee**
- **Associate employee**

Independent contractor

Any person:

- Who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion)
- Who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate
- Who tells the Company he/she is an independent contractor, or is employed by another company while providing services to the Company, even if the worker is, or may be reclassified at a later date as, an employee of the Company by the courts, the IRS or the DOL.

Determination of Eligibility for Health Benefit Options

You are eligible for the STANDARD Medical Option, CORE Medical Option, VALUE Medical Option or an HMO only if you reside where the Network/Claim Administrator or HMO offers a network. Your eligibility is determined by the ZIP code of your alternate address on record.

If you do not live in an area with an administrator or HMO, then the Company will advise you on your eligibility for the Out-Of-Area Medical Option.

You are allowed to list two addresses:

1. a permanent address (for tax purposes or for your permanent residence)
2. an alternate address (for a P.O. Box or street address other than your permanent residence).

If you do not have an alternate address listed in the [Update My Information](#) page of Jetnet, your benefit eligibility is based on your permanent address.

Benefits Effective Date for New Hires

Benefits are effective on your date of hire if you enroll within your given enrollment window.

If you are not at work on the date coverage would otherwise begin, coverage is effective on the date you are actively at work, unless you are not actively at work due to a health condition; then your health coverage is effective on the date coverage would otherwise begin.

If you do not enroll for coverage when you are first solicited for benefits, you will receive “default coverage,” as described in the “Default Coverage” section below.

After you receive your enrollment information, you may enroll through the American Airlines [Benefits Service Center](#).

Proof of Eligibility

American Airlines Group 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 termination of employment, benefit or plan coverage termination, and efforts to recover any overpaid benefits.

Whether you:

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

You must submit proof of the dependents' eligibility to American Airlines Benefits Service Center within 31 days of the date you request their enrollment. Examples of proof demonstrating your dependents' eligibility for coverage include: official government-issued birth certificates, adoption papers, marriage licenses, etc., as detailed in the [Dependent Eligibility Criteria](#).

Important: Your dependents' coverage and enrollment will be effective only after you have timely requested their enrollment and timely provided satisfactory proof of eligibility.

Proof of Good Health

The following coverage requires proof of good health:

- **As a new employee:** Employee Voluntary Term Life Insurance (in amounts greater than the 1x basic coverage)
- **As an existing employee** (if you waived coverage when first eligible):
 - Employee Voluntary Term Life Insurance (if you wish to increase coverage)
 - Optional Short-Term Disability Insurance
 - Long-Term Disability

- **As a new or existing employee:** Spouse Term Life Insurance (all levels of coverage)

Proof of good health is determined based on the information you supply in the Statement of Health. For coverage requiring proof of good health, coverage becomes effective only after MetLife approves your Statement of Health and your first contribution is paid, either by you or through payroll deductions.

Eligibility During Leaves of Absence and Disability

You may be eligible to continue certain benefits for yourself and your eligible dependents for a period of time during a leave, subject to the specific rules governing leaves of absence. The type of leave you take determines the cost of your benefits (i.e., whether you and the Company share the cost of the benefits or you pay the full cost of benefits). In order to continue your benefits during a leave of absence, you must timely pay the required contributions for your benefits during your leave.

Your leave of absence begins when your payroll transaction record is changed to reflect that you are on a leave of absence.

American Airlines Benefits Service Center will send you a notification acknowledging your leave, instructing you where to find important information regarding your benefits while on your leave of absence, describing how to process the “going on leave of absence” Life Event, and asking you to decide if you will or will not continue your benefits while on leave.

Once you record your Life Event and benefit elections on the American Airlines [Benefits Service Center](#), it will display a confirmation statement showing your choices, the monthly cost of benefits, covered dependents, etc.

If you have not received the notification within 10 days of being placed on a leave, immediately contact American Airlines Benefits Service Center for help.

If you elect not to continue your benefits during your leave of absence or if you fail to timely pay the required monthly contributions for coverage, your benefits will terminate for the duration of your leave of absence. When you return to active employee status, you may reactivate most of your benefits. However, some benefits will require you to supply proof of good health in order to reactivate (e.g., Voluntary Term Life Insurance Benefit, Disability Benefits).

Family Medical Leave of Absence (FMLA) or Military Leave

If your leave is an FMLA or military leave, special rules govern your rights to continue or resume your benefits.

During the first 12 months of an unpaid sick or injury-on-duty leave of absence you may keep the same health and welfare benefits you had by continuing to pay your share of the cost.

If your FMLA continues beyond 12 months, you will be solicited for COBRA continuation coverage for up to a period of 36 months.

New

When you are on a military leave you may continue health coverage for you and your eligible dependents. For more information see Continuation of Coverage for Employees in the Uniformed Services.

You may review a detailed description of each leave of absence or consult with your supervisor/manager.

Eligibility After Age 65

When you reach age 65 (or your spouse reaches age 65), you (or your spouse) must notify the Company in writing if you want Medicare to be your only coverage.

If you elect Medicare as your only coverage: your Company-sponsored active medical coverage will terminate, including coverage for your dependents.

If your spouse elects Medicare as his or her only coverage, only your spouse's Company-sponsored active coverage will terminate.

Note: This section does not refer to the Retiree Medical Benefit coverage.

Dependent Eligibility by Benefit

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

Medical Coverage

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

- Legally married spouse, Company-recognized Domestic Partner, or common law spouse. Company-recognized Domestic Partners and their children may be eligible for coverage under your HMO. Contact your HMO directly for eligibility criteria. Company-recognized Domestic Partners and their children are not eligible to participate in Flexible Spending Accounts.
- End of month that Child turns age 26 (as defined below in the Determining a Child's Eligibility section)
- Incapacitated child age 26 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

New

Coverage for an Incapacitated Child — Medical Coverage Only

**Below you will find the critical steps that you, as the employee, are responsible for requesting incapacitated status for your disabled child. **

An "incapacitated child" age 26 or older is eligible for continuation of coverage if all of the following criteria are met:

- The child was already continuously covered as your dependent under this Plan before reaching age 26.
- The child is mentally or physically incapable of self-support.
- You file a [Statement of Dependent Eligibility for Incapacitated Child](#):
- Inform your Network/Claim Administrator within 31 days prior to the date coverage would otherwise end

- For HMOs: Contact your HMO for the time limit
- Your Network/Claim 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/Claim Administrator from time-to-time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your Network/Claim Administrator determines the child is no longer incapacitated. If you elect to drop coverage for your child, you may not later reinstate it.
- Either the child maintains legal residence with you and is wholly dependent on you for maintenance and support, or you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Dental and Vision Coverage

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

- Legally married spouse, Company-recognized Domestic Partner, or common law spouse.
- End of month that Child turns age 26 (as defined below in the Determining a Child's Eligibility section)
- Incapacitated child age 26 or over who maintains legal residence with you and is wholly dependent upon you for maintenance and support.
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

New

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

An eligible dependent is an individual (other than the employee covered by the Benefits Program) who lives in the United States, Puerto Rico or the U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. Child means the following:

- End of month that Child turns age 26 (as defined below in the Determining a Child's Eligibility section)

New

The term Child does not include any person who:

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

For Texas residents "child" means the following for Life Insurance ONLY:

- Your grandchild who is under age 25, unmarried and who was able to be claimed by you as a dependent for Federal Income Tax purposes at the time you applied for Life Insurance.
- A child will be considered your adopted child during the period you are party to a suit in which you are seeking the adoption of the child.

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

An eligible dependent is an individual (other than the employee covered by the benefits program) who lives in the United States, Puerto Rico or the U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways: Your legally married spouse, Company-recognized Domestic Partner, or common law spouse not employed by the Company.

Dependent Eligibility Requirements - Generally (All Benefits)

Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered spouse, Company-recognized Domestic Partner, or common law spouse as defined by the Plan
- Stepchild
- 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 wholly dependent on you for maintenance and support.
 - You must submit a [Statement of Dependent Eligibility for Special Dependent Form](#) to American Airlines Benefits Service Center and American Airlines Benefits Service Center must approve the form. (Complete and return the form to American Airlines Benefits Service Center, along with copies of the official court documents awarding you custodianship or guardianship of the child.) You must receive confirmation from American Airlines Benefits Service Center notifying you of its determination.
 - American Airlines Benefits Service Center will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 31 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by American Airlines Benefits Service Center. If you submit the request after the 31day time frame, the child will not be added to your coverage.

You are required to provide coverage 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 "Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice" under "[Qualified Medical Child Support Orders \(QMCSO\) Procedures](#)" in the *Additional Health Benefit Rules* section).

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

Flexible Spending Account section) if you claim your parent or grandchild as a dependent on your federal income tax return.

Dependents of Deceased Employees

If you have elected medical coverage for your spouse and children and you die as an active employee, your dependents' medical coverage will continue for 90 days at no contribution cost.

Your covered dependents are also eligible to continue medical, dental, and vision coverage for up to 36 months under COBRA Continuation Coverage at the full COBRA rate, if they had these benefits at the time of your death. See "[Continuation of Coverage – COBRA Continuation](#)" in the *Additional Health Benefit Rules* section. The 90 days of coverage are part of the 36 months of COBRA coverage.

If you are over age 55 but not yet 65 and working as an active employee with 10 or more years of seniority, your surviving spouse is eligible for Retiree Medical Benefits if you would have been eligible for Retiree Medical Benefits if you had retired on your date of death.

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

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 the Company's benefits.

Opposite-Sex Spouse

Your opposite-sex spouse means the lawful wife of a male employee or the lawful husband of a female employee, provided such marriage has been licensed by a governmental authority. If you and your spouse were married outside the United States or its territories and protectorates, 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 changes to the federal Defense of Marriage Act (DOMA), effective January 1, 2014, the Plan(s) recognize same-sex marriage for purposes of benefit eligibility, and your same-sex spouse now has the same eligibility for and coverage that is available to any other company employee and his/her opposite-sex spouse. For your same-sex spouse to be eligible for coverage under the Plan(s) you and your same-sex spouse must have been legally married in one of the U.S. states, districts, territories, protectorates or other countries or jurisdictions that have legalized same-sex marriage. 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.

Common Law Spouse

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

Although criteria vary by state, states generally require the following criteria to be satisfied in order for an individual to be recognized as a common law spouse:

- 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.

Domestic Partner

Company-recognized Domestic Partners are defined 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 American Airlines Benefits Service Center (see "[Contact Information](#)" in the *reference Information* section).

Company-recognized Domestic Partners and their eligible dependent children are eligible to be covered under the following benefits or Plans:

- STANDARD, VALUE, CORE, and OUT-OF-AREA Medical Benefit Options
 - Note: Home-Based Representatives or Level 84 Premium Services Representatives are only eligible for the CORE Medical Benefit Option.
- Dental Benefit
- Vision Insurance Benefits
- Spouse and Child Life Insurance Benefits
- Retiree Medical Benefits
- Accident Insurance Benefits

Under current laws, A Company-recognized Domestic Partner's health care expenses may not be reimbursed from:

Your Health Care FSA, your Limited Purpose Health Care FSA, or your Health Savings Account, unless the Domestic Partner is your tax dependent.

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.

Unless your Domestic Partner and your Domestic Partner's children are your tax dependents, the Company will be required to report the value of any Medical coverage provided to them as additional wages on your Form W-2. Please see the Domestic Partner Enrollment Kit for further details.

Employees Married to Other Employees

Employees of the Company or a Participating Employer who are married to other employees of the Company or a Participating Employer ("Married Employees") have the option of being covered: (1) under one employee's medical, dental and/or vision benefits as an employee and a dependent; or (2) separately as employees under the medical, dental and/or vision benefits. Married Employees may elect to be covered under one employee's benefits during Annual Benefits Enrollment or at the time of a Life Event.

During Annual Benefits Enrollment, the employee who is electing to cover both employees for medical, dental and/or vision benefits will add the spouse/Company Recognized Domestic Partner as a dependent (and any other eligible dependents) in the "Dependents" area of the online [Benefits Service Center](#). The employee who will be covered as a dependent must elect No Coverage.

The following benefits, plans and voluntary benefits must still be maintained independently:

- Accident Insurance Benefits
- Employee Term Life Insurance Benefits
- Retiree Medical Benefits (when available)
- Health Reimbursement and Health Incentive Accounts

Employees married to other employees in other workgroups or other American Airlines Group Inc. subsidiaries that are not Participating Employers in the Plan should carefully consider available Options and costs before making any decisions. If you have any questions regarding your benefits under this situation, please contact American Airlines Benefits Service Center (see "[Contact Information](#)" in the *Reference Information* section).

Change in spouse's employment: If employees choose to maintain separate benefits and one spouse ends his or her employment with the Company or a Participating Employer or moves to a subsidiary that does not offer the benefits program, the spouse who changes his or her employment is eligible for coverage as a dependent (if he or she waives coverage under the subsidiary's health plan). However, if an employee is discharged for gross misconduct not related to any existing health condition for which treatment was provided for under the Plans, benefits or Options, he or she cannot be covered as a dependent of the active employee.

Retirees married to active employees: Retirees married to active employees are only eligible for coverage as dependents of active employees if they are not enrolled in Retiree Medical Benefits. The benefits available and benefit limits, if any, are defined by the active

employee's coverage. When the actively working spouse retires, each retiree is covered under his or her own retiree health benefit, if applicable. Please refer to the Retiree Health and Life Benefits Guide for Retirees of Participating American Airlines Group Subsidiaries (Retiree Benefits Guide or RBG) for information specific to each workgroup.

Spouse on leave of absence: When Company-provided benefits terminate for a spouse on a leave of absence, the spouse may continue to purchase coverage as an employee on leave or elect to be covered as the dependent of the actively working spouse, but not both. The actively working spouse's health coverage determines the health benefit coverage for all dependents. Because a leave of absence is a Life Event (see the [Life Events](#) section), the actively working spouse may make changes to his or her other coverages.

The actively working spouse may elect to:

- Add the spouse on leave as a dependent
- Cover only eligible dependent children
- Cover both the spouse and children
- Enroll himself or herself, and the spouse and children as dependents

If an employee elects to be covered as a dependent during a leave of absence, the following conditions apply:

Optional coverages the person elected as an active employee end, unless payment for these coverages is continued while on leave.

Proof of good health may be required to re-enroll or increase optional coverages upon the employee's return to work.

Provided the employee on leave makes timely payments for benefits, Company-provided coverage (where the Company pays its share of the cost and the employee on leave pays his/her share) will continue for the first twelve months of leave of absence for employees on family, sick, injury-on-duty or maternity leaves. These employees cannot be covered as dependents. For other types of leaves, the employee must timely pay the full cost of his/her coverage while on leave.

Other Information Related to Married Employees

Eligible dependent children:

- Children cannot be covered under both parents' Medical Benefit Options.
- If one spouse is covered under the Benefit Option, the children are covered under the parent who participates in the Benefit Option.
- If both spouses are covered under the Benefit Option, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year.

The parent(s) covered under the Benefit Option can contact American Airlines Benefits Service Center to elect otherwise.

Contributions: Both you and your spouse may elect to be covered independently under the Benefit Options for which you are each eligible. If Married Employees choose to be covered under one employee, the contributions for the employee covering both will reflect either Employee plus Spouse/Domestic Partner, Employee plus Child(ren) or Employee plus Family, whichever is applicable. This applies to contributions for the Medical and Vision Benefits. Contributions for benefits that still must be maintained independently, such as Life Insurance (see the [Life Insurance](#) section), will be applied appropriately and payroll-deducted from each employee's paycheck.

Family deductibles: If the parents choose different Options, the family deductible applies to the employee covering the children and the individual deductible applies separately to the other parent.

Accident coverage: Both you and your spouse or Company-recognized Domestic Partner must enroll for yourselves (for married employees without children) — you cannot be covered both as an employee and as a dependent. For married employees with dependents, you cannot be covered as an employee and as a dependent; therefore, only the parent who elects medical coverage for the dependent children may elect family accident coverage, and the spouse or Company-recognized Domestic Partner, must waive coverage. If your spouse or Company-recognized Domestic Partner works for an American Airlines Group Inc. subsidiary that does not offer accident coverage, you may elect Voluntary AD&D Insurance Benefit for him or her (see the [Accident Insurance Benefits](#) section).

Flexible Spending Accounts: Contributions to the Health Care Flexible Spending Account and/or the Limited Purpose Spending Account (see the [Health Care Flexible Spending Account](#) section) and Dependent Care Flexible Spending Account (see the [Dependent Care Flexible Spending Account](#) section) may be made by one or both spouses. Either of you may submit claims to the account. However, if only one spouse is making contributions to the account, claims must be submitted under that person's Social Security number. If you both make contributions to the Dependent Care Flexible Spending Account, you may only contribute the maximum amount federal law permits for a couple filing a joint tax return. For the Health Care Flexible Spending Account or Limited Purpose Spending Account, you may both make contributions up to \$2,500 per employee.

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

Health Savings Account: You may not file claims for expenses incurred by a Company-recognized Domestic Partner who is an employee of the Company or a Participating Employer (or his or her dependents) under your Health Savings Account according to federal law, unless he or she is your tax dependents.

Retiree Medical Benefits: If you are both eligible for benefits, you must each maintain your Retiree Medical Benefits as individuals. By maintaining your Retiree Medical Benefits separately, the death of your spouse or a divorce would not jeopardize your eligibility for Retiree Medical Benefits.

Rescission in Event of Fraud

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

What benefits could I be eligible for?

- Medical Benefit Options
 - Self-Funded Medical Benefit Options Overview
 - STANDARD Medical Option with HRA
 - VALUE Medical Option with HIA
 - CORE Medical Option with HSA
 - Out-of-Area (OOA) with HRA
 - Covered Expenses
 - Excluded Expenses
 - Network/Claims Administrator
 - CheckFirst (Predetermination of Benefits)
 - QuickReview (Pre-Authorization)
 - Health Maintenance Organizations (HMOs)
- Mental Health and Substance Abuse
- EAP
- Wellness Resources
- Dental Benefits
- Vision Benefits
- Flexible Spending Accounts
 - Health Care Flexible Spending Account (HCFSA)
 - Limited Purpose Flexible Spending Account (LPFSA)
 - Dependent Care Flexible Spending Account (DCFSA)
- Life Insurance Benefits
 - Basic Term Life
 - Voluntary Term Life
 - Spouse and Child Term Life
- Accidental Insurance Benefits
 - Accidental Death and Dismemberment (AD&D)
 - Other Accident Insurance
- Disability Benefits
 - Optional Short-Term (OSTD)
 - Long-Term Disability

Medical Benefit Options Overview

The Company offers you the opportunity to enroll in medical coverage for you and your eligible dependent(s) that provides protection in the event of illness or injury. You may choose from several Medical Options or you may waive coverage completely. If you do not enroll in or waive medical coverage, you will be automatically enrolled in the default coverage described in the “Default Coverage” section below.

These are the available Medical Benefit Options: STANDARD Medical Benefit Option, CORE Medical Benefit Option, VALUE Medical Benefit Option, OUT-OF-AREA Medical Benefit Option and HMO Medical Benefit Option (if available in your area).

Medical Benefit Options

You may choose one of the following Medical Benefit Options:

- **The STANDARD, VALUE and CORE Medical Benefit Options** are self-funded by the Company. Blue Cross and Blue Shield of Texas and UnitedHealthcare (UHC) administer these Benefit Options. Reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company or a trust.
- **The OUT-OF-AREA (OOA) Medical Option.** The OOA Medical Benefit Option is self-funded by the Company. UnitedHealthcare (UHC) administers this Benefit Option. Reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company or a trust. If you do not live within any network service area, the Company will offer enrollment in the OOA Medical Benefit Option.
- **Health Maintenance Organization (HMO) Medical Benefit Option.** HMOs are insured Medical Benefit Options whose covered services are paid by the HMO. The Company pays a flat monthly premium and the HMO pays for all covered services. HMOs are offered in many locations, but their coverage and features vary by location. If you live in a location where an HMO is offered, it will be indicated as an available Medical Benefit Option when you enroll online. You must go to each HMO's website to read and understand the details of their benefit coverage.

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

You may choose from the following coverage levels:

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

If you are married to an employee of the Company or a Participating Employer, see "[Employees Married to Other Employees](#)" in the *General Eligibility* section for more information.

You will not be able to file claims under a Medical Benefit Option of any American Airlines Group subsidiary if you waive coverage.

Your dependents must be enrolled in the same Medical Benefit Option that you are enrolled in. You cannot enroll your dependents in a different Medical Benefit Option. If you waive coverage, your dependents cannot be enrolled in coverage. See the [General Eligibility](#) section for additional rules.

You can only enroll in a Medical Benefit Option when you are first hired, during Annual Benefits Enrollment, or if you experience a recognized Life Event during the year (see the [Life Events](#) section).

Medical Benefit Options Comparison

The table in this section provides a summary of features under the STANDARD Medical Benefit Option, CORE Medical Benefit Option, VALUE Medical Benefit Option and OUT-OF-AREA Medical Benefit Option. Benefits are available for eligible expenses that are medically necessary. Reimbursement for in-network services are based on network-contracted rates while out-of-network services utilized before June 1, 2015 must be within the usual and prevailing (U&P) fee limits. See the [Glossary](#) section for a definition of U&P. For out-of-network services utilized on or after June 1, 2015, out-of-network reimbursements will be based on the Maximum Out-of-Network Charge (MOC). See the Glossary section for a definition of MOC.

For the OUT-OF-AREA Medical Benefit Option, benefits are available for eligible expenses that are medically necessary and must be within the usual and prevailing (U&P) fee limits. See the [Glossary](#) section for the definition of U&P.

The table shows the amount or percentage you pay for eligible expenses. You also pay any amounts not covered by the Medical Benefit Options. You also must satisfy your selected Medical Benefit Option's calendar year deductible amount before benefits are payable for medical services subject to co-insurance. There are certain covered expenses that do not require satisfaction of the deductible and these are referenced in the following chart.

As you review the benefit comparison tables, keep the following in mind:

- For the STANDARD Medical Benefit Option, VALUE Medical Benefit Option and OUT-OF-AREA Medical Benefit Option, copayments and coinsurance apply to the Out-Of-Pocket maximum. However, once your Out-Of-Pocket maximum has been satisfied you will still pay applicable co-payment amounts, until the PPACA Out-of-Pocket maximum limit is reached. The Out-Of-Pocket maximum does not include deductibles, amounts not covered, or amounts exceeding the U&P (or MOC) fee limits for out-of-network benefits.
- For the CORE Medical Benefit Option the out-of-pocket maximum does include the deductible and co-insurance.
- Retail pharmacy and mail order prescription drug co-insurance amounts apply to the Out-Of-Pocket maximum for all Medical Benefit Options. Once your Out-Of-Pocket maximum has been satisfied you will still pay applicable co-payment amounts. You do not have to meet your deductible for pharmacy co-insurance to apply.

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

Due to the Patient Protection and Affordable Care Act (PPACA), with amendments made by the Health Care and Education Reconciliation Act (HCERA), signed into law March 23, 2010, the government has published recommendations of what services should be covered with no cost-sharing as preventive care. [<https://www.healthcare.gov/preventive-care-benefits/>] Contact your Network/Claim Administrator for more information about covered services. Please see "Covered Expenses" for more information.

All services must be medically necessary. Medical necessity is determined by the Network/Claim Administrator.

Important Facts For You To Know About The Medical Benefit Options Comparison Chart...

Co-Insurance	This is the percentage of covered expense that you're required to pay. When you see a percentage referenced in the Medical Benefit Options Comparison chart, it is the co-insurance that is your financial responsibility. Medical co-insurance applies once the deductible has been met.
Co-Payment, Co-Pay	This is the flat dollar amount of covered expense that you're required to pay. When you see a flat dollar amount in the Medical Benefit Options comparison chart (\$100 or less, and associated with physician's visits, maternity care, emergency room expense, etc.), it is the co-pay that is your financial responsibility.
Deductible	For most covered expenses, you must meet your elected Medical Benefit Option's annual (calendar year) deductible amount before you start receiving benefits. Certain covered expenses, however, may be payable even if you haven't yet met your deductible for the calendar year. The Medical Benefit Options Comparison chart references those particular expenses that are payable whether or not you've met your deductible. Unless the covered expenses in the chart specifically state that benefits are payable even if you haven't met your deductible for the calendar year, you should know that you have to meet your deductible before benefits can be paid. Only covered expenses can be used to meet your deductible amount.
HIA - Health Incentive Account (applies to the VALUE Medical Benefit Option only)	If you participate in the Healthmatters Rewards wellness program, dollars that you earn will be deposited into your HIA. You can use these funds on a tax-free basis to help offset out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. If you do not earn Healthmatters Rewards, you will not have an HIA. Funds must be in the account before you can use them.

Important Facts For You To Know About The Medical Benefit Options Comparison Chart...

<p>HSA- Health Savings Account (applies to the CORE Medical Benefit Option only)</p>	<p>This account allows you to deposit funds that you may use to help pay your health care costs on a tax-free basis, now or in the future. If you want to make pre-tax contributions, you must establish your HSA through Benefits Service. If you establish your HSA through any other financial institution, your contributions will be after-tax and you generally can deduct them when you file your Form 1040 to avoid income taxation (the amounts will still be subject to FICA/FUTA taxes). If you participate in the Healthmatters Rewards wellness program, dollars that you earn will be deposited into your HSA. You can use these funds to help offset out-of-pocket expenses (deductible, co-pay, co-insurance). Funds must be in the account before you can use them. See the CORE Medical Option section for more information.</p>
<p>HRA - Health Reimbursement Account (applies to the STANDARD and OUT-OF-AREA Medical Benefit Options only)</p>	<p>If you participate in the Healthmatters Rewards wellness program, dollars that you earn will be deposited into your HRA. You can use these funds on a tax-free basis to help offset out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. If you do not earn Healthmatters Rewards, you will not have an HRA. Funds must be in the account before you can use them.</p>
<p>Flexible Spending Accounts HCFSA – Health Care Flexible Spending Account LPFSA- Limited Purpose Flexible Spending Account (applies to the CORE Benefit Option only)</p>	<p>You can allocate pre-tax dollars to your HCFSA and can use those funds on a tax-free basis to pay out-of-pocket expenses (deductible, co-pay, co-insurance). The entire amount of your election is available as soon as the first salary reduction is credited to the account. See the Flexible Spending Account section for more information.</p> <p>You can allocate pre-tax dollars to your LPFSA if you are enrolled in the CORE Medical Option, and can use those funds on a tax-free basis to pay for dental and vision out-of-pocket expenses (deductible, co-pay, co-insurance). The entire amount of your election is available as soon as you make the first deposit into the account. See the Flexible Spending Account section for more information.</p> <p>A minimum contribution amount of \$120 will be required at the time of enrollment if you elect an HCFSA or an LPFSA.</p>
<p>Medical Necessity</p>	<p>ALL of the medical services and supplies described in the Medical Benefit Options Comparison chart must be covered by the Plan and be medically necessary in order to be determined to be covered expenses. If those services and supplies are not medically necessary, they cannot be covered by the Plan.</p>
<p>Out-Of-Pocket/Out-Of-Pocket Maximum</p>	<p>This is the portion of covered expenses that you have to pay during the Plan year. Out-of-Pocket maximum never includes expenses that are excluded from coverage, and expenses that</p>

Important Facts For You To Know About The Medical Benefit Options Comparison Chart...

exceed the Usual and Prevailing, or Maximum Out-of-Network Charge limits for out-of-network services.

For the STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options, medical and prescription out-of-pocket expenses include your co-pays and co-insurance, but DO NOT INCLUDE your deductible. In-network and out-of-network out-of-pocket maximums are accumulated separately. Co-pays for in-network services will continue up to the PPACA out-of-pocket maximum limit is met; this limit for self-only coverage is \$6,600 and for family coverage is \$13,200. When you reach the PPACA out-of-pocket maximum, the Plan begins paying 100% of any further covered in-network expenses for the remainder of the calendar year.

For the CORE Medical Benefit Option, out-of-pocket expenses that count toward your out-of-pocket maximum include the deductible and your medical and prescription co-insurance. In-network and out-of-network out-of-pocket maximums are accumulated separately.

New
Limits

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
HSA- Health Savings Account	Not Available		You can contribute up to: Employee: \$3,350 including up to \$250 in earned Healthmatters rewards; Employee + Child(ren): \$6,650 including up to \$250 in earned Healthmatters rewards; Employee + Covered SP/DP Family: \$6,650 including up to \$500 in earned HM rewards (\$250 employee and \$250 SP/DP); Employee + Family: \$6,650 including up to \$500 in earned Healthmatters rewards (\$250 employee and \$250 SP/DP)		Not Available		Not Available
Your elected employee contributions to the HSA can be used on a tax-free basis to pay medical expenses that the CORE Medical Benefit Option cannot. The IRS sets the annual maximum amounts you can contribute and the expenses that are payable/not payable from the HSA on a tax-free basis. You can earn employer contributions by earning Healthmatters rewards. If you elect your HSA with YSA, the contributions can be deducted pre-tax from your paychecks, or you can establish an HSA with an external financial institution (these must be after tax contributions that you can later deduct on your Form 1040). See the CORE Medical Benefit Option section for details on how this account works. Note that the HSA maximum contribution referenced above takes into account Healthmatters Rewards that you are eligible to earn in 2015.							
HRA - Health Reimbursement Account	You can earn Healthmatters Rewards up to: Employee: \$250 + SP/DP: \$250		Not Available		Not Available		You can earn Healthmatters Rewards up to: Employee: \$250 + SP/DP: \$250
HIA - Health Incentive Account	Not Available		Not Available		You can earn Healthmatters Rewards up to: Employee: \$250 + SP/DP: \$250		Not Available

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
HCFSA - Health Care Flexible Spending Account	Up to \$2500		Not Available		Up to \$2500		Up to \$2500
FACTS ABOUT THE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (HCFSA) You can make pre-tax deductions from your paychecks to your HCFSA (up to \$2,500) to help pay (on a tax-free basis) for your medical, dental, and vision expenses (examples are deductibles, coinsurance, copays, amounts exceeding your medical, dental, vision coverage limits, etc.). The IRS sets the annual maximum amounts you can contribute, and dictates what types of expenses are payable/not payable from an HCFSA. See your EBG in the Flexible Spending Account section for details on how this account works.							
(LPFSA)—Limited Purpose Flexible Spending Account	Not Available		Up to \$2,500		Not Available		Not Available
FACTS ABOUT THE LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT (FSA) You can make pre-tax deductions from your paychecks to your LPFSA (up to \$2,500) to help pay (on a tax-free basis) for dental and vision care expenses (examples are deductibles, coinsurance, copays, amounts exceeding your dental and vision coverage limits, vision correction surgery, dental implants, etc.). The IRS sets the annual maximum amounts you can contribute, and dictates what types of expenses are payable/not payable from an LPFSA. See the EBG under “Health Care Flexible Spending Accounts” for details on how this account works.							
Annual (Calendar Year) Deductibles, Out-of-Pocket Limits, and Maximum Medical Benefit							
Individual annual deductible	\$800	\$3,000	\$2,000	\$4,000	\$350	\$1,550	\$800
FACTS ABOUT THE INDIVIDUAL ANNUAL DEDUCTIBLE • For most covered expenses subject to co-insurance, the deductible must be met before benefits are payable. To satisfy the deductible, you must pay all of the covered expenses yourself (except as noted below) until the amount you’ve paid equals the deductible amount shown for the calendar year under your elected Medical Benefit Option—only then will the Medical Benefit Option begin to pay its percentage of the covered expenses. • <i>Flat dollar amounts (copay)</i> for covered expenses (for physician visits, emergency room, maternity care), and prescription drug coinsurance amounts do NOT count toward your satisfaction of the deductible for the calendar year. • For some of the Medical Benefit Options, some types of <i>in-network</i> expenses that are subject to copay (such as preventive care, certain physician visits, and certain prescription drugs) are paid by the Medical Option <i>even if you’ve not yet satisfied your deductible</i> .							
Family annual deductible	\$2,400	\$9,000	\$4,000	\$8,000	\$1,050	\$4,650	\$2,400
FACTS ABOUT THE FAMILY ANNUAL DEDUCTIBLE For most covered expenses subject to co-insurance, the deductible must be met before benefits are payable. The family deductible limits apply if more than one person is covered in the Medical Benefit Option. STANDARD/VALUE/OOA Medical Benefit Option: • The family deductible is satisfied when you have paid all you and your covered dependents’ covered expenses equal to the individual deductible for a covered person. • If there are two people covered under family coverage then, each person must reach the individual deductible amount before the family deductible is satisfied. • If there are three or more people covered under your family coverage, a maximum of three members of your family have to reach the individual deductible amount before the family deductible is satisfied. • Once a minimum of two members and a maximum of three members of your family have met their individual deductibles, the family deductible is deemed satisfied and then the Medical Benefit Option will begin to pay its percentage of							

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	

the covered expenses.

- You do not have to meet the family deductible amounts under the STANDARD, VALUE or OOA Medical Benefit Options in order for your Medical Benefit Option to begin paying its percentage for a family member that has met his/her individual deductible.

If the Medical Benefit Option requires you and your covered dependents to pay a flat dollar amount (copay) of the covered expense (for physician visits, emergency room, maternity care), prescription drug coinsurance, the dollar amount you must pay will NOT count toward your satisfaction of the deductible.

CORE Medical Benefit Option: If more than one person is covered under the CORE Medical Option, the Family deductible must be met before the CORE Medical Option starts to pay benefits. Covered expenses from any and all covered persons can be used to meet the family annual deductible.

Some types of in-network expenses (such as preventive care, certain physician visits, and certain prescription drugs) are paid by the Medical Option even if you've not yet satisfied your deductible.

New

Individual annual out-of-pocket maximum	\$2,000 per covered person	\$6,000	\$4,000	\$12,000	\$2,000 per covered person	\$6,000	\$2,000 per covered person
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FACTS ABOUT THE INDIVIDUAL OUT-OF-POCKET MAXIMUM

The OOP maximum is the point where the coverage will pay 100% of the covered expense for the remainder of the calendar year) with certain exceptions described below.

• **STANDARD, VALUE and OUT-OF-AREA Medical Benefit Options:** Copays and coinsurance counts toward the individual annual out-of-pocket maximum. Even after your Out-of-Pocket maximum is met, you will continue to pay copays until the PPACA out-of-pocket maximums have been met. Then coverage pays benefits at 100% for the remainder of the calendar year. The deductible DOES NOT COUNT toward the annual out-of-pocket maximum.

• **CORE Medical Benefit Option:** Covered expenses you must pay to satisfy your annual deductible **ARE USED** to meet the individual annual out-of-pocket maximum (the limit where this coverage pays benefits at 100% for the remainder of the calendar year). If more than one person is covered, the family out-of-pocket maximum must be satisfied before expenses are payable at 100%.

Only each covered individual's portion of covered expenses can be used to meet his/her individual annual out-of-pocket maximum

New

Family out-of-pocket maximum	\$5,000	\$15,000	\$8,000	\$24,000	\$5,000	\$15,000	\$5,000
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FACTS ABOUT THE FAMILY OUT-OF-POCKET MAXIMUM

• **STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options:** Co-pays and coinsurance count toward the family out-of-pocket maximum. Even after your Out-of-Pocket maximum is met, you will continue to pay copays until the PPACA out-of-pocket maximums have been met. Then coverage pays benefits at 100% for the remainder of the calendar year. The deductible DOES NOT COUNT toward the annual out-of-pocket maximum.

• **CORE Medical Benefit Option:** You and your covered dependents' deductibles and covered medical expenses that require you to pay a *percentage* of the cost (*co-insurance*) ARE counted toward the satisfaction of this maximum (the point where the coverage will pay 100% of the covered expenses for the remainder of the calendar year).

If more than one person is covered, the family out-of-pocket maximum must be satisfied before expenses are payable at 100%.

Individual medical	Unlimited for all self-funded Medical Benefit Options
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Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
<i>maximum benefit</i>							
Preventive Care							
<i>Annual routine physical exams</i>	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you
<i>Well-child care</i>	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you
Medical Care							
<i>Physician's office visit (including X-ray and lab work)</i>	\$30 per visit; deductible does not apply	40%	20%	40%	\$20 per visit; deductible does not apply	40%	\$30 per visit; deductible does not apply
<i>Specialist's office visit</i>	20%	40%	20%	40%	\$40 per visit; deductible does not apply	40%	20%
<i>Retail/ Convenience Clinic visit</i> (i.e., clinics inside of CVS, Walgreens, Wal-mart, etc.) Including lab, x-ray and other charges	20%	40%	20%	40%	\$40 per visit; deductible does not apply	40%	20%
<i>Urgent care clinic, lab, x- ray, and other charges made by the urgent care clinic</i>	20%	40%	20%	40%	\$40 per visit; deductible does not apply	40%	20%
<i>Gyne- cological care</i> (see Mammogram for coverage information on routine screening or diagnostic mammograms, See Pregnancy for coverage)	No cost to you for annual preventiv e exam \$30 per visit to an OB/GYN diagnostic ; deductible does not apply	40% for treatment of illness/ injury and preventive exam	No cost to you for annual preventive exam 20% for treatment of illness/injur y	40% for treatment of illness/injur y and preventive exam	No cost to you for annual preventive exam \$20 per visit to an OB/GYN diagnostic; deductible does not	40% for treatment of illness/injury and preventive exam	No cost to you for annual preventive exam \$30 per visit to an OB/GYN diagnostic; deductible does not apply

New
for
CORE

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
<i>information on pregnancy and maternity care)</i>					apply		
Preventive Pap tests: routine screening	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you
Diagnostic Pap tests: test performed for a medical problem	No cost to you if performed in the doctor's office. Otherwise 20%	40%	20%	40%	No cost to you if performed in the doctor's office. Otherwise 20%	40%	No cost to you if performed in the doctor's office. Otherwise 20%
Preventive Mammo-gram/Colonoscopy: routine screening done according to national age specific guidelines and regardless of where the service is performed	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you
Diagnostic Mammo-gram/Colonoscopy: test performed for a <u>medical</u> problem	No cost if part of office visit or at an independent facility. 20% if performed in outpatient hospital	40%	20%	40%	No cost to you if part of office visit or at an independent facility. 20% if performed in outpatient hospital	40%	No cost if part of office visit or at an independent facility. 20% if performed in outpatient hospital
Pregnancy and Maternity Care: <u>OB-GYN's Charges Only.</u> <i>Includes</i>	Routine prenatal care, no cost to you. All other	40%	Routine prenatal care, no cost to you. All other	40%	Routine prenatal care, no cost to you. All other	40%	Routine prenatal care, no cost to you. All other services, 20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
<i>prenatal and postnatal care, and delivery charges</i>	services, 20%		services 20%		doctor's services, \$150 per pregnancy		
Pregnancy and Maternity Care: <u>Hospital and Other Ancillary Charges Only.</u> Includes labor/delivery and postnatal expenses	20%	40%	20%	40%	20%	40%	20%
Second surgical opinions No cost if ordered by the Plan or claim administrator	20% if elected by participant	40% if elected by participant	20% if elected by participant	40% if elected by participant	\$40 per visit if elected by participant; deductible does not apply	40% if elected by participant	20% if elected by participant
Chiropractic care Maximum 20 visits per calendar year per covered family member for both in-network and out-of-network visits combined. Maintenance care is not covered	20%	40%	20%	40%	\$40 per visit; deductible does not apply	40%	20%
Speech, physical, occupational, restorative and rehabilitative therapy, if medically necessary <i>Educational Services are not covered</i>	20%	40%	20%	40%	\$40 per visit; deductible does not apply	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
Allergy Care							
Physician's office visit for allergy care	If PCP: \$30 per visit; deductible does not apply If Specialist: 20%	40%	20%	40%	If PCP – \$20 per visit; deductible does not apply If Specialist – \$40 per visit; deductible does not apply	40%	If PCP: \$30 per visit; deductible does not apply If Specialist: 20%
Allergy testing, shots or serum	20% No cost for Allergy testing performed in the doctor's office	40%	20%	40%	No cost to you if administered in physician's office. \$20 per visit if PCP office visit is charged, If Specialist – \$40 per visit; deductible does not apply	40%	20% No cost for Allergy testing performed in the doctor's office
Outpatient Services							
Diagnostic X-ray and lab (for non-urgent, non-immediate and non-emergent care)	No cost to you if performed at doctor's office or non-hospital imaging center/lab 20% if at hospital	40%	20%	40%	No cost to you if performed at doctor's office or non-hospital imaging center/lab ;	40%	No cost to you if performed at doctor's office or non-hospital imaging center/lab 20% if at hospital

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
					20% if at hospital		
Outpatient surgery in physician's office Pre-authorization is recommended to ensure medical necessity; see "CheckFirst"	PCP – \$30 per visit; deductible does not apply If Specialist – 20%	40%	20%	40%	PCP – \$20 per visit. If Specialist – \$40 per visit; deductible does not apply	40%	20%
Outpatient surgery in a hospital or free standing surgical facility Pre-authorization is recommended to ensure medical necessity; see "CheckFirst"	20%	40%	20%	40%	20%	40%	20%
Pre-admission testing	No cost if performed at lab or in doctor's office; 20% if at hospital	40%	20%	40%	No cost if performed at lab or in doctor's office; 20% if at hospital	40%	No cost if performed at lab or in doctor's office; 20% if at hospital
Hospital Services – Preauthorization required for out-of-network hospitalization. If you fail to get preauthorization you will pay a \$250 penalty.							
Inpatient room and board	20%	40%	20%	40%	20%	40%	20%
Intensive care unit and special care unit	20%	40%	20%	40%	20%	40%	20%
Ancillary services, including radiology, pathology, operating	20%	40%	20%	40%	20%	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
room and supplies							
Newborn nursery care	20%	40%	20%	40%	20%	40%	20%
FACTS ABOUT NEWBORN NURSERY CARE <ul style="list-style-type: none"> • This care is considered under the baby's coverage, not the mother's; therefore, the baby must be enrolled in coverage for his/her newborn claims to be covered. • Within 31 days of the birth, you must process a Life Event change online through American Airlines Benefits Service Center to request enrollment for your baby in your health coverage. If you do not, you must wait until the next Annual Benefits Enrollment period to enroll your baby unless you experience another qualifying life event. • Payment of maternity claims does not automatically enroll your baby. 							
Surgery and related expenses (such as anesthesia and medically necessary assistant surgeon)	20%	40%	20%	40%	20%	40%	20%
Blood transfusions	20%	40%	20%	40%	No cost to you if performed in doctor's office; 20% if at hospital	40%	20%
Organ transplants <i>Preauthorization required (no coverage without preauthorization)</i>	20%	40%	20%	40%	20%	40%	20%
Emergency ambulance	20%	20%	20%	20%	No cost to you	No cost to you	20%
Emergency room	\$100 copay PLUS 20% on full amount allowed on the bill	\$100 copay, PLUS 20% on full amount allowed on the bill Non Emergency - \$100	20%	40%	\$100 copay, PLUS 20% on full amount allowed on the bill	\$100 copay, PLUS 20% on full amount allowed of the bill Non Emergenc	\$100 copay, PLUS 20% on full allowed amount of the bill

New

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
		copay PLUS 40% on full amount allowed				y- \$100 copay PLUS 40% on full amount allowed	
FACTS ABOUT EMERGENCY ROOM CLAIMS STANDARD, VALUE, and OUT-OF-AREA Medical Options: If you're admitted to the hospital as an inpatient directly from the emergency room, the \$100 copay is waived, and you are only required to pay any amount needed to meet your deductible and your percentage of the covered expense							
Out-of-Hospital Care							
Conval- escent and skilled nursing facilities following hospital- ization Within 15 days of hospitaliz- ation. Maximum of 60 days per illness/injury for in-network and out-of- network facilities combined	20%	40%	20%	40%	20%	40%	20%
Home health care	20%	40%	20%	40%	No cost to you when approved by your network admin- istrator	40%	20%
Hospice care	20%	40%	20%	40%	20%	40%	20%
Other Services							
Tubal ligation (Reversals are not covered)	No cost to you	40%	No cost to you	40%	No cost to you	40%	No cost to you
Vasectomy (Reversals are not covered)	If PCP - \$30; If Specialist - 20%	40%	20%	40%	If PCP - \$20; If Specialist - \$40;	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
					otherwise, 20%		
New Erectile Dysfunction Medications	Covered under the Prescription Drug Benefit, up to six (6) pills per month.						
New Infertility treatment, including in- vitro fertilization	Fertility prescription medications are covered under the Prescription Drug Benefit. The maximum benefit is \$15,000 for the entire time the person is covered under the Plan. Any other fertility treatment services are not covered by any of the self-funded Medical Benefit Options.						
Radiation therapy and chemo- therapy	20%	40%	20%	40%	No cost to you if in physician office; otherwise, 20%	40%	20%
Kidney dialysis (If the dialysis continues more than 12 months, participant must apply for Medicare)	20%	40%	20%	40%	No cost to you if in physician office; otherwise, 20%	40%	20%
Supplies, equipment and durable medical equipment (DME)	20%	40%	20%	40%	20%	40%	20%
FACTS ABOUT SUPPLIES, EQUIPMENT, DME Your cost is the percentage shown above, regardless of where the device is purchased, and is <i>in addition to</i> any physician's visit costs you're required to pay.							
Mental Health Benefits - No Treatment Limits In-House EAP approval IS REQUIRED for all cases resulting from regulatory or Company policy violations.							
Inpatient mental health care	20%	40%	20%	40%	20%	40%	20%
Alternative mental health care center — residential treatment	20%	40%	20%	40%	20%	40%	20%
Alternative mental health care center — intensive outpatient	20%	40%	20%	40%	20%	40%	20%

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
<i>and partial hospitalization</i>							
Outpatient mental health care	No cost (100% coverage) for PCP or Specialist Office Visits; 20% for all other outpatient services	40%	20%	40%	\$20 per visit for PCP, deductible does not apply; \$40 per visit for Specialist; 20% outpatient hospital	40%	No cost (100% coverage) for PCP or Specialist Office Visits; 20% for all other outpatient services
Marriage/relationship/family counseling	Not covered by any of the self-funded Medical Benefit Options						
Chemical Dependency Benefits - No Treatment Limits American EAP approval IS REQUIRED for all cases resulting from regulatory or Company policy violations. Detoxification services will be covered in the same manner as chemical dependency services depending upon the type of services (i.e., outpatient, in-network; outpatient, out-of-network; inpatient, in-network; inpatient, in-network; inpatient, out-of-network; emergency services and pharmacy services).							
Inpatient chemical dependency rehabilitation	20%	40%	20%	40%	20%	40%	20%
Outpatient chemical dependency rehabilitation	No cost (100% covered) for PCP or Specialist Office Visits; 20% for all other outpatient services	40%	20%	40%	\$20 per visit PCP; \$40 per visit Specialist; 20% outpatient facility	40%	No cost (100% covered) for PCP or Specialist Office Visits; 20% for all other outpatient services
Gender Reassignment Benefit (Cumulative maximum benefit for travel is \$10,000). These are the maximum benefits payable for the entire time the person is covered under the Plan.							

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In- Network	Out-of- Network	In- Network	Out-of- Network	In- Network	Out-of- Network	
<i>Surgery</i> One bilateral mastectomy or bilateral augmentation mammoplasty AND One genital revision surgery	20%	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<i>Travel Expenses</i> For yourself and one caregiver to travel to the network facility and for time while you're hospitalized/receiving medically necessary outpatient care following surgery	No cost to you, up to \$10,000	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<i>Non-Surgical Treatments</i> Physician's visits Specialist visits Outpatient mental health care X-rays and lab work Retail prescription drugs Mail order prescription drugs	Covered as mental health care benefits described above	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Prescription Medication							
<i>RETAIL Pharmacy</i> (typically a 30-day supply)	Generic: • 20% • \$10 min • \$40 max Preferred Brand: • 30% • \$30 min	Generic: • 20% • \$10 min • \$40 max Preferred Brand: • 30%	20% after deductible (in-network) 40% after deductible (out-of-network)		Generic: • 20% • \$10 min • \$40 max Preferred Brand: • 30%	Generic: • 20% • \$10 min • \$40 max Preferred Brand: • 30%	Generic: • 20% • \$10 min • \$40 max Preferred Brand: • 30% • \$30 min

New
for
Value

Features	STANDARD		CORE		VALUE		OOA Medical Benefit Option
	Medical Benefit Option		Medical Benefit Option		Medical Benefit Option		
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
	<ul style="list-style-type: none">• \$100 max• Non-Pref Brand:• 50%• \$45 min• \$150 max	<ul style="list-style-type: none">• \$30 min• \$100 max• Non-Pref Brand:• 50%• \$45 min• \$150 max			<ul style="list-style-type: none">• \$20 min• \$75 max• Non-Pref Brand:• 50%• \$35 min• \$90 max	<ul style="list-style-type: none">• \$20 min• \$75 max• Non-Pref Brand:• 50%• \$35 min• \$90 max	<ul style="list-style-type: none">• \$100 max• Non-Pref Brand:• 50%• \$45 min• \$150 max
	Prescriptions are not subject to deductible		Preventive medications are not subject to deductible		Prescriptions are not subject to deductible		
FACTS ABOUT THE RETAIL PRESCRIPTION COVERAGE <ul style="list-style-type: none">• Generic vs Preferred or Non-Preferred for STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options: If you select a non-Preferred brand medication when a generic equivalent is available, you'll pay the generic copay or co-insurance PLUS the difference between the generic and non-Preferred brand costs. Out of pocket maximums do not apply.• Retail Refill Allowance for all Medical Benefit Options: This allowance refers to long-term medications—beginning with your fourth purchase (or earlier), you should switch your 90-day prescriptions to Express Scripts (ESI) Mail Order or Express Scripts Smart 90 Program, which includes local CVS or Safeway-owned pharmacies. This coverage allows retail coverage at the stated percentages for the first three fills of each long-term prescription drug. If you continue to fill your long-term prescriptions at retail pharmacies beyond this three fill allowance, you'll have to pay 50% of the cost with no maximum, unless you fill your long-term 90-day medications at a local CVS or Safeway-owned pharmacy. See the "Prescription Drug Benefits" section under your <i>Medical Benefit Option</i> section for your elected Medical Benefit Option.• If you fill your prescriptions at an out-of-network retail pharmacy, your benefit will be based on the Express Scripts in-network discounted rate, which means the amount you'll have to pay for your prescription will be greater than if you used an in-network retail pharmacy.							
MAIL ORDER (typically a 90 day supply)	Generic: <ul style="list-style-type: none">• 20%• \$5 min• \$80 max Preferred Brand: <ul style="list-style-type: none">• 30%• \$60 min• \$200 max Non-Preferred Brand <ul style="list-style-type: none">• 50%• \$90 min• \$300 max	Not covered	20% after the deductible	Not covered	Generic: <ul style="list-style-type: none">• 20%• \$5 min• \$80 max Preferred Brand: <ul style="list-style-type: none">• 30%• \$40 min• \$150 max Non-Preferred Brand <ul style="list-style-type: none">• 50%• \$70 min• \$180 max	Not covered	Generic: <ul style="list-style-type: none">• 20%• \$5 min• \$80 max Preferred Brand: <ul style="list-style-type: none">• 30%• \$60 min• \$200 max Non-Preferred Brand <ul style="list-style-type: none">• 50%• \$90 min• \$300 max

Features	STANDARD Medical Benefit Option		CORE Medical Benefit Option		VALUE Medical Benefit Option		OOA Medical Benefit Option
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	
FACTS ABOUT MAIL ORDER PRESCRIPTION COVERAGE: <ul style="list-style-type: none">• Generic vs Non-Preferred for STANDARD, VALUE, and OUT-OF-AREA Medical Benefit Options: If you select a non-Preferred brand medication when a generic equivalent is available, you'll pay the generic co-pay/coinsurance PLUS the difference between the generic and non-Preferred brand costs (out-of-pocket maximums do not apply).• For mail order prescriptions, you <i>must</i> purchase through ESI Mail Order; otherwise, you'll have to pay 100% of the cost yourself and the plan will not pay any of the cost. As an alternative to mail order, you can utilize the ESI Smart 90 Program, which allows you to fill your long-term medications at a local CVS or Safeway-owned pharmacy.							
Specialty Medications	For certain specialty medications, you <i>must</i> obtain them from Accredo (Express Scripts specialty mail order pharmacy) or an in-network retail pharmacy; otherwise, you'll have to pay 100% of the cost yourself and the plan will not pay any of the cost. Contact Express Scripts to find out if your specialty medication is covered under the prescription drug benefit.						
Oral contraceptives	Oral contraceptives, transdermal and intravaginal contraceptives are covered at 100% by ESI Mail Order and the ESI Smart 90 Program through which prescriptions can be filled at a local CVS or Safeway-owned pharmacy. This includes both generic and brand name (Preferred or non-Preferred) contraceptives. If you purchase at a retail pharmacy other than a CVS or a Safeway-owned pharmacy, the plan will not pay any of the cost. If you purchase a brand name contraceptive through Mail Order when a generic equivalent is available, you will be responsible for the cost difference between generic and brand.						
Fertility (infertility) medications	Medications used to treat infertility or to promote fertility are covered by the self-funded Medical Benefit Options, subject to an overall lifetime maximum of \$15,000 per person.						
Over-the-counter medication (OTC)	Over-the-counter medications are not covered under the Medical Options. See the " Prescription Drug Benefits " section under your <i>Medical Benefit Option</i> section for information about certain coverage allowances.						
Other Information							
Predetermination of benefits	Recommended before hospitalization and surgery for all the self-funded Medical Benefit Options						
Hospital pre-authorization	Required for hospitalization and recommended before outpatient surgery						

Covered Expenses

This section contains descriptions of the eligible medical expenses (listed alphabetically) that are covered under the self-funded Medical Benefit Options when medically necessary. Benefits for some of these eligible expenses vary depending on the Medical Benefit Option you have selected and whether or not you use in-network providers. See "[Medical Benefit Options Comparison](#)" for information on how most services are covered. For covered expenses under an HMO, check with the HMO directly.

For a list of items that are excluded from coverage, see "[Excluded Expenses](#)".

Acupuncture: Medically necessary treatment for illness or injury (performed by a Certified Acupuncturist) for diagnosed illness or injury, only when acupuncture treatment has been proven to be both safe and effective treatment for such diagnosed illness or injury. (Coverage does not include acupuncture treatment for conditions in which the treatment has not been proven safe and effective

Quick Tip

If you have an HMO, check with your HMO directly to find out covered and excluded expenses.

such as: glaucoma, hypertension, acute low back pain, infectious disease and allergies.)

Allergy care: Charges for medically necessary physician's office visits, allergy testing, shots and serum are covered.

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

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

Ancillary charges: Ancillary charges including, charges for hospital services, supplies and operating room use.

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

Assistant surgeon: Only covered 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 pre-determination procedure.

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

Chiropractic care: Coverage includes medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered. You are limited to 20 visits per year for combined in-network

Convalescent or skilled nursing facilities: To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital for a covered inpatient hospital confinement and be recommended by your physician for the condition that caused the hospitalization. Eligible expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician, and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement and your Network/Claim Administrator must approve your stay. Maximum benefit is 60 days per illness or injury for network and out-of-network facilities. Custodial care is not covered.

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

- As a result of a non-work related injury.

- For replacement of diseased tissue surgically removed.
- Other cosmetic surgery is not covered because it is not medically necessary.

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,



- Dental treatment due to accidental injury must begin within 12 months of the date of the accident



- If the accidental injury requires that you have dental implants, the maximum benefit is \$15,000 for the entire time the person is covered under this plan

- Fractures and/or dislocations of the jaw, or
- Cutting procedures in the mouth (this does not include extractions, dental implants, repair or care of the teeth and gums, etc., unless required as the result of accidental injury, as stated in the first bullet above)

Detoxification: Detoxification is covered as a chemical dependency condition. Contact your Network/Claim Administrator for details.

Dietician services: Dietician services are covered under the STANDARD Medical Benefit Option, CORE Medical Benefit Option, VALUE Medical Benefit Option or OUT-OF-AREA Medical Benefit Option.

Durable medical equipment (DME): Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Medical Benefit Option may, in its discretion, approve the purchase of such items instead of rental. Replacement of DME is covered only 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.

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.

Emergency room: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. You must call your Network/Claim Administrator for QuickReview approval within 48 hours of an emergency resulting in admission to the hospital.



Erectile Dysfunction Medication: Medications are covered up to a maximum of 6 pills per month.

Eyeglasses or contact lenses: If cataract surgery is performed, coverage is available for the first pair of eyeglasses or contact lenses required after cataract surgery. For all other vision care, see the [Vision Insurance Benefit](#) Option section.

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

Gender reassignment/sex changes: Covered under the Gender Reassignment Benefit (GRB) under the STANDARD Medical Benefit Option. It is not covered under VALUE Medical Benefit Option, CORE Medical Benefit Option or OUT-OF-AREA Medical Benefit Option.

Hearing care: Covered expenses include medically necessary hearing exams performed by an audiologist or physician and medically necessary hearing aids, subject to a maximum payable of \$3,500 per hearing aid. Replacement hearing aids are allowed once every 36 months and the maximum payable for replacement is \$3,500 per hearing aid. Cochlear implants and/or osseointegrated hearing systems are covered only if medically necessary.

Hemodialysis: Coverage provided for medically necessary hemodialysis.

Home health care: Home health care, when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. Custodial care is not covered. You should call your Network/Claim Administrator to initiate the QuickReview process 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/Claim Administrator. You should contact your Network/Claim Administrator to initiate the QuickReview process.

Infertility: Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease.

Inpatient room and board expenses: Eligible expenses are based on the negotiated rates with that particular in-network hospital. For out-of-network, eligible expenses are determined based on the most common semiprivate room rate in that geographic area. **Precertification is required for all out-of-network hospitalizations. Failure to do so will result in a \$250 penalty.**

New

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

IUD: Insertion or removal of an IUD. Covered if performed in an in-network physician's office (covered as outpatient surgery). Service not covered out-of-network.

Laboratory or pathology expenses: Coverage is provided for medically necessary diagnostic laboratory tests. In-network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility. If you use an in-network, non-hospital facility (doctor's office, lab, etc.), then these services are covered at 100%.

Mammograms (diagnostic - required as part of a work-up for symptoms or a medical condition):

Diagnostic mammograms are covered, regardless of age under all Medical Benefit Options both in-network and out-of-network.

Mammograms (routine screening or preventive):

In-network, routine screening mammograms are covered under all Medical Benefit Options at 100%.

Out-of-network, routine screening mammograms are covered:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared,
- Once every year from ages 40 and up as recommended by your physician.

Mastectomy: Medically necessary mastectomy and certain reconstructive and related services after a mastectomy are covered. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:

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

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

- Oxygen, blood and plasma
- Sterile items including sterile surgical trays, gloves and dressings
- Needles and syringes
- Colostomy bags
- Diabetic supplies, including needles, chem-strips, lancets and test tape covered under the prescription drug benefit
- Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered

Multiple surgical procedures: Reimbursement for simultaneous multiple surgical procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. In-network surgeries are based on the network provider's contractor rates. Out-of-network surgeries are based on Usual and Prevailing (U&P) or Maximum Out-of-Network Charge (MOC) fee limits. To determine the amount of coverage, and to be sure the charges are within the usual and prevailing fee limits, contact your Network/Claim Administrator to use the CheckFirst pre-determination program.

Newborn nursery care: The hospital expenses for a newborn baby are considered under the baby's coverage, not the mother's. The hospital expenses for a newborn baby are covered, provided you timely process a Life Event. To enroll your newborn baby in your health benefits, you must process a Life Event change within 31 days of the birth. If you miss the 31-day deadline you will not be able to add your baby to your coverage until the next Annual Benefits Enrollment period unless you experience another qualifying life event, even if you already have other children enrolled in coverage. The filing or payment of a maternity claim does not automatically enroll the baby.

Oral surgery: Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process, only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the Medical Benefit Option will pay room and board, anesthesia and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the Medical Options. However, they may be covered under the Dental 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 your Network/Claim Administrator to initiate the QuickReview process to ensure the procedure is medically necessary.

Physical or occupational therapy: Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a physician. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered.

Physician's services: Office visits and other medical care, treatment, surgical procedures and post-operative care for medically necessary diagnosis or treatment of an illness or injury. The Medical Benefit Options cover office visits for certain preventive care, as explained under Preventive Care.

New

Pregnancy: Charges in connection with pregnancy, for female employees, female spouses/Company-recognized Domestic Partners, common law spouses, and covered female dependent of the employee. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed or certified by the state in which he or she practices.

- Within the first 12 weeks of pregnancy, you should call ActiveHealth Management to participate in the MaternityMatters pregnancy program if you are enrolled in the self-funded plans. This is offered at no cost to employees and their covered dependents.
- Routine prenatal expenses are covered at 100% in-network. Labor, delivery and post-natal expenses are covered by the applicable co-insurance percentage.
- Employees enrolled in an HMO should contact their HMO.
- Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority.
- Prescription prenatal vitamin supplements are covered by Medical Benefit Options.
- Federal law prohibits the Plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery, 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.

- This includes Preventive OTC covered with a prescription if required by the Affordable Care Act.

- Prescriptions for the treatment of obesity or weight control are covered only for the diagnosis of morbid obesity.
- Oral contraceptive drugs, patches, implants, transdermal, and intravaginal contraceptives are covered if purchased through mail order or at any local CVS or Safeway-owned retail pharmacies.
- Medications provided, administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit with the exception of certain specialty medications that are only covered under the prescription drug benefit.
- Medications that are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy are covered as part of the facility's ancillary charges.
- Medications that are administered as part of home health care.
- Diabetic supplies, including insulin, needles, chem-strips, lancets and test tape. These diabetic supplies are covered up to 100% if you or your covered dependent are participating in the StayWell Prescription Program, and you purchased them from ESI mail order or the ESI Smart 90 Program.
- Medications or products used for smoking or tobacco as determined by the participation in the [Healthmatters](#) smoking cessation program.
- Prescription medications that treat infertility are covered, subject to a \$15,000 per person the entire time the person is covered by the Plan.

New

Certain types of medicines and drugs that are not covered by the medical benefits may be reimbursed under the Health Care Flexible Spending Accounts (see "[Covered Expenses](#)" in the *Health Care Flexible Spending Account* section).

New

Preventive care: Covers preventive care, including well-child care, immunizations, routine screening mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages. Non-routine tests for certification, sports or insurance are not covered unless medically necessary.

The Company provides non-grandfathered group health plans that comply with the Affordable Care Act (ACA) preventive care requirements.

Preventive care focuses on evaluating your current health status when you are symptom free.

Preventive services include those performed on a person who:

1. has not had a preventive screening done before and does not have symptoms or other a documented related existing care related to the outcomes of the screening
2. has had diagnostic screenings that were normal after which your physician recommends future preventive screening
3. has a preventive service done that results in a therapeutic service done at the same time (e.g. polyp removal during a preventive colonoscopy)

American follows the USPSTF Grade A & B recommendations, CDC and HRSA guidelines for preventive care. To get a full list of in-network preventive care covered at no cost to you

visit, <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> or <https://www.healthcare.gov/preventive-care-benefits/>

Some preventive services have age and frequency limitations. These limitations can be based on medical necessity, medical review boards of the carriers in which we partner with to provide health care services and the ACA. Call your claims/network administrator for details on coverage.

If you receive, preventive care at any location other than a physician's office such as urgent care or emergency room, or from an out-of-network provider, services may not be covered at 100%.

Your health care provider determines how you are billed for all health plan expenses. When a service is performed for the purpose of preventive screening and is appropriately billed as such by your provider, then it will be covered under preventive services.

Private duty nursing care: Coverage includes medically necessary care by a licensed nurse in a home setting.

Prostheses: Prostheses (such as a leg, foot, arm, hand or breast) necessary because of illness, injury or surgery. Replacement 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): Examination and treatment by X-ray or other radioactive substances, imaging/scanning (MRI, PET, CAT and ultrasound), diagnostic laboratory tests and routine mammography screenings for women (see "Mammograms" in this section for guidelines).

In-network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility. If you use an in-network, non-hospital facility (doctor's office, imaging center, etc.), then these services are covered at 100%.

Reconstructive surgery: Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive services include:

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

Retail Clinic Visits: If you go to an in-network retail clinic (such as Minute Clinic in CVS stores, Healthcare Clinics in Walgreens stores, the Clinic at WalMart, etc.) and you are enrolled in the STANDARD/OOA Medical Benefit Option for health care services, the eligible expense is subject to the deductible and co-insurance, and is not paid as a co-payment.

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

Surgery: When medically necessary and performed in a hospital, freestanding surgical facility or physician's office. (See "[CheckFirst \(Predetermination of Benefits\)](#)" for details about hospital pre-authorization and pre-determination 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
- Temporomandibular joint replacement, ONLY if ALL of the following conditions are met:
 - It is the treatment of last resort ("salvage" treatment)
 - It has been documented by clinical records that all other medically appropriate lesser treatments have been performed and have failed (and the failure is not due to patient non-compliance)
 - The prosthetic implant system being used is a total implant system manufactured by either TMJ Concepts, Inc. or Walter Lorenz Surgical, Inc.
 - The patient meets all generally accepted medical/surgical criteria for total replacement of the TMJ
 - The TMJ replacement is not used on an experimental or investigational basis

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. Keep in mind that transplants must be preauthorized. **The transplant will not be covered if preauthorization is not obtained.**

New

Donor and recipient coverage is as follows:

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

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

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

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

For information on ambulance services, see “Ambulance” in this section.

Tubal ligation and vasectomy: These procedures are covered; however, reversal of these procedures is not covered.

Urgent/immediate care: Charges for services and supplies provided at an Urgent Treatment Clinic are covered. In order to receive the in-network benefit level, you should contact your network provider or your Network/Claim Administrator if you go to an out-of-network provider within 48 hours to ensure that you receive the in-network level of benefits.

Well-child care: Initial hospitalization following birth, immunizations, and well-child care visits.

New

Wigs and hairpieces: The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery or severe burns. This benefit is subject to the usual and prevailing fee limits, deductibles, co-pays, co-insurance and out-of-pocket limits of the selected Medical Benefit Option. The maximum benefit available for wigs and hairpieces is \$1,000 for the entire time that a person is covered under the Plan. Hair transplants, styling, shampoo and accessories are excluded.

Excluded Expenses

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

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

Alternative and/or Complementary medicine: Evaluation, testing, treatment, therapy, care and medicines that constitute alternative or Complementary medicine, including but not limited to herbal, holistic and homeopathic medicine.

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

Care not medically necessary: All services, procedures, and supplies considered not medically necessary.

Cosmetic 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: Custodial care is not covered.

Custodial care items: Custodial care items such as incontinence briefs, liners, diapers and other items when used for custodial purposes are not covered, unless provided during an inpatient confinement in a hospital or convalescent or skilled nursing facility.

Dietician services: Dietician services are excluded if you use an out-of-network provider. Contact your in-network provider to determine the services that are covered.

Ecological and environmental medicine: See “Alternative and/or Complementary Medicine” in this section.

Educational Services: The Plan does not pay the cost of Educational Services. This exclusion applies regardless of the condition being treated.

See the “Educational Services” definition in the Glossary under the *Reference Information* section.

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 implantation
- Plasmapheresis

See the Experimental, Investigational or Unproven Treatment definition in the [Glossary](#) under 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 (GRB): Covered under the STANDARD Medical Benefit Option only. 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 any other eligible dependents.

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

Infertility treatment services: 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.

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

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

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

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

Nursing care:

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

Organ donation: Expenses incurred as an organ donor, when the recipient is not covered under the Plan. For additional information, see "Transplant" under "[Covered Expenses](#)".

Prescription Drugs:

- Drugs that are not required to bear the legend "Caution-Federal Law Prohibits Dispensing Without Prescription"
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order

- Oral contraceptive drugs, patches, implants, transdermal, and intravaginal contraceptive purchased from any other retail pharmacies that are not CVS or Safeway owned.
- 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); however the Plan does provide coverage for Folic Acid and pediatric multivitamins with Fluoride in accordance with the Affordable Care Act.
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Drugs labeled “Caution-Limited by Federal Law to Investigational Use,” drugs not approved by the Food and Drug Administration (FDA) or experimental drugs, even though the individual is charged for such drugs
- Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis
- Medications or products used for smoking or tobacco use cessation. The only exception is through the participation in smoking cessation program through [Healthmatters](#).
- Prescription medications not approved for the condition being treated; prescription medications compounded with ingredients not approved by the US Food and Drug Administration (FDA); prescription medications prescribed and/or utilized or administered in a manner other than what has been FDA-approved for the medication; prescription medications utilized or administered with quantities, dosages, or routes of administration not approved by the FDA

Preventive care: Not all preventive care may be covered. Consult your Network/Claim Administrator to learn what preventive care is not covered.

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 Partner, including adopted and step relatives).

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

Erectile Dysfunction Treatment: Procedures devices (not including devices used to administer prescribed medication), administered or recommended to treat erectile dysfunction 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, 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: Any portion of fees charged by out-of-network physicians, hospitals and other providers that exceeds the usual and prevailing fee limits, or that exceeds the Maximum Out-of-Network Charge. This applies to out-of-network expenses under all Medical Options and all expenses incurred under OOA.

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/Claim Administrator (or HMO if applicable) to determine if treatment is covered.

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
- Services related to vocation, including but not limited to: physical or FAA exams, performance testing and work hardening programs

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

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

Network/Claim Administrator

A Network/Claim Administrator is the health plan administrator that processes health care claims and manages a network of health care providers and care facilities. Medical necessity is determined by your Network/Claim Administrator. The Plan Administrator may, at its sole discretion, pay benefits for services and supplies not specifically stated under the Medical Benefit Option.

The Plan’s self-funded Medical Benefit Options (STANDARD, VALUE and CORE) are administered by two Network/Claim Administrator:

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

The OUT-OF-AREA Medical Benefit Option is administered by UnitedHealthcare. Your eligibility for the OUT-OF-AREA Medical Benefit Option is determined by your five-digit ZIP code, whether or not your residence is outside the network access area. Employees living outside the access area are eligible for the OUT-OF-AREA Medical Benefit Option. At the time you enroll, the Company will determine whether or not you are eligible for the OUT-OF-AREA Medical Benefit Option.

Each state has a designated preferred Network/Claim Administrator. Your preferred administrator is determined by the ZIP code of your alternate address on record. If you do

not have an alternate address listed in the [Update MY Information](#) page of Jetnet, your Network/Claim Administrator is based on your permanent address.

The map of the Network/Claim Administrators by state can be found on [my.aa.com](#).

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

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

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

Relocation and my Network/Claim Administrator

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

When you move from one network/claim administrator to another either at Annual Enrollment or due to a life event, you may have a need for Transition of Care. If your Network/Claim Administrator changes and you or a covered family member has a serious illness, or you or your spouse is in the 20th (or later) week of pregnancy, you can ask your new Network/Claim Administrator to evaluate your need for transition of care. This allows you to continue with your current care provider at the in-network benefit level for a period of time, even if that provider is not part of the network for your new Network/Claim Administrator. Contact your Network/Claim Administrator for more information. Go to [My.aa.com](#) to learn more.

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

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

- move from one American Airlines workgroup to another, or
- move from American Airlines to another American Airlines Group subsidiary, or
- relocate and your Medical Benefit Option is no longer available in your new location, or
- retire, or
- you or your dependents move from Active coverage to COBRA coverage.

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

If...	Your Deductible and Out-of-Pocket Maximum...
You transfer/relocate and you have to select a new Medical Benefit Option because your existing Medical Benefit Option is not offered in your transfer/relocation area	will not carry over
<p>You declined coverage because you or your dependents had coverage elsewhere, and then that coverage was lost</p> <p>You want to add medical coverage for yourself and/or your dependents as a result of your marriage, birth/adoption of a child</p> <p>Your other medical coverage was COBRA and you exhausted your COBRA coverage;</p> <p>Your other coverage was lost due to that plan sponsor's termination of its plan or if contributions were no longer paid for the other coverage</p> <p>Your other medical coverage was lost because you no longer lived in the service area.</p>	will carry over
If you change medical plan options during the year (any funds already paid towards the deductible and out of pocket maximum will not be refunded if you select a plan option with a lower deductible and out of pocket maximum)	will carry over
You retire and move from Active coverage to Retiree coverage	will not carry over
You or your dependent(s) move from Active to COBRA continuation coverage	will carry over

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/Claim Administrator must include the following:

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

Make copies of the original itemized bill or receipt provided by your physician, hospital or other medical service provider for your own records. All medical claims payments are provided to you with an Explanation of Benefits (EOB) explaining the amount paid, 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 your enrolled Medical Option, contact your Network/Claim Administrator (see "[Contact Information](#)" in the *Reference Information* section).

Claims Filing Deadline

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

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

CheckFirst (Predetermination of Benefits)

CheckFirst allows you to find out if:

- The recommended service or treatment is covered by your selected Medical Option
- Your physician's proposed charges fall within the Plan's usual fees (applies to out-of-network expenses under all Medical Options).

If you are receiving discounted provider's fees, or if are using in-network providers, the provider's fees are not subject to usual and prevailing fee limits. However, you may want to contact your Network/Claim Administrator at the appropriate CheckFirst number for your Medical Option to determine if the proposed services are covered under your selected Medical Option.

To use CheckFirst, you may either submit a [CheckFirst Pre-determination of Medical Benefits form](#) before your proposed treatment or you may call your Network/Claim Administrator to obtain a pre-determination of benefits by phone or to request the pre-determination form. If you are having surgery your Network/Claim Administrator (as part of

your Network/Claim Administrator's hospital pre-authorization process) will determine the medical necessity of your proposed surgery before making a pre-determination of benefits. Your Network/Claim Administrator will mail you a written response. Even if you use CheckFirst, your Network/Claim Administrator reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different than the information submitted for pre-determination of benefits. Claims are processed in order of receipt. Payment of a claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Plan(s) (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

For hospital stays, CheckFirst can pre-determine the amount payable by the Plan. A CheckFirst pre-determination does not pre-authorize the length of a hospital stay or determine medical necessity. You must call your Network/Claim Administrator for your Medical Plan Option for pre-authorization (see [“QuickReview \(Pre-Authorization\)”](#))

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 pre-determination 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/Claim 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)

You or your provider acting on your behalf are required to request pre-authorization from your Network/Claim 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/Claim Administrator, your expenses are still subject to review and will not be covered under the Plan if they are considered not medically necessary. **Failure to pre-authorize will result in a \$250 penalty per out-of-network hospitalization.** If you are enrolled in one of the self-funded Medical Benefit Options, request pre-authorization by calling your Network/Claim Administrator. If you are covered by an HMO, contact your HMO before any hospitalization.

New

When to Request Approval from Your Network/Claim Administrator

Any portion of a stay that has not been approved through your Network/Claim Administrator is considered not medically necessary and will not be covered by the Medical Benefit Option. For example, if your Network/Claim 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/Claim Administrator to request pre-authorization for approval of any additional hospital days.

Call your Network/Claim 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 any procedure that will incur a substantial expense

The list above is not comprehensive. Contact your Network/Claim Administrator for more information.

If you are using in-network providers, your provider will call for you. If you are using out-of-network providers, you must call yourself (or a family member can call on your behalf).

If your physician recommends surgery or hospitalization, ask your physician for the following information before calling your Network/Claim 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/Claim Administrator, any of the following may call on your behalf:

- A family member or friend
- Your physician
- The hospital
- Your Network/Claim Administrator will tell you:
- Whether the proposed treatment is considered medical necessity and appropriate for your condition

- The number of approved days of hospitalization

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

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

If you are scheduled for outpatient surgery, you should call your Network/Claim 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/Claim 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).

Care While Traveling Out of the Country

As part of your US enrolled medical and dental coverage, emergency and urgent care will be covered under your elected plan when you travel out of the country. Before leaving the country, contact your Network/Claims Administrator for details on coverage and services:

BlueCross BlueShield Worldwide Benefits 1-800-810 BLUE or collect 1-804-673-1177

UnitedHealthcare Out-of-Country Benefits 1-866-802-8572

Metlife International Dental 1-888-558-2704 or collect 1-312-356-5970

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

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 co-pay or co-insurance and the provider should file your claim for you. Any non-emergency or non-urgent care such as routine physician care or preventive care is not covered when you travel abroad.

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

Mental Health and Chemical Dependency Care

The Medical Benefit Options cover the following medically necessary mental health and chemical dependency care:

Inpatient mental health care: When you use in-network providers under the Medical Benefit Options for hospitalization for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses (see “[Covered Expenses](#)” in this section).

Alternative mental health care center – residential treatment:

- Under the STANDARD, VALUE, CORE Medical Benefit Options, such treatment is covered at 80% (after deductible is met) when you use in-network providers and at 60% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Benefit Option, such treatment is covered at 80%.

Alternative mental health care center – intensive outpatient and partial hospitalization:

- Under the STANDARD, VALUE, CORE Medical Benefit Options, such treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Benefit Option, such treatment is covered at 80%.

Outpatient mental health care (physician’s office):

New

- Under the STANDARD Medical Benefit Option, such treatment is covered at 100% (no cost to employee).
- Under the CORE Medical Benefit Option, such treatment is covered at 80% after the deductible is met when you use in-network providers and at 60% when you use out-of-network providers.
- Under the VALUE Medical Benefit Option, such treatment is covered with a \$20 copay for primary care provider office visits and a \$40 copay for specialist office visits.

New

- Under the OUT-OF-AREA Medical Benefit Option, such treatment is covered at 100% (no cost to employee).

Outpatient mental health care (all other outpatient benefits):

- Under the STANDARD, VALUE, CORE Medical Benefit Options, such treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Benefit Option, such treatment is covered at 80%.

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).

You must obtain In-House EAP approval for all cases resulting from regulatory or Company policy violations. In all other instances, In-House EAP approval is not required for an inpatient or outpatient chemical dependency rehabilitation treatment.

The Medical Benefit Options do not cover expenses for a family member to accompany the patient being treated, although many chemical dependency treatment centers include family care at no additional cost.

New

- Under the STANDARD Medical Benefit Option, inpatient treatment is covered at 80% when you use in-network providers, and at 60% when you use out-of-network providers. Under the STANDARD Medical Benefit Option, outpatient treatment is covered at 100% (no cost to employee).
- Under the VALUE Medical Benefit Option, inpatient treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers. For outpatient treatment through an in-network provider under the VALUE Medical Benefit Option, the co-pay is \$20 per PCP visit and \$40 per specialist visit. Outpatient treatment is covered at 60% when you use out-of-network providers.
- Under the CORE Medical Benefit Option, inpatient treatment is covered at 80% when you use in-network providers and at 60% when you use out-of-network providers.
- Under the OUT-OF-AREA Medical Benefit Option, inpatient treatment is covered at 80% while outpatient treatment is covered at 100% (no cost to employee).

New

Detoxification:

- Under the STANDARD, VALUE, CORE and OUT-OF-AREA Medical Benefit Options, such treatment is covered in the same way that other mental health and chemical dependency benefits are covered.

Wellness Resources

Wellness programs and resources are available to American Airlines employees and eligible family members. Wellness programs provide access to personal health professionals and support for managing your health.

Eligible employees and covered spouses and domestic partners may earn wellness incentives by participating in selected programs. Those incentive amounts are deposited into an HRA, HIA or an H.S.A. depending on your enrolled medical Option.

Eligibility varies by program. See <http://www.my.aa.com/en/Healthmatters> for more information.

Participation is completely voluntary and confidential. These programs and services are not part of the American-sponsored health and welfare plans.

Network/Claim Administrator Resources

Participants in the self-funded Medical Benefit Options may also have access to medical case management through their Network/Claim Administrator.

Contact your Network/Claim Administrator at the member services website or call (see "[Contact Information](#)" in the *Reference Information* section).

HMO participants should check with their HMO directly for wellness resources and programs.

Employee Assistance Programs (EAP)

New

Optum Employee Assistance Program (EAP)

All American Airlines employees and their family members are eligible for Optum EAP services. Optum provides assistance and support for issues like depression and stress. They can assist with family concerns and provide financial and legal advice. Assistance is available on line at **www.liveandworkwell.com**, access code: “American” or by calling (800) 363-7190.

American Airlines In-house Employee Assistance Program (EAP)

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

For EAP managed cases, medical necessity is determined by the EAP. In these cases, the EAP will work with your Network/Claim Administrator to locate an in-network facility. The Medical Benefit Options will provide benefits for eligible medically necessary treatment and rehabilitation programs, regardless if your case requires EAP management or not.

If you fail to go through the EAP for substance abuse cases that involve Company policy or regulation violations, this will not reduce the benefit for which you are eligible. However, your job status may be impacted. See the [EAP Policy](#).

For cases that are not EAP managed, medical necessity will be determined by your Network/Claims Administrator. This includes cases not related to Company policy or regulation violations, such as spouse and dependent cases. The benefit will be paid at the Medical Benefit Option benefit level. See “Mental Health Benefits” in the “[Medical Benefit Options Comparison](#)” chart in *Medical Benefit Options Overview* section.

To contact the in-house EAP, call 1-800-555-8810.

Standard Medical Option

This section includes:

- How the Standard Medical Option Works
 - In-Network Services
 - Out-of-Network Services
 - Other Information
 - Features of the Standard Medical Option
- Covered and Excluded Expenses
- Filing Claims
- Claims Filing Deadline
- Prescription Drug Benefits
- Retail Drug Coverage
 - Filling Prescriptions and Filing Claims
 - Filing Claims for Prescriptions
 - Retail Refill Allowance — Long-Term Medications
 - Retail Prescription Clinical Programs
 - Generic Drugs .
 - Prior Authorization
 - Specialty Pharmacy Services
 - ESI Smart 90 Program
 - ESI Mail Order
 - Mail Order Prescription Clinical Programs
 - Generic Drugs
 - Ordering Prescriptions by Mail
 - Internet Refill Option
 - Other Refill Options
 - Claims Filing Deadline
 - Reimbursement of Co-insurance
- Health Reimbursement Account
- Gender Reassignment Benefit (GRB)
- Notice for Employees Who Work in (Are Based in) Massachusetts

The STANDARD Medical Option is non-grandfathered, effective January 1, 2013.

If you are eligible to enroll in this option, you can cover yourself, your spouse/Company-recognized Domestic Partner and/or your dependent children.

How the Standard Medical Option Works

The STANDARD Medical Option offers a network of preferred 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. If you use an in-network provider, the STANDARD Medical Option will pay your expenses at a higher level of benefit. When you use an in-network provider, you pay only a co-pay or deductible and co-insurance for most services. If you choose to use an out-of-network provider, the charges will be subject to usual and prevailing fee limits and the STANDARD Medical Option will pay your expenses at a lower level of benefit.

Go online or call your Network/Claim Administrator for more information and to access a list of in-network providers. See "Negotiated Rates" in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

Benefit Overview				
STANDARD Medical Option	Annual Deductible		Annual Out-of-Pocket Maximum	
	Individual	Family	Individual	Family
In-Network	\$800	\$2,400	\$2,000	\$5,000
Out-of-Network	\$3,000	\$9,000	\$6,000	\$15,000

New

In-Network Services, Deductible and Out-of-Pocket Maximums

In-network providers who contract with your Network/Claim 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 and a \$800 per person annual deductible.

Each covered person, which includes you and any covered dependents, must first satisfy an annual in-network deductible before the Option begins paying a percentage of eligible medical expenses that are subject to co-insurance (this does not include prescription drugs, annual physical or PCP visits).

After the annual in-network deductible of \$800 has been satisfied, the STANDARD Medical Option pays 80% of in-network eligible expenses. You pay 20% co-insurance for in-network services and co-pays where applicable.

After you or your covered dependents meet the individual annual out-of-pocket maximum of \$2,000 for services that require you to pay 20% co-insurance, further eligible expenses are covered at 100% for the remainder of the calendar year for that individual.

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.

- You pay \$30 co-pay per PCP visit and the deductible does not apply.
- You must meet your deductible and/or pay 20% co-insurance when you see an in-network specialist or visit a retail/urgent care clinic.

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.

Out-of-Network Services (OON), Deductible and Out-of-Pocket Maximums

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).

Each covered person, which includes you and any covered dependents, must first satisfy an annual out-of-network deductible of \$3,000 before the Option begins paying a percentage of eligible expenses. After you meet the annual out-of-network deductible, the STANDARD Medical Option pays 60% of out-of-network eligible expenses, up to usual and prevailing fee

limits of Fair Health, for most medically necessary services. You pay 40% co-insurance for out-of-network services. Additionally, you must pay any amount of the provider's billed fee that exceeds the usual and prevailing (U&P) fee limits.

New

Notwithstanding the above, the rules governing Out-of-Network reimbursement will change. Effective June 1, 2015, reimbursement rates for Out-of-Network services will be based on the Maximum Out-of-Network Charge (or MOC) instead of U&P. The MOC is a percentage of the rate that the federal Medicare program would pay for the service. Generally, the MOC for out-of-network providers and facilities will be limited to 140% of the amount the federal Medicare program would have paid for the same service. Your claims administrator will determine the MOC based on this formula. In addition to the percentage of coinsurance you must pay under the terms of the Plan, you may be responsible for any amount your out-of-network provider or facility charges over 140% of the Medicare fee schedule for the service rendered.

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

- If the claim is for care in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the STANDARD Medical 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/Claim Administrator's network gap mile limit), and the covered person has received prior approval from the Network/Claim Administrator, the Medical Option will allow the out-of-network provider's full billed charge as an eligible expense.
- If the claim is for care in a "clinical gap", the Medical Option will allow the out-of-network provider's full billed charge as an eligible expense, as long as all of the following apply:
 - In-network providers in the area with the same credentials cannot provide the specific treatment that a patient needs

New

- If the claim is for services for which no usual and prevailing fee data exist, the STANDARD Medical Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense. For claims incurred on or after June 1, 2015, if the claims administrator is unable to determine the MOC based on Medicare reimbursements, the STANDARD Medical Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.

Covered and Excluded Expenses

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

Prescription Drug Benefits

Prescription drug coverage is based upon a formulary. The amount of co-insurance you pay under the STANDARD, VALUE and CORE Medical Options is based upon whether the medication is a generic drug, a preferred brand drug (formerly known as a "formulary drug") or a non-preferred brand drug (formerly known as a "non-formulary drug").

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

Preferred brand name drugs are Express Scripts' formulary drugs.

Non-preferred are brand names that are Express Scripts' non-formulary. They have preferred alternatives (either generic or brand) that are in the Express Scripts formulary. Express Scripts (ESI) is the prescription drug vendor for the STANDARD, VALUE and CORE Medical Options. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the ESI Mail Order Prescription Drug 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 them at 1-800-988-4125.

Retail Drug Coverage

Always try to have your prescriptions filled at a network pharmacy or through ESI Mail Order. You must present your Express Scripts prescription drug card *every time* you purchase prescription drugs in order to receive the discounted medication rates and to have your pharmacy claim processed at the time of purchase. If you do not present your Express Scripts prescription drug card at the time of purchase, you will have to pay the full cost. By showing your Express Scripts ID card, the pharmacy will process your claim at the time of purchase and you will only pay your co-insurance portion. Showing your Express Scripts ID card also allows your out-of-pocket pharmacy expense to be applied toward satisfaction of your annual out-of-pocket maximum. Co-insurance, which is subject to change, is currently:

- **Generic Drugs:** 20% co-insurance per prescription or refill for generic drugs. The minimum amount you will pay is \$10 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$40. You do not have to satisfy your deductible for this benefit.
- **Preferred Brand Drugs:** 30% co-insurance per prescription or refill for formulary/brand name drugs. The minimum amount you will pay is \$30 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$100. You do not have to satisfy your deductible for this benefit.
- **Non-preferred Brand Drugs:** 50% co-insurance per prescription or refill for non-formulary/brand name drugs. The minimum amount you will pay is \$45 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$150. You do not have to satisfy your deductible for this benefit.

These co-insurance amounts are the same whether you use an in network or out of network pharmacy, however if you use an out of network pharmacy the negotiated discounted rates do not apply.

If you select a brand name drug when a generic is available, you will pay the generic co-insurance plus the cost difference between generic and brand name prices. Maximums do not apply. Once you have met your annual out-of-pocket maximum, you will continue to pay the cost difference between generic and brand name prices.

Note: You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted price and to have your pharmacy claim processed at the time of purchase.

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

Out-of-network pharmacies:

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

- At the time of purchase, you will pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Express Scripts. See Filing Claims for Prescriptions below for more information on how to file a claim.

Standard Option OON Rx Reimbursement Example	
Cost of Non-preferred prescription at pharmacy	\$250
Express Scripts discount price	\$150
You Pay	\$75 (50% co-insurance of \$150), plus \$100 (the difference between the pharmacy cost and the Express Scripts discount price)
Your Total	\$175

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

If you are enrolled in the STANDARD Medical Option and you participate in the Health Care Flexible Spending Account (HCFSA), your eligible retail drug out-of-pocket expense is reimbursable under your HCFSA (see “[Covered Expenses](#)” in the *Health Care Flexible Spending Account* section). If you have funds in your Health Reimbursement Account (HRA), you can use those funds to pay eligible retail drug out-of-pocket expenses once your HCFSA funds have been exhausted.

If you have questions concerning your prescription drug coverage, call the Express Scripts Member Services number on your Express Scripts ID card. (Your ID card may still reflect “ESI”)

New

Retail Refill Allowance — Long-Term Medications

You and your covered dependents will pay 50% of the drug cost for long-term prescription medications at a retail pharmacy after your third purchase, unless you utilize retail pharmacies that are part of the ESI Smart 90 Program (see below for additional info). 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.

If you do not choose to use the ESI Mail Order program or the Smart 90 Program, beginning with your fourth purchase of a 90-day prescription, 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 or co-insurance.

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. 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 ESI 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 an 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, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications. Express Scripts also has specialty pharmacists trained in specific medical conditions (e.g., diabetes, cardiovascular, cancer, etc.). If you would like to talk to a pharmacist, call the Member Services phone number on your pharmacy ID card.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at an in-network retail pharmacy or one of Accredo's Health Group pharmacies (mail order) 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

This is not an all-inclusive listing. 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 an in-network retail pharmacy using your Express Scripts ID card or through Accredo Mail Order for you to receive prescription drug benefits. Accredo Mail Order 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 co-insurance associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions.

New

Express Scripts Smart 90 Program

You and your covered dependents are eligible for the Express Scripts (ESI) Smart 90 Program. You may use this option to purchase a 90-day supply of the prescription drugs

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

Express Scripts Mail Order

You and your covered dependents are also eligible for ESI Mail Order, which is an alternative to the ESI Smart 90 Program. 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. Ordering medications on a 90-day supply basis through ESI Mail Order will often save you more money than if you fill your prescriptions at a retail pharmacy on a 30-day basis.

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

- **Generic Drugs:** 20% co-insurance per prescription or refill for generic drugs. The minimum amount you will pay is \$5 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$80. You do not have to satisfy your deductible for this benefit.
- **Preferred Brand Drugs:** 30% co-insurance per prescription or refill for formulary/brand name drugs. The minimum amount you will pay is \$60 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$200. You do not have to satisfy your deductible for this benefit.
- **Non-preferred Brand Drugs:** 50% co-insurance per prescription or refill for non-formulary/brand name drugs. The minimum amount you will pay is \$90 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$300. You do not have to satisfy your deductible for this benefit.

There are no out-of-network mail order benefits.

If you select a brand name drug when a generic is available, you will pay a 20% generic mail order co-insurance PLUS the cost difference between generic and brand prices. Maximums do not apply.

New

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100% under the STANDARD Medical Option through ESI Mail Order or when filled at a local CVS or Safeway-owned pharmacy only. If you purchase contraceptives from a retail pharmacy not affiliated with the Smart 90 program, no benefits are payable. If you are taking contraceptives specifically for the purpose of preventing pregnancy, please be aware some services have age and frequency limitations. These limitations can be based on medical necessity, medical review boards of the carriers in which we partner with to provide health care services and ACA. If you purchase contraceptives for reasons other than the prevention of pregnancy, the appropriate co-insurance will apply. If you purchase a brand

name contraceptive that has a generic equivalent, you are responsible for the cost difference between the brand name and generic, unless your health care provider determines that a generic contraceptive would be medically inappropriate.

Mail Order Prescription Clinical Programs

Express Scripts 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 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 your physician considers it appropriate. Generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using generic drugs, you save money. If a brand name drug is not specified, your prescription may be filled with the generic.

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.
- You will be billed 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.

- Once you have established mail order service, your physician can fax new prescriptions directly to Express Scripts.

Internet Refill Option

You have online access to ESI Mail Order 24-hours a day, seven days a week. At 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 1-800-988-4125 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 ESI Mail Order refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order. You can also use the form that was delivered with your prescription.

Pharmacy Discount Cards and Manufacturer Coupons

Pharmacy discount cards or manufacturer coupons may be used at the pharmacy in lieu of billing your insurance. Discount cards and manufacturer coupons are not health insurance policies and are not intended as a substitute for prescription insurance. However, these programs can provide discounts and may lower your out-of-pocket costs on certain medications. These discount cards or coupons cannot be combined with your insurance card. When you present your insurance card and a pharmacy discount card or manufacturer coupon, the pharmacy can advise you which card will provide the most savings on a particular medication. Please note: Medicare participants are prohibited from using drug manufacturer coupons and pharmacy discount cards.

Claims Filing Deadline

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

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

Reimbursement of Co-insurance

Your mail order co-insurance is the out-of-pocket amount you must pay when you fill your prescription drugs. It is not eligible for reimbursement under the STANDARD Medical Option. However, if you elected to participate in the Health Care Flexible Spending Account (HCFSAs), your co-insurance may be eligible for reimbursement. See the [Health Care Flexible Spending Account](#) section for more information.

If you have exhausted your HCFSAs or did not elect an HCFSAs and have funds in your Health Reimbursement Account (HRA), you can receive reimbursement for your co-insurance.

New

HRA - Health Reimbursement Account

If you participate in the [Healthmatters](#) wellness program, dollars that you earn for completing certain activities will be deposited into your HRA. You can use these funds to help offset eligible medical, prescription, dental and vision out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. Funds must be in the account before you can use them.

Gender Reassignment Benefit (GRB)

For information on Company policies about transgender issues, read the [Policy](#).

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 reimbursement for travel expenses as outlined below.

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 the STANDARD Medical Option only:

This 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 benefit under the GRB for active employees cannot receive any additional benefits under the GRB for retirees. However, if you have not received the maximum GRB under the medical plan for active employees, you may receive a balance GRB, not to exceed a combined \$10,000 travel reimbursement.

GRB Coverage

The Plan pays the following benefits:

- Continuous hormone replacement (hormones of the desired gender), including laboratory testing to monitor the safety of continuous hormone therapy.

- Evaluation and diagnosis by a psychological professional and psychotherapy, as set forth in standard treatment protocols.

- Genital revision surgery and bilateral mastectomy or bilateral augmentation mammoplasty, as applicable to the desired gender.

New

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 this 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.

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/Claims 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/Claims Administrator. Contact your Network/Claim Administrator for instructions on receiving reimbursement for your expenses.

Preauthorization for the GRB

You must have approval from the Network/Claim Administrator both at the time you begin your treatment and at the time you are admitted for surgery. Your failure to obtain 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 \(Predetermination of Benefits\)](#)" and "[QuickReview \(Pre-Authorization\)](#)" for additional information.

VALUE Medical Option

This section includes:

- How the VALUE Medical Option Works
 - In-Network Services
 - Out-of-Network Services
 - Other Information
- Features of the Value Medical Option
- Covered and Excluded Expenses
- Filing Claims
 - Claims Filing Deadline
- Prescription Drug Benefits
 - Retail Drug Coverage
 - Filling Prescriptions and Filing Claims
 - Filing Claims for Prescriptions
 - Retail Refill Allowance — Long-Term Medications
 - Retail Prescription Clinical Programs
 - Generic Drugs
 - Prior Authorization
 - Specialty Pharmacy Services
 - ESI Smart 90 Program
 - ESI Mail Order
 - Mail Order Prescription Clinical Programs
 - Generic Drugs
 - Ordering Prescriptions by Mail
 - Internet Refill Option
 - Other Refill Options
 - Claims Filing Deadline
 - Reimbursement of Co-insurance
 - Health Incentive Account

The VALUE Medical Option is non-grandfathered, effective January 1, 2013.

If you are eligible to enroll in this option, you can cover yourself, your spouse/Company-recognized Domestic Partner and/or your dependent children.

How the Value Medical Option Works

The VALUE Medical Option offers a network of preferred physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services (this contracted agreement is made with the Network/Claim Administrator). You may use any qualified licensed physician you wish. If you use an in-network provider, the VALUE Medical Option will pay your expenses at a higher level of benefit. When you use an in-network provider, you pay only a co-pay or deductible and co-insurance for most services. If you choose to use an out-of-network provider, the charges will be subject to usual and prevailing fee limits and the VALUE Medical Option will pay your expenses at a lower level of benefit.

Go online or call your Network/Claim Administrator for more information and to access a list of in-network providers. See “Negotiated Rates” in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

Benefit Overview				
VALUE Medical Option	Annual Deductible		Annual Out-of-Pocket Maximum	
	Individual	Family	Individual	Family
In-Network	\$350	\$1,050	\$2,000	\$5,000
Out-of-Network	\$1,550	\$4,650	\$6,000	\$15,000

New

In-Network Services, Deductible and Out-of-Pocket Maximums

In-network providers who contract with your Network/Claim 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 and a \$350 per person annual deductible.

Each covered person, which includes you and any covered dependents, must first satisfy an annual in-network deductible before the Option begins paying a percentage of eligible medical expenses that are subject to co-insurance (prescription drugs are not subject to the deductible).

After the annual in-network deductible of \$350 has been satisfied, the VALUE Medical Option pays 80% of in-network eligible expenses. You pay 20% co-insurance for in-network services and co-pays where applicable.

After you and your covered dependents each meet the individual annual out-of-pocket maximum of \$2,000 for services that require you to pay 20% co-insurance, further eligible expenses are covered at 100% for the remainder of the year (prescription drugs are not subject to the deductible).

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.

- You pay \$20 co-pay per PCP visit. The deductible does not apply.
- You pay \$40 co-pay per Specialist visit. The deductible does not apply.

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.

Out-of-Network Services (OON), Deductible and Out-of-Pocket Maximums

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).

Each covered person, which includes you and any covered dependents, must first satisfy an annual out-of-network deductible of \$1,550 before the Option begins paying a percentage of eligible expenses. After you meet the annual out-of-network deductible, the VALUE Medical Option pays 60% of out-of-network eligible expenses, up to usual and prevailing fee limits of Fair Health, for most medically necessary services. You pay 40% co-insurance for out-of-network services. Additionally, you must pay any amount of the provider's billed fee that exceeds the usual and prevailing (U&P) fee limits.

New

Notwithstanding the above, the rules governing Out-of-Network reimbursement will change. Effective June 1, 2015, reimbursement rates for Out-of-Network services will be based on the Maximum Out-of-Network Charge (or MOC) instead of U&P. The MOC is a percentage of the rate that the federal Medicare program would pay for the service. Generally, the MOC for out-of-network providers and facilities will be limited to 140% of the amount the federal Medicare program would have paid for the same service. Your claims administrator will determine the MOC based on this formula. In addition to the percentage of coinsurance you must pay under the terms of the Plan, you may be responsible for any amount your out-of-network provider or facility charges over 140% of the Medicare fee schedule for the service rendered.

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

- If the claim is for care in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the VALUE Medical 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/Claim Administrator's network gap mile limit), and the covered person has received prior approval from the Network/Claim Administrator, the Medical Option will allow the out-of-network provider's full billed charge as an eligible expense.
- If the claim is for care in a "clinical gap", the Medical Option will allow the out-of-network provider's full billed charge as an eligible expense, as long as all of the following apply:
 - In-network providers in the area with the same credentials cannot provide the specific treatment that a patient needs

New

- If the claim is for services for which no usual and prevailing fee data exist, the VALUE Medical Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense. For claims incurred on or after June 1, 2015, if the claims administrator is unable to determine the MOC based on Medicare reimbursements, the VALUE Medical Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.

Covered and Excluded Expenses

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

Prescription Drug Benefits

Prescription drug coverage is based upon a formulary. The amount of co-insurance you pay under the STANDARD, VALUE and CORE Medical Options is based upon whether the medication is a generic drug, a preferred brand drug (formerly known as a "formulary drug") or a non-preferred brand drug (formerly known as a "non-formulary drug").

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

Preferred brand name drugs are Express Scripts' formulary drugs.

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

Express Scripts (ESI) is the prescription drug vendor for the STANDARD, VALUE and CORE Medical Options. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the ESI Mail Order Prescription Drug 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 them at 1-800-988-4125.

Retail Drug Coverage

Always try to have your prescriptions filled at a network pharmacy or through ESI Mail Order. You must present your Express Scripts prescription drug card *every time* you purchase prescription drugs in order to receive the discounted medication rates and to have your pharmacy claim processed at the time of purchase. If you do not present your Express Scripts prescription drug card at the time of purchase, you will have to pay the full cost. By showing your Express Scripts ID card, the pharmacy will process your claim at the time of purchase and you will only pay your co-insurance portion. Showing your Express Scripts ID card also allows your out-of-pocket pharmacy expense to be applied toward satisfaction of your annual out-of-pocket maximum. Co-insurance, which is subject to change, is currently:

New

- **Generic Drugs:** 20% co-insurance per prescription or refill for generic drugs. The minimum amount you will pay is \$10 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$40. You do not have to satisfy your deductible for this benefit.
- **Preferred Brand Drugs:** 30% co-insurance per prescription or refill for formulary/brand name drugs. The minimum amount you will pay is \$20 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$75. You do not have to satisfy your deductible for this benefit.
- **Non-preferred Brand Drugs:** 50% co-insurance per prescription or refill for non-formulary/brand name drugs. The minimum amount you will pay is \$35 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$90. You do not have to satisfy your deductible for this benefit.

These co-insurance amounts are the same whether you use an in network or out of network pharmacy, however if you use an out of network pharmacy the negotiated discounted rates do not apply.

If you select a brand name drug when a generic is available, you will pay the generic co-insurance plus the cost difference between generic and brand name prices. Maximums do not apply. Once you have met your annual out-of-pocket maximum, you will continue to pay the cost difference between generic and brand name prices.

Note: You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted price and to have your pharmacy claim processed at the time of purchase.

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

Out-of-network pharmacies:

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

- At the time of purchase, you will pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Express Scripts. See Filing Claims for Prescriptions below for more information on how to file a claim.

VALUE Option OON Rx Reimbursement Example	
Cost of Non-preferred prescription at pharmacy	\$250
Express Scripts discount price	\$90
You Pay	\$45 (50% co-insurance of \$90 max), plus \$160 (the difference between the pharmacy cost and the Express Scripts discount price)
Your Total	\$205

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

If you are enrolled in the VALUE Medical Option and you participate in the Health Care Flexible Spending Account (HCFSA), your eligible retail drug out-of-pocket expense is reimbursable under your HCFSA (see “[Covered Expenses](#)” in the *Health Care Flexible Spending Account* section). If you have funds in your Health Incentive Account (HIA), you can use those funds to pay eligible retail drug out-of-pocket expenses once your HCFSA funds have been exhausted.

If you have questions concerning your prescription drug coverage, call the Express Scripts Member Services number on your Express Scripts ID card. (Your ID card may still reflect “ESI”)

New

Retail Refill Allowance — Long-Term Medications

You and your covered dependents will pay 50% of the drug cost for long-term prescription medications at a retail pharmacy after your third purchase, unless you utilize retail pharmacies that are part of the ESI Smart 90 Program (see below for additional info). 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.

If you do not choose to use the ESI Mail Order program or the Smart 90 Program, beginning with your fourth purchase of a 90-day prescription, 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 or co-insurance.

You and your covered dependents will pay 50% of the drug cost for long-term prescription medications at a retail pharmacy after your third purchase, unless you utilize retail pharmacies that are part of the ESI Smart 90 Program (see below for more information). 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.

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 *ESI Smart 90 Program* and *ESI Mail Order* in this section for more information.

If you do not choose to use the ESI Mail Order program or the Smart 90 Program, beginning with your fourth purchase of a 90-day prescription, 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 or co-insurance.

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. 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 ESI 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 an 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, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications. Express Scripts also has specialty pharmacists trained in specific medical conditions (e.g., diabetes, cardiovascular, cancer, etc.). If you would like to talk to a pharmacist, call the Member Services phone number on your pharmacy ID card.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at an in-network retail pharmacy or one of Accredo's Health Group pharmacies (mail order) 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

This is not an all-inclusive listing. 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 an in-network retail pharmacy using your Express Scripts ID card or through Accredo Mail Order for you to receive prescription drug benefits. Accredo Mail Order 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 co-insurance associated with the prescription drug benefit will apply to the Specialty Pharmacy prescriptions.

New

Express Scripts Smart 90 Program

You and your covered dependents are eligible for the Express Scripts (ESI) Smart 90 Program. You may use this option to purchase a 90-day supply of the prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You can order medications on a 90-day supply basis through ESI's Smart 90 Program at a local CVS or Safeway-owned pharmacy, such as Tom Thumb, Randall's, Vons or Dominick's. Ordering medications on a 90-day supply basis will save you more money than if you fill your prescriptions at other retail pharmacies not affiliated with the Smart 90 Program.

Express Scripts Mail Order

You and your covered dependents are eligible for ESI 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. Ordering medications on a 90-day supply basis through ESI Mail Order will often save you more money than if you fill your prescriptions at a retail pharmacy on a 30-day basis.

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

New

- **Generic Drugs:** 20% co-insurance per prescription or refill for generic drugs. The minimum amount you will pay is \$5 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$80. You do not have to satisfy your deductible for this benefit.
- **Preferred Brand Drugs:** 30% co-insurance per prescription or refill for formulary/brand name drugs. The minimum amount you will pay is \$40 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$150. You do not have to satisfy your deductible for this benefit.

- **Non-preferred Brand Drugs:** 50% co-insurance per prescription or refill for non-formulary/brand name drugs. The minimum amount you will pay is \$70 (or the actual cost of the drug, if the prescription cost is less) and the maximum you will pay is \$180. You do not have to satisfy your deductible for this benefit.

There are no out of network mail order benefits.

If you select a brand name drug when a generic is available, you will pay a 20% generic mail order co-insurance PLUS the cost difference between generic and brand prices. Maximums do not apply.

New

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100% under the VALUE Medical Option through ESI Mail Order or when filled at a local CVS or Safeway-owned pharmacy only. If you purchase contraceptives from a retail pharmacy not affiliated with the Smart 90 program, no benefits are payable. If you are taking contraceptives specifically for the purpose of preventing pregnancy, please be aware some services have age and frequency limitations. These limitations can be based on medical necessity, medical review boards of the carriers in which we partner with to provide health care services and ACA. If you purchase contraceptives for reasons other than the prevention of pregnancy, the appropriate co-insurance will apply. If you purchase a brand name contraceptive that has a generic equivalent, you are responsible for the cost difference between the brand name and generic, unless your health care provider determines that a generic contraceptive would be medically inappropriate.

Mail Order Prescription Clinical Programs

Express Scripts 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 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 your physician considers it appropriate. Generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using generic drugs, you save money. If a brand name drug is not specified, your prescription may be filled with the generic.

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.
- You will be billed 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.
- Once you have established mail order service, your physician can fax new prescriptions directly to Express Scripts.

Internet Refill Option

You have online access to ESI Mail Order 24-hours a day, seven days a week. At 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 1-800-988-4125 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 ESI Mail Order refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order. You can also use the form that was delivered with your prescription.

Pharmacy Discount Cards and Manufacturer Coupons

Pharmacy discount cards or manufacturer coupons may be used at the pharmacy in lieu of billing your insurance. Discount cards and manufacturer coupons are not health insurance policies and are not intended as a substitute for prescription insurance. However, these programs can provide discounts and may lower your out-of-pocket costs on certain medications. These discount cards or coupons cannot be combined with your insurance card. When you present your insurance card and a pharmacy discount card or manufacturer coupon, the pharmacy can advise you which card will provide the most savings on a

particular medication. Please note: Medicare participants are prohibited from using drug manufacturer coupons and pharmacy discount cards.

Claims Filing Deadline

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

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

Reimbursement of Co-insurance

Your mail order co-insurance is the out-of-pocket amount you must pay when you fill your prescription drugs. It is not eligible for reimbursement under the VALUE Medical Option. However, if you elected to participate in the Health Care Flexible Spending Account (HCFSA), your co-insurance may be eligible for reimbursement. See the [Health Care Flexible Spending Account](#) section for more information.

If you have exhausted your HCFSA, and have funds in your Health Incentive Account (HIA), you can receive reimbursement for your co-insurance.

New

HIA - Health Incentive Account

If you participate in the [Healthmatters](#) wellness program, dollars that you earn for completing certain activities will be deposited into your HIA. You can use these funds to help offset eligible medical, prescription, dental and vision out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your HCFSA. Funds must be in the account before you can use them.

Core Medical Option

This section includes:

- Eligibility for CORE Medical Option
- How the CORE Medical Option Works
 - In-Network Services
 - Out-of-Network Services
 - Network/Claims Administrator
 - Special Provisions
- Covered and Excluded Expenses
- Filing Claims
 - Claims Filing Deadline
- Prescription Drug Benefits
 - Retail Drug Coverage
 - Express Scripts Smart 90 Program
 - Express Scripts Mail Order
 - Reimbursement of Co-insurance
- Health Savings Account (HSA)
 - HSA Funds
 - Setting Up an HSA
 - Using Your HSA Funds
 - Eligible HSA Expenses
 - Ineligible HSA Expenses
 - Limited Purpose Health Care Flexible Spending Account (LPFSA)

This Medical Benefit Option is non-grandfathered.

Eligibility for the CORE MEDICAL Option

As of January 1, 2012, Home-Based Representatives or Level 84 Premium Services Representatives are eligible to enroll in the CORE Medical Option only.

All active, full-time or part-time employees of American Airlines, Inc. and US Airways, Inc. are eligible for the CORE Medical Option described in this Guide but excluding any employees listed as ineligible in the "Ineligibility Section".

How the CORE Medical Option Works

The CORE Medical Option offers a network of preferred 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. If you use an in-network provider, the CORE Medical Option will pay your expenses at a higher level of benefit. When you use an in-network provider, you pay only a co-pay or deductible and co-insurance for most services. If you choose to use an out-of-network provider, the charges will be subject to usual and prevailing fee limits or the Maximum Out-of-Network Charge and the CORE Medical Option will pay your expenses at a lower level of benefit.

Go online or call your Network/Claim Administrator for more information and to access a list of in-network providers. See "Negotiated Rates" in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

Benefit Overview

CORE Medical Option	Annual Deductible		Annual Out-of-Pocket Maximum	
	Individual	Family	Individual	Family
In-Network	\$2,000	\$4,000	\$4,000	\$8,000
Out-of-Network	\$4,000	\$8,000	\$12,000	\$24,000

New

In-Network Services, Deductible and Out-of-Pocket Maximums

You must satisfy the individual in-network annual deductible of \$2,000 (if you cover yourself only) or the family in-network annual deductible of \$4,000 (if you elect coverage for yourself and any dependents) before the Option begins paying a percentage of eligible benefits.

After you meet the annual in-network deductible, the CORE Medical Option pays 80% of in-network eligible expenses up to the negotiated rate. You pay 20% co-insurance for in-network services. After you meet the annual out-of-pocket maximum, eligible expenses are covered at 100% for the remainder of the year. The family out-of-pocket maximum applies if you cover dependents. The deductible applies to the out-of-pocket maximum.

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.

After you satisfy the individual in-network annual out-of-pocket maximum of \$4,000 for eligible expenses, the CORE Medical Option pays 100% of in-network eligible expenses for the rest of the calendar year (with a few exceptions).

If more than one person is covered under this Option, you must satisfy the \$8,000 in-network annual family out-of-pocket maximum before the CORE Medical Option pays 100% of in-network eligible expenses for the rest of the calendar year. Under the CORE Medical Option, the covered person's co-insurance amounts apply to the annual out-of-pocket maximum. Deductibles apply toward the out-of-pocket maximum.

Out-of-Network Services (OON), Deductible and Out-of-Pocket Maximums

You must satisfy the individual out-of-network annual deductible of \$4,000 (if you cover yourself only) or the family out-of-network annual deductible of \$8,000 (if you elect family coverage) before the Option begins paying a percentage of eligible benefits.

After you meet the annual out-of-network deductible, the CORE Medical Option pays 60% of out-of-network eligible expenses, up to [usual and prevailing fee](#) limits of Fair Health, for most medically necessary services. You pay 40% co-insurance for out-of-network services. Additionally, you must pay any amount of the provider's billed fee that exceeds the usual and prevailing (U&P) fee limits.

New

Notwithstanding the above, the rules governing Out-of-Network reimbursement will change. Effective June 1, 2015, reimbursement rates for Out-of-Network services will be based on the Maximum Out-of-Network Charge (or MOC) instead of U&P. The MOC is a percentage of the rate that the federal Medicare program would pay for the service. Generally, the MOC for out-of-network providers and facilities will be limited to 140% of the amount the federal Medicare program would have paid for the same service. Your claims administrator will determine the MOC based on this formula. In addition to the percentage of coinsurance you

must pay under the terms of the Plan, you may be responsible for any amount your out-of-network provider or facility charges over 140% of the Medicare fee schedule for the service rendered.

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

- If the claim is for care in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the CORE Medical 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/Claim Administrator's network gap mile limit), and the covered person has received prior approval from the Network/Claim Administrator, the Medical Option will allow the out-of-network provider's full billed charge as an eligible expense.
 - If the claim is for care in a "clinical gap", the Medical Option will allow the out-of-network provider's full billed charge as an eligible expense, as long as all of the following apply:
 - In-network providers in the area with the same credentials cannot provide the specific treatment that a patient needs
- New
- If the claim is for services for which no usual and prevailing fee data exist, the CORE Medical Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense. For claims incurred on or after June 1, 2015, if the claims administrator is unable to determine the MOC based on Medicare reimbursements, the CORE Medical Option will allow 50% of the out-of-network provider's full billed charge as an eligible expense.

After you meet the annual out-of-pocket maximum, eligible expenses are covered at 100% for the remainder of the year. The deductible applies to the out-of-pocket maximum. The family out-of-network out-of-pocket maximum applies if you cover dependents.

Covered and Excluded Expenses

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

Prescription Drug Benefits

Express Scripts is the prescription drug vendor for the CORE Medical Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the ESI Mail Order benefit. Only eligible expenses for covered prescription drugs apply to your deductible and/or out-of-pocket maximum.

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, go to 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.

When you fill your prescriptions at a network retail pharmacy, you must first satisfy your annual deductible before benefits begin (with the exception of certain preventive medications).

Once you meet your deductible, you pay 20% co-insurance (in-network) and 40% co-insurance (out-of-network) for the cost of your prescriptions

You pay 20% co-insurance for medications taken for preventive purposes as identified by Express Scripts, unless such medications are required to be covered at 100% under the Affordable Care Act. Visit the [Express Scripts website](#) or call 1-800-988-4125 to find out if your prescription meets the criteria for a preventive medication.

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.
- Express Scripts will notify your Network/Claim Administrator of all amounts applied to the deductible and out-of-pocket maximum.

Out-of-network pharmacies:

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

- At the time of purchase, you will pay the full retail prescription cost and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Express Scripts. See *Filing Claims for Prescriptions* for more information on how to file a claim.

Cost of prescription at pharmacy	\$250
Express Scripts discount price	\$100
You Pay	\$30 (30% co-insurance of \$100), plus \$150 (the difference between the pharmacy cost and the Express Scripts discount price)
Your Total	\$180

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.

New

Retail Refill Allowance — Long-Term Medications

You and your covered dependents will pay 50% of the drug cost for long-term prescription medications at a retail pharmacy after your third purchase, unless you utilize retail pharmacies that are part of the ESI Smart 90 Program (see below for more information). 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.

If you do not choose to use the ESI Mail Order program or the Smart 90 Program, beginning with your fourth purchase of a 90-day prescription, 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 or co-insurance.

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. 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 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 an 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, 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 if you want 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, 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 an in-network 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 be reimbursed through your medical benefit Option and must be filled at an in-network retail pharmacy using your Express Scripts ID card or through Accredo for you to receive prescription drug benefits. Accredo 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 Smart 90 Program

You and your covered dependents are eligible for the Express Scripts (ESI) Smart 90 Program. You may use this option to purchase a 90-day supply of the prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You can order medications on a 90-day supply basis through ESI's Smart 90 Program at a local CVS or Safeway-owned pharmacy, such as Tom Thumb, Randall's, Vons or Dominick's. Ordering medications on a 90-day supply basis will save you more money than if you fill your prescriptions at other retail pharmacies not affiliated with the Smart 90 Program.

When you fill your prescription through the ESI Smart 90 Program, you must first satisfy your annual deductible before benefits begin. Once you meet your deductible, you pay 20% co-insurance for the cost of your prescriptions purchased through the ESI Smart 90 Program.

Express Scripts Mail Order

You and your covered dependents are also eligible for Express Scripts Mail Order. 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 Mail Order will often save you money than if you fill your prescriptions at a retail pharmacy on a 30-day basis.

When you fill your prescriptions through Express Scripts Mail Order, you must first satisfy your annual deductible before benefits begin.

Once you meet your deductible, you pay 20% co-insurance for the cost of your prescriptions purchased through Express Scripts Mail Order. There is no out-of-network mail order option.

New

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100% under the CORE Medical Option through ESI Mail Order or when filled at a local CVS or Safeway-owned pharmacy only. If you purchase contraceptives from a retail pharmacy not affiliated with the Smart 90 program, no benefits are payable. If you are taking contraceptives specifically for the purpose of preventing pregnancy, please be aware some services have age and frequency limitations. These limitations can be based on medical necessity, medical review boards of the carriers in which we partner with to provide health care services and ACA. If you purchase contraceptives for reasons other than the prevention of pregnancy, the appropriate co-insurance will apply. If you purchase a brand name contraceptive that has a generic equivalent, you are responsible for the cost difference between the brand name and generic, unless your health care provider determines that a generic contraceptive would be medically inappropriate.

You pay 20% co-insurance for medications taken for preventive purposes as identified by Express Scripts, but these medications are not subject to the deductible. Contact Express Scripts to find out if your prescription meets the criteria for a preventive medication.

Mail Order Prescription Clinical Programs

Express Scripts 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 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 your physician considers it appropriate. Generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using generic drugs, you save money. If a brand name drug is not specified, your prescription may be filled with the generic.

Ordering Prescriptions by Mail

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

Complete the [Mail Order Form](#), and 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, or
- Your Health Savings Account (HSA) debit card, or
- 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 online access to Express Scripts Mail Order 24-hours a day, seven days a week. At 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 1-800-988-4125 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 Express Scripts refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

Pharmacy Discount Cards and Manufacturer Coupons

Pharmacy discount cards or manufacturer coupons may be used at the pharmacy in lieu of billing your insurance. Discount cards and manufacturer coupons are not health insurance policies and are not intended as a substitute for prescription insurance. However, these programs can provide discounts and may lower your out-of-pocket costs on certain medications. These discount cards or coupons cannot be combined with your insurance card. When you present your insurance card and a pharmacy discount card or manufacturer

coupon, the pharmacy can advise you which card will provide the most savings on a particular medication. Please note: Medicare participants are prohibited from using drug manufacturer coupons and pharmacy discount cards.

Reimbursement of Co-insurance

Your retail and mail order co-insurance is the out-of-pocket amount you must pay when you purchase your prescription drugs. It is not eligible for reimbursement under the CORE Medical Option. However, if you elected to participate in the Health Savings Account (HSA), your co-insurance may be eligible for reimbursement.

HSA - Health Savings Account

A Health Savings Account (HSA) HSA is a tax-favored medical savings account available only to enrollees in the CORE Medical Option who have no non-high deductible health plan coverage through any other source. The HSA is not sponsored or maintained by the Company. Rather, it is your own account to which you can contribute pre-tax or after-tax dollars. The Company will also contribute dollars to your HSA as described below. You can use the money in your HSA on a tax-free basis to pay for any qualified medical expenses, including your annual Deductible responsibility if you choose. Furthermore, unused dollars roll over from year to year and therefore can be saved or invested and accumulate through retirement. If you use the money in your HSA to pay for any expenses that are not qualified medical expenses, the distribution is subject to income tax, and may be subject to a 20% penalty. Over-the-counter drugs are only considered to be a qualified medical expense if you obtain a prescription for such drugs from your doctor (this rule does not apply to insulin).

You elect to deduct pre-tax dollars from payroll when you enroll in an HSA with Your Spending Account (YSA) on Benefits Service Center. You can change your election amount anytime during the year, except for the last 30 days of the benefit year.

Employer contributions will be made in the form of reward dollars that you earn by completing specific Healthmatters activities. See Healthmatters for more information.

The IRS sets the HSA limits, including catch-up contribution amounts for individuals over the age of 50. These limits may increase or decrease in the future.

New

The amounts noted below are the maximum amounts you can contribute to your HSA during 2015, including any Healthmatters Rewards dollars you may earn during the year.

Employee Only:	\$3,350
Employee + Covered Spouse/Domestic Partner:	\$6,650
Employee + Family:	\$6,650
Employee + Child(ren):	\$6,650

HSA Funds

You must have the money in your HSA before the funds are available to pay for eligible expenses. There is no “use it or lose it” rule with an HSA. Your funds remain in your account, until you choose to withdraw them. You may enhance account growth through investment earnings such as mutual funds, money markets or other investment type products.

Setting Up an HSA

The rules for setting up and using an HSA are determined by the Internal Revenue Service (IRS).

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

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

For example:

My annual HSA deduction is \$5,000

I get paid every 2 weeks = 26 times a year.

My pre-tax per pay period payroll deduction = \$192.31

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

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

Using Your HSA Funds

After enrollment you will automatically receive a health care debit card to access your HSA funds during the year. You can use your card at the point of purchase to pay for eligible medical, dental and vision expenses.

At the same time you receive your card, you will receive instructions on how to access your YSA online account. When you are logged onto your account you can review your account payment history, request to be reimbursed for eligible expenses paid out-of-pocket and learn more about how to manage your HSA.

You may need to prove to the IRS that distributions from your HSA were for eligible expenses and not otherwise reimbursed. It is an IRS requirement that participants keep all receipts when using an HSA to pay for eligible expenses. If you use your HSA to purchase non-eligible expenses, the distribution will be subject to income tax and may be subject to a 20% penalty.

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

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

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

You do not have to pay account management fees with YSA as an American employee when you initiate your HSA and remain enrolled year-over-year. If you have an HSA from the previous year and elect not to contribute to the HSA the following year, you will be responsible for any account fees.

HSA Expenses	
This table contains an alphabetical list of some items that are eligible/ineligible HSA expenses. For a full list of eligible HSA expenses, see IRS Publication 969 .	
Eligible HSA Expenses	Ineligible HSA Expenses
Acupuncture Blood tests Chiropractor Contraceptives Diagnostic devices (such as a blood sugar monitor) Hearing aids Hospital services Insulin (including administration supplies) Lab tests Prescription medications Nursing services Wheelchairs	Athletic club memberships Cosmetic surgery Cosmetics, hygiene products and similar items Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits Over-the-counter medications without a doctor's prescription Tobacco cessation programs Weight loss programs

Limited Purpose Flexible Spending Account (LPFSA)

IRS regulations do not permit CORE Medical Option participants to contribute to both an HSA and a Health Care FSA. However, you can elect a Limited Purpose Health Care FSA. The Limited Purpose FSA can be used for eligible vision and dental expenses. See the [Health Care Flexible Spending Accounts](#) section for more information.

Out-of-Area Coverage

This section includes:

- How Out-of-Area Coverage Works
 - Network/Claim Administrator
 - Special Provisions
- Covered and Excluded Expenses
- Filing Claims
 - Claims Filing Deadline
- Prescription Drug Benefits
- Retail Drug Coverage
 - Filling Prescriptions at a Network Pharmacy
 - Filling Prescriptions at an Out-of-Network Pharmacy
 - Reimbursement of Co-insurance
 - ESI Smart 90 Program
 - ESI Mail Order
 - Mail Order Prescription Clinical Programs
 - Generic Drugs
 - Ordering Prescriptions by Mail
 - Internet Refill Option
 - Other Refill Options
 - Claims Filing Deadline
 - Reimbursement of Co-insurance
 - Health Reimbursement Account

This OUT-OF-AREA Medical Option is non-grandfathered.

Employees whose alternate address ZIP code is not part of their preferred administrator's network of providers will be offered the OUT-OF-AREA Coverage as an Option. You can cover yourself, your spouse/Company-recognized Domestic Partner, your dependent children and/or your spouse/Company-recognized Domestic Partner's children under OUT-OF-AREA coverage.

The sole Network/Claim Administrator for the OUT-OF-AREA Medical Option is UnitedHealthcare. Each covered person, which includes you and any covered dependents, must satisfy an individual annual deductible before the Option begins paying a percentage of the eligible expenses.

Each covered person, which includes you and any covered dependents, must satisfy an individual annual out-of-pocket maximum before the Option begins paying 100% of the eligible expenses.

When you use a UHC contracted physician, hospital and/or other medical service provider, your eligible expenses will be based on the negotiated rates.

When you use a physician, hospital, or other medical service provider that does not have a contract with your medical plan administrator, your eligible expenses are based on 90% of Usual & Prevailing fees (U&P). U&P fees will depend on the range and complexity of the services provided, and the typical charges for the same service in the geographic area where the service or supply is rendered/provided. See the Glossary for a complete definition of U&P.

Benefit Overview

	Individual Annual Deductible	Family Annual Deductible	Individual Annual Co-Insurance Maximum	Family Annual Out-Of-Pocket Maximum
New	\$800	\$2,400	\$2,000	\$5,000

How Out-of-Area Coverage Works

In rare cases, a U.S. employee may live outside all of the network service areas and not have ready access to any of the preferred provider networks. Employees who do not have access to network providers that meet the guidelines determined by the Network/Claim Administrator will have OUT-OF-AREA coverage as an Option. If you are eligible for OUT-OF-AREA coverage, you will see it listed as an Option in the [Benefits Service Center](#) when you enroll.

OUT-OF-AREA coverage offers a preferred provider network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. You may use any qualified licensed physician you wish, but you will receive the discount if you use a preferred provider. Contact your Network/Claim Administrator for more information and to access a list of preferred providers. See "Negotiated Rates" in this section for information regarding providers that have agreed to charge negotiated rates for medical services.

See "[Medical Benefits Option Comparison](#)" in the *Medical Benefits Options Overview* section to see a comparison of your benefits under the OUT-OF-AREA Medical Option.

Each covered person, which includes you and any covered dependents, must satisfy an individual annual deductible of \$800 before the Option begins paying a percentage of the eligible expenses (with the exception of preventive care and prescription drugs). After you and your covered dependents meet the annual deductible, the OUT-OF-AREA Medical Option pays 80% of eligible expenses up to the negotiated rate or usual and prevailing. You pay 20% co-insurance for 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 certain prescription drug expenses.

Network/Claims Administrator

OUT-OF-AREA coverage is administered by UnitedHealthcare (UHC). Therefore, you cannot select a different Network/Claim Administrator for OUT-OF-AREA coverage.

If you relocate to a new state, your Network/Claim Administrator does not change. Your medical plan Option election and contribution rates remain the same for the remainder of the plan year.

Special Provisions

OUT-OF-AREA Coverage includes the following special provisions:

Individual Annual Out-of-Pocket Maximum: The covered persons coinsurance and copay amounts apply to the out-of-pocket maximum. After you satisfy the individual annual out-of-pocket maximum of \$2,000 for eligible expenses, OUT-OF-AREA coverage pays 100% of eligible expenses for the rest of the calendar year. Under OUT-OF-AREA coverage, Deductibles do not count towards the out-of-pocket maximum.

Negotiated Rates: If you are enrolled in OUT-OF-AREA coverage, it is because there are not any network providers where you reside. However, there may be instances in which you receive services from a network provider.

OUT-OF-AREA coverage offers a network of physicians, hospitals and other medical service providers that have agreed to charge negotiated rates for medical services. The negotiated rates save you money when you or your covered dependent needs medical care and chooses a participating provider.

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

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

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 a preferred provider, you will receive the in-network negotiated rate for hospital charges; however, 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 physician or hospital uses a lab that

is not part of the network. Note, some lab and X-ray services performed in a hospital may be contracted out to an out-of-network provider.

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 *Medical Benefit Options Overview* section.

Prescription Drug Benefits

Express Scripts is the prescription drug vendor for the OUT-OF-AREA Medical Option. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the ESI Mail Order benefit. Only eligible expenses for covered prescription drugs apply to your out-of-pocket maximum.

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 but will receive better coverage at a network pharmacy or by using mail order. You must present your Express Scripts prescription drug card every time you purchase prescription drugs in order to receive the discounted medication rates at network pharmacies. If you do not present your Express Scripts prescription drug card at the time of purchase at a network pharmacy, 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 co-insurance.

Here is an example:

Cost of prescription at pharmacy:	\$250
Express Scripts discount price:	\$100
You Pay:	\$20 (20% co-insurance of \$100), plus \$150 (the difference between the actual pharmacy cost and the Express Scripts discount price)
Your Total:	\$170

Generic Drugs: 20% co-insurance (\$10 min/\$40 max per prescription)

Formulary/Brand Name Drugs: 30% co-insurance (\$30 min/\$100 max per prescription)*

Non-Formulary/Brand Name Drugs: 50% co-insurance (\$45 min/\$150 max per prescription)*

- * If you select a brand name drug when a generic equivalent is available, you will pay 20% generic co-insurance, plus the cost difference between generic and brand prices. Maximums do not apply.

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

Filling Prescriptions at a Network Pharmacy

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

Express Scripts reports the claim to your Network/Claims Administrator. Any eligible amounts will be applied to your out-of-pocket maximum.

- **Filling Prescriptions at an Out-of-Network Pharmacy**

Follow these steps to fill prescriptions:

Out-of-Network pharmacies:

- Pay the full cost for the prescription
- Send your prescription receipt to Express Scripts
- Express Scripts reports the claim to your Network/Claims Administrator. Any eligible amounts will be applied to your out-of-pocket maximum.

Reimbursement of Co-insurance

If you are enrolled in the OUT-OF-AREA Medical Option and you participate in the Health Care Flexible Spending Account, your eligible retail drug out-of-pocket expense is reimbursable under your FSA (see [“Covered Expenses”](#) in the *Health Care Flexible Spending Accounts* section). If you have funds in your Health Reimbursement Account, you can use those funds to pay out-of-pocket expenses. However, keep in mind that you can access your Health Reimbursement Account only after you’ve exhausted your Health Care Flexible Spending Account.

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/Claim Administrator (for specialty medications see “Specialty Pharmacy Services” in this section).

New

Retail Refill Allowance — Long-Term Medications

You and your covered dependents will pay 50% of the drug cost for long-term prescription medications at a retail pharmacy after your third purchase, unless you utilize retail pharmacies that are part of the ESI Smart 90 Program (see below for more information). 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.

If you do not choose to use the ESI Mail Order program or the Smart 90 Program, beginning with your fourth purchase of a 90-day prescription, 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 or co-insurance.

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. 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 ESI Mail Order Prescription Drug benefit. Examples of medications requiring prior authorization include growth hormones and rheumatoid arthritis drugs and all medications that are compounded by registered pharmacists.

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 an 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 if you want 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, 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 will no longer be reimbursed through your medical benefit Option and must be filled at a retail pharmacy using your Express Scripts ID card or through ESI Mail Order 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.

New

Express Scripts Smart 90 Program

You and your covered dependents are eligible for the Express Scripts (ESI) Smart 90 Program. You may use this option to purchase a 90-day supply of the prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You can order medications on a 90-day supply basis through ESI's Smart 90 Program at a local CVS or Safeway-owned pharmacy, such as Tom Thumb, Randall's, Vons or Dominick's. Ordering medications on a 90-day supply basis will save you more money than if you fill your prescriptions at other retail pharmacies not affiliated with the Smart 90 Program.

Express Scripts Mail Order

You and your covered dependents are also eligible for ESI 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 co-insurance (with no annual deductible) for each prescription or refill. Co-insurance, which is subject to change, is currently:

Generic Drugs: 20% co-insurance per prescription or refill for generic drugs (or the actual cost of the drug, if the prescription cost is less). The minimum amount you will pay is \$5 and the maximum you will pay is \$80.

Formulary Brand Name Drugs: 30% co-insurance per prescription or refill for formulary/brand name drugs (or the actual cost of the drug, if the prescription cost is less). The minimum amount you will pay is \$60 and the maximum you will pay is \$200.

Non-formulary Brand Name Drugs: 50% co-insurance per prescription or refill for non-formulary/brand name drugs (or the actual cost of the drug, if the prescription cost is less). The minimum amount you will pay is \$90 and the maximum you will pay is \$300.

New

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100% under the OUT-OF-AREA Medical Option through ESI Mail Order or when filled at a local CVS or Safeway-owned pharmacy only. If you purchase contraceptives from a retail pharmacy not affiliated with the Smart 90 program, no benefits are payable. If you are taking contraceptives specifically for the purpose of preventing pregnancy, please be aware some services have age and frequency limitations. These limitations can be based on medical necessity, medical review boards of the carriers in which we partner with to provide health care services and ACA. If you purchase contraceptives for reasons other than the prevention of pregnancy, the appropriate co-insurance will apply. If you purchase a brand name contraceptive that has a generic equivalent, you are responsible for the cost difference between the brand name and generic, unless your health care provider determines that a generic contraceptive would be medically inappropriate.

Mail Order Prescription Clinical Programs

Express Scripts 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 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 your physician considers it appropriate. Generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using generic drugs, you save money. If a brand name drug is not specified, your prescription may be filled with the generic.

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.

ESI Mail Order 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 online access to ESI Mail Order 24-hours a day, seven days a week. At 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 1-800-988-4125 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 ESI Mail Order refill prescription label to the form or write the prescription refill number on the form. Include your payment with your order.

Pharmacy Discount Cards and Manufacturer Coupons

Pharmacy discount cards or manufacturer coupons may be used at the pharmacy in lieu of billing your insurance. Discount cards and manufacturer coupons are not health insurance policies and are not intended as a substitute for prescription insurance. However, these programs can provide discounts and may lower your out-of-pocket costs on certain medications. These discount cards or coupons cannot be combined with your insurance card. When you present your insurance card and a pharmacy discount card or manufacturer coupon, the pharmacy can advise you which card will provide the most savings on a particular medication. Please note: Medicare participants are prohibited from using drug manufacturer coupons and pharmacy discount cards.

Claims Filing Deadline

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

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

Reimbursement of Co-insurance

Your mail order co-insurance is the out-of-pocket amount you must pay when you fill your prescription drugs. It is not eligible for reimbursement under the Out-of-Area Medical Option. However, if you elected to participate in the Health Care Flexible Spending Account, your co-insurance may be eligible for reimbursement. See the [Health Care Flexible Spending Accounts](#) section for more information.

If you have exhausted your Health Care Flexible Spending Account, and have funds in your Health Reimbursement Account, you can receive reimbursement for your co-insurance.

New

HRA - Health Reimbursement Account

If you participate in the [Healthmatters](#) wellness program, dollars that you earn for completing certain activities will be deposited into your HRA. You can use these funds to help offset medical, prescription, dental and vision out-of-pocket expenses (deductible, co-pay, co-insurance). However, you can access these funds only after you have exhausted your Health Care Flexible Spending Account. Funds must be in the account before you can use them.

Health Maintenance Organizations (HMOs)

Eligibility

- Children Living Outside of the Service Area

- Termination of Coverage

- If You Reach Age 65 and are Still an Active Employee

How HMOs Work

HMO Contact Information

- Problems and Complaints

Your HMO Medical Option may be either grandfathered or non-grandfathered, depending upon the HMO Medical Option; contact your specific HMO for this information.

HMOs are fully insured programs that provide medical care through a network of physicians, hospitals and other medical service providers.

If you enroll in an HMO Medical Option, you will receive information from the HMO describing the services and exclusions of that HMO.

Company-recognized Domestic Partners may be eligible for coverage under HMOs. Contact your HMO directly to learn about their eligibility rules.

Most HMOs require 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 HMOs.

HMO Medical Option Eligibility

HMO Medical Option eligibility is determined by the ZIP code of your American Airlines Benefits Service Center alternate address on record. If you are eligible to enroll in an HMO, the names of the HMOs will appear as options in the [Benefits Service Center](#) during Annual Benefits Enrollment (or as a new employee when you enroll for benefits the first time).

Eligibility

Company-recognized Domestic Partners may be eligible for coverage under your HMO Medical Option. If your Company-recognized Domestic Partner can be covered under your HMO Medical Option, 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.

HMO offerings vary by location. You must reside within the HMO's service area in order to be eligible for the HMO. Your eligibility is determined by the ZIP code of your Benefits Service Center alternate address on record. Benefits Service Center allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (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 Benefits Service Center; however, your alternate address determines your eligibility. If you do not have an alternate address listed in Benefits Service Center, your eligibility is based on your permanent address.

If you are eligible to enroll in an HMO Medical Option, the names of the HMOs will appear as options in the [Benefits Service Center](#) during Annual Benefits Enrollment (or as a new employee when you enroll for benefits the first time). If you elect coverage under an HMO, all your claims for benefits are solely under the HMO contract or policy and all benefits are provided solely through the HMO.

There are some additional rules regarding your coverage when you are enrolled in an HMO.

Children Living Outside of the Service Area

If your child does not live with you, contact the HMO to find out if your child can be covered.

If you are providing the child's coverage under a Qualified Medical Child Support Order (QMCSO) and the HMO cannot cover your child, you may be required to select a different Medical Benefit Option for your entire family. See "[Qualified Medical Child Support Orders \(QMCSO\) Procedures](#)" in the *Additional Health Benefit Rules* section.

Termination of Coverage

Your HMO coverage terminates on the date when:

Your employment terminates. If your employment terminates, you may be eligible to continue HMO coverage under COBRA. You may also apply for individual HMO coverage. You will automatically be solicited for continuation of your HMO coverage under COBRA by Aon Hewitt, the COBRA administrator.

You leave the service area. You must register this move as a Life Event on Benefits Service Center, and enroll in another HMO (if available) or self-funded Medical Benefit Option. Contact American Airlines Benefits Service Center within 31 days of your move. If you do not notify American Airlines Benefits Service Center of your move, you will be enrolled the default Medical Benefit Option for your workgroup and will receive a confirmation statement indicating your new coverage.

You retire. If you retire while covered by an HMO, your coverage will change. See the [Retiree Medical Benefit Guide](#) for your workgroup eligibility. HMO membership is not currently available

FAQ: How do I know if I'm eligible for an HMO?

HMO eligibility is determined by your ZIP code. If you are eligible, your HMO option(s) will appear in the [Benefits Service Center](#) when you enroll for benefits.

to retirees unless you live in Puerto Rico. Retirees in Puerto Rico may enroll in the Triple S HMO.

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

If You Reach Age 65 and are Still an Active Employee

If you or your covered eligible dependent reaches age 65 or becomes eligible for Medicare while covered under an HMO, most HMOs allow you to continue coverage. Coordination of benefits with Medicare applies. The HMO is primary and Medicare is secondary as long as you are an active employee (see “[Coordination of Benefits](#)” in the *Additional Health Benefit Rules* section).

How HMOs Work

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

Choose a primary care physician (PCP) who coordinates all your medical care, and

Obtain a referral from your PCP before receiving care from a specialist.

HMOs are completely independent of the Company. Because each HMO is an independent organization, the benefits, restrictions and conditions of coverage vary from one HMO to another. The Company cannot influence or dictate the coverage provided.

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

In general, features of HMOs include:

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

If you elect an HMO, your HMO coverage replaces medical coverage offered through self-funded Medical Benefit Options. Your benefits, including prescription drugs and mental health care, are covered according to the rules of your HMO.

Glossary Term: Primary Care Physician (PCP)

A PCP is a physician who coordinates all of your covered medical care, including specialist visits.

HMO Contact Information

For more information on HMOs, contact the individual HMO.

HMO Name	Phone Number	Website Address	Group Number
Community Care Managed Healthcare	1-800-777-4890	http://aa.ccok.com	C01338

HMO Name	Phone Number	Website Address	Group Number
Plans of Oklahoma			
Health Plan Hawaii (HMSA)	1-808-948-6372	http://www.hmsa.com/	C92U (Referred to as Agent Code)
Humana Health Plans of Puerto Rico	1-800-314-3121	http://www.humana.com/	113262
Kaiser Northern California	1-800-464-4000	http://www.my.kp.org/americanairlines	8653
Kaiser Southern California	1-800-464-4000	http://www.my.kp.org/americanairlines	102105
Kaiser Mid-Atlantic States (Maryland and Washington, D.C.)	1-800-777-7902	http://www.my.kp.org/americanairlines	3381
TRIPLE-S Inc. (Puerto Rico only)	1-787-774-6060	http://www.ssspr.com/	SP0003447

Problems and Complaints

Each HMO has a grievance procedure or policy to appeal claim denials or other issues involving the HMO. Call your HMO for information on filing complaints or grievances.

Dental Benefits

This section includes:

- How the Dental Benefit Works
 - Eligibility
 - Plan Comparison Chart
 - Special Provisions
- Covered Expenses
 - Preventive Services
 - Basic and Major Services
 - Orthodontia
- Excluded Expenses
- Filing Claims
 - Claim Filing Deadline

Dental benefits help you and your covered dependents take care of your dental needs. Coverage is provided for routine dental care and treatment for disease, defect and injury.

Eligible employees and their eligible dependents can enroll in Dental Benefits, even if they do not elect medical coverage.

You must enroll yourself in the Dental Benefit if you would like to cover any dependents under the Dental Benefit.

Orthodontia coverage is included for eligible children and adults.

MetLife administers a Preferred Dental Provider (PDP) network that offer services at discounted rates. You may use any dentist you wish, but preventive services are covered at 100% if you use an in-network PDP provider or 80% if you use an out-of-network PDP. For TWU-Represented employees preventative services are covered at 100% if you use an in-network or out-of-network PDP.

The Dental Benefit covers medically necessary dental and orthodontic items and services for covered eligible adults and children.

MetLife's Role

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

Benefit Overview

Eligibility	Coverage Levels		Key Features
All eligible employees and their eligible dependents	These coverage levels apply to AMS workgroups: Employee Employee + Spouse/Company-recognized Domestic Partner Employee + Child(ren) Employee + Family	These coverage levels apply to TWU: EE Only EE + 1 Dependent EE + 2 Dependents	Annual deductible of \$50 Preventive care provided by an in-network dentist at 100% Preventive care provided by an out-of-network dentist at 80% Basic and major care at 80% Orthodontia services at 50% For TWU-Represented employees, in-network or out-of-network preventive care is covered 100%

How the Dental Benefit Works

The Dental Benefit offers a network of participating dentists and specialists nationwide who provide fee discounts to Dental Benefit participants.

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

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

AQ: How do I find a PDP network dentist?

Visit the [MetLife website](#) or call 1-866-838-1072. Take a copy of the [Dental Claim Form](#) with you when you visit your dentist

Eligibility

You must enroll yourself in the Dental Benefit if you would like to cover any eligible dependents in the Dental Benefits. See "[Dependent Eligibility by Benefit](#)" in the *General Eligibility* section for age requirements.

Plan Comparison Chart

These are the features of the Dental Benefit Options:

Feature	Benefit
Annual Deductible (You pay this amount before benefits are	\$50 per person

Feature	Benefit
paid)	
Dental Services Plan pays:	
<i>Preventive Service - Services Provided by a Network Provider</i> Twice per year: exams and cleanings Once per year: routine X-rays	100% (Deductible does not apply)
<i>Preventive Service - Services Not Provided by a Network Provider</i> Twice per year: exams and cleanings Once per year: routine X-rays	80% (Deductible does apply) 100% for TWU-Represented employees
<i>Basic & Major Services</i> (fillings, extractions, crowns, bridges, dentures)	80%
<i>Maximum Benefit</i> (per person per year)	\$1,500
Orthodontia Services Plan pays:	
<i>Orthodontia Services</i> (annual deductible does not apply)	50%
<i>Maximum Lifetime Orthodontia Benefit (Adult or eligible dependent child)</i>	\$1,500

Special Provisions

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

Covered Expenses

There are two types of Covered Expenses:

- Preventive Services
- Basic and Major Services

Glossary Term:
Usual and
Prevailing Fee
Limits

The maximum amount that the Plan will consider as an eligible expense for dental services and supplies.

Preventive treatment:

- Exams twice per calendar year
- Routine X-rays once per calendar year
 - TWU-Represented employee adults can have bitewings 2x a year
 - Children can have bitewings 2x a year
- Full mouth X-rays once every five years; three years for TWU-Represented employees
- Teeth cleaning twice per calendar year
- Fluoride treatments once a year for children under age 18 (not covered on or after the child's 18th birthday)
- Sealants for children under age 15 (not covered on or after the child's 15th birthday)
- Space maintainers

Basic and Major Services

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

Dentures and bridgework: Full and partial dentures and fixed or removable bridgework, including:

Installation of the initial appliance to replace natural teeth extracted, including adjustments within six months of installation.

Replacement if the appliance is more than five years old and cannot be repaired.

(Appliances that are over five years old but can be made serviceable will be repaired, not replaced.)

Installation of the appliance for teeth missing as a result of a congenital anomaly.

(Charges are limited to the allowance for a standard prosthetic device.)

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

Extractions, medically necessary surgery and medically necessary related

anesthetics: These services are considered covered dental treatments. Treatment of certain injuries and conditions may be covered under Medical Benefit Options. See "[Covered Expenses](#)" in the *Medical Benefits Options Overview* section.

Fillings and crowns: Silver, porcelain or composite fillings and plastic restorations subject to the following:

Porcelain crowns are covered only for the 10 front upper and 10 front lower teeth.

Porcelain or plastic facings on crowns posterior to the second bicuspid are not covered.

Gold fillings and crowns are covered only when the tooth cannot be restored with other materials.

Crowns may only be replaced if the existing crown is more than five years old, regardless of the reason for the replacement.

Dental implants, implant restorations: Only if medically necessary (if the tooth or teeth cannot be restored by any other means) and approved by independent dental consultants selected by the Company.

Inlays and onlays: Only if medically necessary and approved by independent dental consultants selected by the Company.

Oral examinations, X-rays and laboratory tests: These are covered if medically necessary to determine dental treatment.

Oral surgery: If you have medically necessary oral surgery and it requires medically necessary hospitalization, the expenses for the hospitalization would be payable under the Medical Benefit Option. See [“Covered Expenses”](#) in the *Medical Benefits Option Overview* section.

Periodontal treatment: Medically necessary periodontal treatment of the gums and supporting structures of the teeth and medically necessary anesthetics are covered, with the frequency of treatment based on generally accepted standards of good periodontal care. Examples are scaling and root planing and gingivectomy.

Root canals: Root canals and other endodontic treatments are covered. The charge for root canal therapy is considered to have been incurred on the date the tooth is opened.

Orthodontia

The Dental Benefit covers orthodontic treatment for eligible covered individuals only to a maximum benefit of \$1,500 during the entire time the covered individuals are covered under the Dental Benefit.

Orthodontic coverage includes:

- Examinations
- X-rays
- Laboratory tests
- Other necessary treatments and appliances

There is no deductible for orthodontic treatments, and payments for orthodontia do not reduce the annual maximum benefit for other services.

The following explains additional information about orthodontia coverage:

Ongoing orthodontic coverage: To remain eligible for coverage of orthodontic treatments that extend into a new coverage period (for example, the next calendar year), you must continue to cover the patient under your Dental Benefit during each annual enrollment period.

Paying orthodontia claims: Payment is made according to the following procedures (regardless of the payment method you arrange with your provider):

- The provider of service (orthodontist) should submit one billing that reflects the total cost of the patient's orthodontic treatment – even if the duration of treatment moves across calendar years. The Dental Benefit will pay up to the maximum benefit of \$1,500, in one

lump sum, based upon the orthodontist's lump-sum billing for orthodontia treatment (provided the treatment is determined to be an eligible expense under the Dental Benefit).

- Coordination of benefits applies if the patient has other orthodontia coverage. If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the \$1,500 maximum benefit.

Excluded Expenses

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

Anesthesia: General anesthetics (unless medically necessary and required for oral surgery or periodontics).

Cosmetic treatment: Treatment or services partly or completely for cosmetic purposes or characterization or personalization of dentures or appliances for specialized techniques.

Crowns or appliances: Crowns, adjustments or appliances used to splint teeth, increase vertical dimensions or restore occlusion. Replacement of crowns less than five years old will not be covered, regardless of the reason for replacement.

Education or training: Education, training or supplies for dietary or nutritional counseling, personal oral hygiene or dental plaque control.

Free care: Charges for services or supplies that you are not legally required to pay.

Medical expenses: Any charge for dental care or treatment that is an eligible expense under your Medical Benefit Option.

Night guards: Also referred to as occlusal guards and bruxism appliances.

Prescription drugs: Dental prescriptions are covered under your Prescription Drug Benefit, not under your Dental Benefit. If you are enrolled in an HMO, check with your HMO to find out if your HMO covers dental prescriptions.

Relatives: Treatment by a dentist or physician who is a close relative, including your spouse/Company-recognized Domestic Partner, children, adopted and step relatives, sisters and brothers, parents and grandparents of you or your spouse/Company-recognized Domestic Partner.

Replacement dentures or bridges: Replacement charges for full or partial dentures or a fixed or removable bridge that is less than five years old. Appliances that are over five years old but can be made serviceable will be repaired, not replaced. Also excluded are any charges that exceed the cost of a standard prosthetic appliance.

Services not provided by dentist, orthodontist or physician: Any service not provided by a dentist, orthodontist or physician, unless performed by a licensed dental hygienist under the supervision of a dentist or physician or for X-ray or laboratory tests ordered by a dentist or physician.

Temporary dentures, crowns or bridges after 12 months: A temporary fixture, such as a temporary denture, crown or bridge that remains in place for 12 months or more is considered permanent and the cost of replacement is only covered when the item is more than five years old.

Temporomandibular joint dysfunction (TMJD): TMJD is considered a medical condition and has limited coverage only under the Medical Benefit Options.

U. S. government services or supplies: Charges for services or supplies furnished by or for the U. S. government.

Usual and prevailing: Charges that exceed the usual and prevailing fee limits.

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

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

Filing Claims

MetLife is the claims processor for the Dental Benefit. To file claims for dental expense benefits:

- Complete the top portion of the [Dental Plan Claim Form](#). Follow the instructions on the form and provide the form to your dental provider, who should complete the remaining portion.
- You or your provider, if completing the form on your behalf, will mail the completed claim form to MetLife at the address on the form.
- You will receive an Explanation of Benefits (EOB) detailing the amount paid for each dental claim submitted.
- Payments may be sent to you or to your dentist or other dental provider if your provider accepts Assignment 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.).

Health Spending Accounts: Certain out-of-pocket dental expenses may be eligible for reimbursement from your Health Care Flexible Spending Account, Health Savings Account (CORE Medical Option), Limited Purpose Health Care Flexible Spending Account Health Reimbursement Account (STANDARD Medical Option) or Health Incentive Account (VALUE Medical Option). (See "[Covered Expenses](#)" in the *Health Care Flexible Spending Account* section.)

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

Claim Filing Deadline

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

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

If the 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.

Vision Benefit

How the Vision Insurance Benefit Works

Eligibility

Covered Expenses

In-Network Provider Benefits

Out-of-Network Provider Benefits

Filing Claims

Vision benefits help you and your covered dependents take care of your vision needs. Coverage is provided for routine eye exams, eyeglass frames and lenses or contact lenses.

- Eligible employees and their dependents can enroll in the Vision Insurance Benefit.
- You have the option of in-network or out-of-network coverage. You have a co-pay if you use an in-network provider.
- If you use an out-of-network provider, a reimbursement rate applies. Co-pays do not apply to out-of-network benefits.

Spectera Vision's Role

Your Vision Insurance Benefit is insured and administered by Spectera Vision. Spectera Vision is the claims administrator for the Vision Insurance Benefit. Visit the [Spectera Vision website](#) or contact Spectera Vision at 1-800-217-0094 for more information on the Vision Insurance Benefit.

Benefit Overview

Benefit	Coverage Tiers	Key Features
Vision Insurance Benefit	<ul style="list-style-type: none">• Employee• Employee + Spouse/Domestic Partner• Employee + Child(ren)• Employee + Family	<ul style="list-style-type: none">• \$10 co-pay for in-network eye exam• \$25 co-pay for in-network eyeglass lenses with a \$130 frame allowance• \$25 co-pay for in-network contact lenses (in lieu of eyeglass lenses and frames)• Out-of-network reimbursement rates

How the Vision Insurance Benefit Works

Spectera Vision's network of providers includes retail chains, such as VisionWorks, Wal-Mart or Sam's Club, as well as independent providers. You can locate participating providers by visiting the [Spectera Vision website](#) or you can contact Spectera Vision at 1-800-217-0094 to locate a provider near you. Or see "[Contact Information](#)" in the *Reference Information* section).

To review your vision benefits, refer to the Spectera Vision Rates and Services Chart and Spectera's Vision Care Brochure on the [Spectera Vision website](#).

You will receive a Spectera Vision ID card when you enroll for vision benefits. Show your ID card at your eye care provider to receive negotiated fees and services. If you don't have your card with you, your provider can verify your participation using your Social Security number.

When you use the Vision Insurance Benefit, services are covered once each calendar year for each covered member. This means you do not have to wait a full 12 months until benefits are available again.

FAQ: How do I find a participating provider?

Visit the [Spectera Vision website](#) or call 1-800-217-0094.

Eligibility

You must elect Vision Insurance for yourself if you would like to cover any of your dependents under the vision plan.

Covered Expenses

In-Network Provider Benefits

When you use an in-network provider, you pay the co-pay directly to your provider. No claims forms are necessary. Co-pays do not apply to out-of-network benefits.

In most cases, it will cost you \$35 for glasses or contact lenses:

- \$10 for comprehensive vision
- \$25 for frames or contact lenses

Covered Services	Cost
Comprehensive Vision Exam	\$10 co-pay
Glasses (lenses and frames)	
Clear single vision, lined bifocal or lined trifocal Selection frames (maximum allowance is \$130 for frames purchased at an in-network retail chain provider)	\$25 co-pay
Clear single vision, lined bifocal or lined trifocal Non-selection frame	\$25 co-pay, plus the difference, if any, of Spectera Vision's preferred price and the \$130 frame allowance
Contact Lenses (in lieu of lenses and frames)	
Selection contact lenses Non-disposable	\$25 co-pay (per single pair of contacts)

Covered Services	Cost
Non-selection contact lenses or special contact lenses (gas permeable, bifocal, astigmatism lenses, etc.) Non-disposable	\$150 allowance toward the evaluation, fitting fees and a single pair of contact lenses
Patient Options	
Selection contact lenses, disposable	\$25 co-pay (up to 6 boxes per year included in \$25 co-pay)
Progressive lenses and tints, etc.	No additional charge (included in the \$25 co-pay)
Scratch-coating protection for lenses	No additional charge (included in the \$25 co-pay)

Out-of-Network Provider Benefits

When you use an out-of-network provider, a reimbursement rate applies. Co-pays do not apply to out-of-network benefits. Vision Insurance Benefit will reimburse you expenses based on the following chart:

Glossary Term: In-Network Provider

An in-network provider is part of Spectera Vision's provider database. If you use an in-network provider you receive discounted fees and services.

Service	Reimbursement Rate
Exam	Up to \$40
Single vision lenses	Up to \$40
Bifocal lenses	Up to \$60
Trifocal lenses	Up to \$80
Lenticular lenses	Up to \$80
Frame	Up to \$45
Elective contact lenses	Up to \$150
Medically necessary contact lenses	Up to \$210

Filing Claims

When you use an in-network provider your provider files claims for you.

When you use an out-of-network provider, you must pay the full fee to the provider and file claims with Spectera Vision. Spectera Vision reimburses services rendered up to the maximum allowance.

Fast Fact

You don't need to file claims if you use an in-network provider. If you use an out-of-network provider call 1-800-839-3242 to get a claim form.

Flexible Spending Accounts

How the Health Care Flexible Spending Account (HCFSA) Works
Special Provisions

Covered Expenses
Reimbursable Medical Expenses
Reimbursable Hearing and Vision Expenses
Reimbursable Dental Expenses

Excluded Expenses

Filing Claims

How the Limited Purpose Flexible Spending Account (LPFSA) Works
Reimbursable Expenses
Receiving Reimbursement Under the LPFSA

If You Elect Both a Health Care and a Dependent Day Care FSA

How the Dependent Care Flexible Spending Account Works
Special Provisions
Who is Covered

Covered Expenses

Filing Claims

If You Elect Both a Health Care and a Dependent Day Care FSA

There are three types of flexible spending accounts that American offers. Each account has its own eligibility and expense rules.

- HCFSA- Health Care Flexible Spending Account
- LP FSA- Limited Purpose Flexible Spending Account
- DCFSA -Dependent Care Flexible Spending Account

New

In order to elect and open any of the above three account types, there is a minimum annual contribution amount of \$120 dollars required to complete enrollment.

Account Administrator

The HCFSA, LPFSA and DCFSA administrator is Your Spending Account (YSA). The [YSA website](#) allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access “Frequently Asked Questions (FAQs),” and manage direct deposit.

How the HCFSA - Health Care Flexible Spending Account Works

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

You do not have to be enrolled in an American Medical, Dental or Vision to enroll in an HCFSA.

IRS rules specify the types of expenses eligible for reimbursement from your HCFSA. Eligible health care expenses that can be reimbursed from your HCFSA include:

- Medical

- Dental
- Vision
- Prescription drugs
- Certain over-the-counter items.
- Other expenses not paid by your Medical Benefit Option, such as deductibles, co-insurance, co-pays and any amounts above the usual and prevailing fee limits.

See “[Covered Expenses](#)” and “[Excluded Expenses](#)” in this section for a list of eligible and ineligible expenses.

You can contribute through payroll deduction up to \$2,500 in 2015 in your HCFSA. A minimum annual election amount of \$120 is required to complete enrollment.

Following your first payroll deposit, the full amount of your elected HCFSA amount for the entire year is available for your use, regardless of the actual balance in your account.

You have until March 15 of the following year to incur claims reimbursable under your HCFSA balance and until June 15 to file claims on your previous year’s eligible expenses.

Benefit Overview		
Option	Who Can Be Reimbursed	Key Features
HCFSA-Health Care FSA	<p>You can be reimbursed for expenses for your:</p> <ul style="list-style-type: none"> • Self • Spouse • Children and young adults • Parents • Other dependents, if you claim them as dependents on your federal income tax return • Company-recognized Domestic Partners and their dependents are not considered eligible dependents, per IRS regulations 	<ul style="list-style-type: none"> • Deposit up to \$2,500 in 2015 • Pre-tax contributions • Have until March 15 to use your prior year’s balance • Have until June 15 to file claims for previous year’s eligible expenses • Eligible dependents do not have to be covered under your medical, dental or vision plan to be eligible for reimbursement • If both you and your spouse are employed by American Airlines, both employees may each deposit up to \$2,500 in an HCFSA during 2015

Special Provisions

You can only stop or change your election mid-year if you experience certain Life Events. If you experience a Life Event and decide to reduce the amount of your HCFSA, you cannot reduce your account balance to an amount that is less than the claims that have already been paid.

If you incur expenses after your Life Event, your claims are payable up to the amount of your newly elected deposit amount.

If you decide to stop the amount of your HCFSA deposits mid-year, this will affect how your claims are paid. You cannot stop if you have already received reimbursement exceeding the amount contributed into your HCFSA account. If your eligible health care expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your HCFSA. You cannot receive reimbursement for expenses incurred after

the date you stopped making contributions to your HCFSAs; however you can submit claims up to the amount in your account, provided they were incurred before the date you stopped.

If you choose to stop the amount of your HCFSAs mid-year, you will lose any remaining balance you have if the contributions you made before your Life Event are greater than your claims before the Life Event.

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your HCFSAs terminate. You may elect to continue your HCFSAs as part of your COBRA Continuation of Coverage options. If you do not continue your HCFSAs through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any contributions that were made and not used before your termination date.

Covered Expenses

You can incur claims that meet reimbursement rules for your HCFSAs only for eligible expenses through March 15 of the following year. You have until June 15 to file your claims for reimbursement for eligible expenses.

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

Out-of-pocket expenses, deductibles, co-insurance, co-pays, prescription medications and supplies not paid by your medical, dental or vision benefit options, whether your coverage is under an American Airlines-sponsored plan or any other health plan.

Certain types of over-the-counter items purchased with a physician's written prescription and used to alleviate or treat personal injuries or sicknesses of the employee and/or the eligible dependents may be eligible for reimbursement through your HCFSAs. For instance, insulin, bandages, crutches and contact lens solution, and the like. Refer to the list of eligible items by visiting the [YSA website](#).

FAQ: How do I know if my OTC items are covered?

Go to the [YSA website](#) or the [IRS website](#).

Reimbursable Medical Expenses

Some medical expenses may not be covered at all by your Medical Benefit Option. However, they may be reimbursed under your HCFSAs. Examples include:

- Acupuncture
- Ambulance service
- Artificial insemination
- Bandages, support hose, other pressure garments (when prescribed by a physician to treat a specific ailment)
- Blood, blood plasma or blood substitutes
- Braces, appliances or equipment, including procurement or use
- Car controls for the handicapped
- Charges in excess of usual and prevailing fee limits
- Confinement to a facility primarily for screening tests and physical therapy
- Experimental procedures
- Foot disorders and treatments such as corns, bunions, calluses and structural disorders
- Halfway house care
- Home health care, hospice care, nurse or home health care aides
- Hypnosis for treatment of illness
- In-vitro fertilization and infertility treatment
- Learning disability tutoring or therapy

- Nursing home care
- Physical therapy
- Prescription vitamins
- Psychiatric or psychological counseling
- Radial keratotomies, lasik and vision correction procedures
- Sexual transformation or treatment of sexual dysfunctions or inadequacies
- Smoking cessation program costs and prescription nicotine withdrawal medications
- Speech therapy
- Syringes, needles and injections
- Transportation expenses to receive medical care, including fares for public transportation and private auto expenses (consult your tax advisor for the current IRS mileage allowance)
- Work-related sickness or injury (not covered by Workers' Compensation)

For a full list of covered medical expenses, go to the [IRS website](#).

Reimbursable Hearing and Vision Expenses

Some hearing and vision expenses that may be reimbursed under your HCFSA include:

Hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading) and the cost of acquiring and training a service animal for the deaf.

Vision expenses, including eyeglasses, contact lenses, ophthalmologist fees, the cost of a service animal for the blind and special education devices for the blind (such as an interpreter).

For a full list of covered hearing and vision expenses, go to the [IRS website](#).

Reimbursable Dental Expenses

Some medical expenses may not be covered at all by your Dental Benefit. However, they may be reimbursed under your HCFSA. Examples include:

- Anesthesia
- Cleaning more than twice per year
- Charges in excess of usual and prevailing fee limits
- Drugs and their administration
- Experimental procedures
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents
- Myofunctional therapy
- Replacement of dentures or bridgework less than five years old
- Replacement of lost, stolen, or missing dentures or orthodontic devices

For a full list of covered dental expenses, go to the [IRS website](#).

Excluded Expenses

Some expenses may not be reimbursed through your HCFSA; examples include:

- Medical insurance premiums/contributions
- Air conditioning units
- Capital expenses
- Cosmetic medical treatment, surgery, and prescriptions and cosmetic dental procedures, such as cosmetic tooth bonding or whitening
- Electrolysis

Health club fees and exercise classes (except in rare cases for treatment of medically diagnosed obesity where weight loss is part of the program)
 Marriage and family counseling
 Massage therapy
 Over-the-counter medications without a prescription
 Personal care items including cosmetics and toiletries
 Structural additions or changes
 Swimming pools
 Transportation expenses for the handicapped to and from work
 Vacation travel for health purposes
 Vitamins and nutritional supplements, unless prescribed by a doctor
 Weight loss programs (unless for treatment of medically diagnosed morbid obesity)
 Wheelchair ramps
 Whirlpools

For a full list of excluded expenses, go to the [IRS website](#).

Filing Claims

Participants who have a Limited Purpose Flexible Spending Account may file claims on the [YSA website](#), by fax, or through the US Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the [YSA website](#).

Per IRS regulations, expenses for your Company-recognized Domestic Partner and their dependents are not eligible for HCFSAs reimbursement. Thus, HCFSAs claims for you and your eligible dependents must be filed via paper, online or fax submissions. This is so claims can be verified by patient identity. Auto reimbursement is not permitted if you have a covered Company-recognized Domestic Partner

How the LPFSA - Limited Purpose Flexible Spending Account Works

The LPFSA is offered to CORE Medical Option participants only, in lieu of the Health Care FSA.

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

You can contribute through payroll deduction up to \$2,500 in 2015 in your HCFSAs. A minimum annual election amount of \$120 is required to complete enrollment.

Following your first payroll deposit, the full amount of your elected LPFSA amount for the entire year is available for your use, regardless of the actual balance in your account.

You have until March 15 of the following year to incur claims reimbursable under your LPFSA balance and until June 15 to file claims on your previous year's eligible expenses.

Benefit Overview		
Option	Who Can Be Reimbursed	Key Features
LPFSA-Limited Purpose Health Care FSA	You can be reimbursed for expenses for your: <ul style="list-style-type: none"> • Self • Spouse • Children and young adults 	<ul style="list-style-type: none"> • Deposit up to \$2,500 in 2015 • Pre-tax contributions • Have until March 15 to use your prior year's balance • Have until June 15 to file

Benefit Overview		
Option	Who Can Be Reimbursed	Key Features
(dental and vision expenses only) Must be enrolled in CORE Option	<ul style="list-style-type: none"> • Parents • Other dependents, if you claim them as dependents on your federal income tax return • Company-recognized Domestic Partners and their dependents are not considered eligible dependents, per IRS regulations 	<ul style="list-style-type: none"> • claims for previous year's eligible expenses • If both you and your spouse are employed by American Airlines, both employees may each deposit up to \$2,500 in an LPFSA during 2015

Reimbursable Expenses

IRS rules specify the types of expenses eligible for reimbursement from your LPFSA. Some vision expenses that may be reimbursed under your LPFSA include:

- Eyeglasses
- Contact lenses
- Ophthalmologist fees
- The cost of a guide dog for the blind and special education devices for the blind (such as an interpreter)
- Some dental expenses that may be reimbursed under your LPFSA include:
 - Anesthesia
 - Cleaning more than twice per year
 - Charges in excess of usual and prevailing fee limits
 - Drugs and their administration
 - Experimental procedures
 - Extra sets of dentures or other dental appliances
 - Medically necessary orthodontia expenses for adults or dependents
 - Myofunctional therapy
 - Replacement of dentures or bridgework less than five years old
 - Replacement of lost, stolen, or missing dentures or orthodontic devices
- You cannot use an LPFSA for medical expenses. If you are enrolled in the CORE Medical Option, you may use a Health Savings Account to pay for eligible health care expenses. See the [CORE Medical Option](#) section for more information.

Filing Claims

Participants who have a Limited Purpose Flexible Spending Account may file claims on the [YSA website](#), by fax, or through the US Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the [YSA website](#).

Per IRS regulations, expenses for your Company-recognized Domestic Partner and their dependents are not eligible for LPFSA reimbursement. Thus, LPFSA claims for you and your eligible dependents must be filed via paper, online or fax submissions. This is so claims can be verified by patient identity. Auto reimbursement is not permitted if you have a covered Company-recognized Domestic Partner.

How the DCFSA- Dependent Care Flexible Spending Account Works

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

A single employee or an employee who files a joint income tax return with his or her spouse and both earn over \$5,000 for the year, may contribute up to \$5,000 per calendar year. A lower limit applies to employees who file separate returns and special rules apply if your spouse does not work. If both you and your spouse work for American Airlines, your combined DCFSA total contribution cannot exceed \$5,000.

A minimum annual election amount of \$120 is required to complete enrollment.

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

You have until March 15 of the following year to incur claims reimbursable under your DCFSA balance and until June 15 to file claims on your previous year's eligible expenses.

Important Note: If you put money into a DCFSA and you do not have any eligible dependents, once the plan year begins that money cannot be refunded to you, per IRS regulations.

Benefit Overview		
Option	Reimbursement	Key Features
Dependent Care FSA	You can be reimbursed for: <ul style="list-style-type: none">• Licensed child and adult day care centers• Private kindergarten• Babysitters• Au pairs	<ul style="list-style-type: none">• Contribute up to \$5,000 a year• Pre-tax contributions• Have until 12/31 of the benefit year to use your prior year's balance• Have until 3/31 to file claims for previous year's eligible expenses• You cannot use your funds until they are deposited in your account

Special Provisions

You and your spouse (if you are married) must be employed or actively seeking employment to be eligible to receive reimbursement from your DCFSA. This benefit limits the amount you may contribute and the type of expenses that may be paid from your DCFSA.

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

- A single employee may contribute up to \$5,000.
- A couple filing a joint income tax return, where both spouses participate in DCFSAs, may contribute a combined amount of up to \$5,000.
- A couple filing separate income tax returns may each contribute up to \$2,500.
- A couple (if both individuals are employed) may contribute up to \$5,000, or the income amount of the lower-paid spouse (if it is less than \$5,000).

Fast Fact

If you are single or married and file your taxes jointly, you can contribute up to \$5,000 a year in your DCFSA.

- If you are a Highly Compensated Employee, as defined by the Internal Revenue Code, your allowable annual pre-tax contribution may be less than \$5,000 per calendar year. For example, as defined by the Internal Revenue Code in 2012, a Highly Compensated Employee is an individual who has an annual income of \$115,000 or more. This amount may be subject to change, and you will be notified if your maximum contribution changes. For more information about Highly Compensated Employee limits, go to the [IRS website](#).
- You can only stop or change your election mid-year if you experience certain Life Events.
- If you experience a Life Event and decide to reduce the amount of your DCFSA, you cannot reduce your account balance to an amount that is less than the claims that have already been paid.
 - If you incur expenses after your Life Event, your claims are payable up to the amount of your newly elected deposit amount.
- If you decide to stop the amount of your DCFSA deposits mid-year, this will affect how your claims are paid.
- You cannot stop if you have already received reimbursement exceeding that amount contributed into your DCFSA account.
- If your eligible expense was incurred before the Life Event, your claim is payable up to the original amount you contributed in your DCFSA.
- You cannot receive reimbursement for expenses incurred after the date you stopped making contributions to your DCFSA; however you can submit claims up to the amount in your account, provided they were incurred before the date you stopped.
- If you choose to stop the amount of your DCFSA mid-year, you will lose any remaining balance you have if the contributions you made before your Life Event are greater than your claims before the Life Event.
- If your employment terminates for any reason (i.e., furlough, resignation, etc.), your DCFSA terminates. You may elect to continue your DCFSA as part of your COBRA Continuation of Coverage options. If you do not continue your DCFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any contributions that were made and not used before your termination date.

Who is Covered

You may claim dependent day care expenses for your eligible dependents including:

Children under age 13

A person age 13 or older (including your child, spouse, or parent), if the person meets **all** of the following criteria:

- Lives with you and depends on you for support,
- Is claimed as a dependent on your federal income tax return,
- Is physically or mentally incapable of self-care, and
- Has a gross income less than the federal income tax personal exemption. Go to the [IRS website](#) for more information.

Glossary Term:
Eligible Dependent
(under the
DCFSA)

Children under 13 and anyone age 13 or over who lives with you, is your dependent, is not capable of self-care and makes less than the federal income tax personal exemption is considered an eligible dependent under the DCFSA.

Because of IRS rules, Company-recognized Domestic Partners and their dependents are not considered eligible dependents under your DCFSA.

Covered Expenses

Expenses paid to the following providers may be reimbursed through your DCFSA, if you can provide their Social Security or taxpayer identification number:

- Someone who cares for an elderly or disabled dependent inside or outside your home
- A licensed child-care center or adult day care center, including churches or non-profit centers
- A private kindergarten (used for day care of child(ren), rather than for educational purposes
 - If the private kindergarten provides both day care and educational services for your dependent child(ren), only the day care portion of the kindergarten's charges are eligible for reimbursement
 - The private kindergarten must separate and itemize the charges on its invoices for payment, clearly separating the day care expenses from the educational expenses
- If you cannot provide a separation/itemization of charges on the invoice, you will not receive reimbursement from your DCFSA
- A babysitter inside or outside your home if the sitter does not care for more than six children at a time (not including the sitter's own dependents)
- A housekeeper whose duties include dependent day care
- A relative who cares for your dependents, but is neither your spouse nor your dependent child under age 19
- Au pairs (foreign visitors to the U.S. who perform day care and domestic services in exchange for living expenses, provided the au pair agency is a non-profit organization or the au pair obtains a U.S. Social Security number for identification purposes)

Filing Claims

Participants who have a Dependent Daycare Flexible Spending Account may file claims on the [YSA website](#), by fax, or through the US Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the [YSA website](#).

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

You can incur claims until the last calendar date of the plan year and submit incurred claims for reimbursement 90 days after that date.

If You Elect Both an HCFSA/LPFSA and a DCFSA

Your FSA and DCFSA Funds are managed separately.

To get reimbursement for eligible DCFSA expenses submit claims via mail, fax, online, or utilize pay my provider online on the [YSA website](#).

Life Insurance Benefits

This section includes:

- How the Life Insurance Benefit Works
 - Basic Term Life Insurance Benefit
 - Voluntary Term Life Insurance Benefit
 - Spouse and Child Term Life Insurance Benefit
- Designating Beneficiaries
- Coverage if You Become Disabled
- Special Provisions
 - Accelerated Benefit Option (ABO)
 - Taxation of Life Insurance
 - Conversion and Portability
 - Assignment of Benefits
 - Total Control Account
 - Verbal Representation
- Filing Claims

The Company provides Basic Term Life Insurance to you at no cost.

You may purchase Voluntary Term Life Insurance and Spouse Term Life Insurance, subject to completion of a Statement of Health as noted below. You may also purchase Child Term Life Insurance at an additional cost.

You can designate your Term 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.

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

Met Life's Role

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

How the Life Insurance Benefit Works

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

You may purchase Voluntary Term Life Insurance coverage over and above your Basic Term Life Insurance Benefit, subject to completion of a Statement of Health as noted below.

Benefit Overview

If you are a Home-Based Representative or a Level 84 Premium Services Representative, you are not eligible for Basic Term Life Insurance.

Benefit	Coverage Levels	Key Features
Basic Term Life Insurance	2 times your pay up to a maximum of \$70,000 (only if your annual pay is less than \$35,000) 1 times pay (if annual salary is less than \$70,000) \$15,000	No cost to employees
Voluntary Term Life Insurance	1 times your pay 2 times your pay 3 times your pay 4 times your pay 5 times your pay 6 times your pay 7 times your pay 8 times your pay	Employee pays the entire cost of coverage After-tax contributions Cost based on age and level of coverage

Basic Term Life Insurance Benefit

If you are a Home-Based Representative or a Level 84 Premium Services Representative, you are not eligible for Basic Term Life Insurance.

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

As an eligible employee, the Company provides coverage equal to two times your pay up to a maximum of \$70,000, at no cost to you. You may elect a level of coverage lower than the amount you are eligible for, and may receive a credit for this lower amount.

Voluntary Term Life Insurance Benefit

In addition to Basic coverage, you may elect to purchase one of eight levels of Voluntary Term Life Insurance at your expense. When you are first eligible for benefits, you may elect the lowest level of coverage (1 times your pay) without providing proof of good health. You must complete a Statement of Health from [MetLife](#) if you wish to elect a higher level of coverage (2 times your pay to 8 times your pay). This means that as a new employee you can elect any level of coverage with a Statement of Health.

After you enroll, you may only increase your coverage by one level per year with proof of good health. Coverage that requires proof of good health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution either directly or through payroll deduction.

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

Below are the available Voluntary options:

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

Cost of Coverage

You pay the entire cost for any Voluntary Term Life Insurance coverage you select. You elect coverage at the rate shown in the [American Airlines Benefits Service Center](#) with after-tax contributions based on your age and selected option.

The following table defines pay for Employee Term Life Insurance:

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

You pay the entire cost of Spouse and Child Term Life Insurance coverage that you select. You elect coverage at the rate shown on your benefits enrollment screen in the [American Airlines Benefits Service Center](#) and pay for this coverage with after-tax contributions. Your spouse's rate is based on your spouse's age, but coverage for your child(ren) is based on a flat rate, regardless of the number of children covered.

The cost of coverage for both the employee and spouse plans will increase or decrease during the year if the amount of your coverage fluctuates due to changes in your pay.

Spouse and Child Term Life Insurance Benefit

You may cover either your spouse (under Spouse Term Life Insurance) or your children (under Child Term Life Insurance), or you may cover both your spouse and your children.

Spouse and Child Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse Term Life Insurance	Option 1 - 1 × pay
	Option 2 - 2 × pay
	Option 3 - 3 × pay
Child Term Life Insurance	\$15,000 for each covered child

Spouse Term Life Insurance

To add or increase Spouse Term Life Insurance, your spouse must complete a Statement of Health Form from [MetLife](#). You must then forward the completed form to MetLife for review within 30 days of your election. Upon approval from MetLife, coverage will be added or increased. Coverage that requires *proof of good health* becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction. New employees may elect any of the three levels of spouse life with proof of good health.

If you do not enroll in Spouse Term Life Insurance as a new employee, you will only be eligible to elect Option 1 at a later date with proof of good health and then will only be eligible to increase coverage by one level per year thereafter, with proof of good health.

Child Term Life Insurance

Coverage is offered at \$15,000 for each child. When you enroll in Child Term Life Insurance, you automatically enroll all of your children. Eligible children are not required to be enrolled in other benefits (e.g., medical, dental, etc.) or listed as dependents in the [American Airlines Benefits Service Center](#) in order for you to elect Child Term Life Insurance. Child Term Life Insurance does not require a Statement of Health (proof of good health).

Filing a Claim

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

The following is a short summary of the procedures for filing a claim for Spouse or Child Term Life Insurance benefits:

Upon the death of your covered spouse or child, you or your supervisor should inform American Airlines Benefits Service Center of the death. You are the sole beneficiary for your spouse or child's term life insurance.

After American Airlines Benefits Service Center is notified of the death, it sends you a letter verifying the amount of life insurance payable. The letter will include a Beneficiary Life Insurance Claim Statement.

Complete the Beneficiary Life Insurance Claim Statement and return it, along with a certified copy of the death certificate, to American Airlines Benefits Service Center. Upon receipt of both items, American Airlines Benefits Service Center will submit the claim to MetLife on your behalf.

The life insurance claim will be paid in approximately four to six weeks after MetLife receives all necessary documentation. You may assign part of the benefits to pay funeral expenses, (see “[Assignment of Benefits](#)“.)

When a spouse or covered dependent dies, you may want to make changes to your benefits coverages. To process these changes, contact American Airlines Benefits Service Center. For a list of allowable changes that may be appropriate at this time, see “[Life Events](#)” in the *Life Events: Making Changes During the Year* section. Updates to your beneficiary designation can be completed online through the [American Airlines Benefits Service Center](#).

Designating Beneficiaries

In the event of your death, Basic and Voluntary Term Life Insurance coverage benefits are paid to the named beneficiaries on file with American Airlines Benefits Service Center. You can name the same or different beneficiaries for your Basic and Voluntary Term Life Insurance coverage. When you enroll for benefits when you are first eligible as a new employee, or during Annual Benefits Enrollment, you designate your beneficiaries. You may change your beneficiary designation at any time during the year by accessing the [American Airlines Benefits Service Center](#).

Unless prohibited by law, your Term Life Insurance Benefits are distributed as you indicated on the American Airlines Service Center. For this reason, you should consider updating your beneficiary designation periodically, especially if you get married, declare a Company-recognized Domestic Partner, you or your spouse give birth or adopt a child, or if you get divorced or cease to have a Company-recognized Domestic Partner relationship.

Quick Tip

Your beneficiary or beneficiaries can be your spouse, Company-recognized Domestic Partner, children, grandchildren, other relatives, friends or your estate.

When you select your beneficiary, the wording is important. The table below 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 Term Life Insurance Benefits to be paid. MetLife requires a certified court document appointing the guardian of the minor's estate or property. If the beneficiary does not have a guardian, the Term Life Insurance Benefits will be retained by MetLife and interest will be compounded daily until the minor child reaches the legal age.

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

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

- Spouse or Company-recognized Domestic Partner
- Children or stepchildren (or children or stepchildren of Company-recognized Domestic Partner)
- Parents

Coverage if You Become Disabled

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

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

You are not engaged in any gainful occupation,

Because of illness, injury, or both, you are completely unable to engage in any occupation for which you are reasonably fit, and

Your disability is such that your inability to work will probably continue for the rest of your life.

To apply for a waiver of Voluntary Term Life Insurance contributions, you must file a claim with MetLife between the 9th and 12th month after the date your disability began. Claims filed after the 12th month will not be considered.

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

If you became disabled on or after January 1, 1995 your life insurance coverage (Basic and Voluntary) will continue until you reach age 55. At age 55, your Voluntary coverage will terminate and your Basic Term Life Insurance will be reduced to the retiree level. If you are not eligible for a pension benefit or Retiree Life Insurance, your coverage stops at age 65

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

Special Provisions

Accelerated Benefit Option (ABO)

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

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

To qualify for an ABO payout, you must have an injury or illness that is expected to result in death within six months, with no reasonable prospect for recovery. A physician's certification is required, and all applications are subject to review and approval by MetLife's medical

department. Based on this review, the claim is either paid or denied. If it is paid, you cannot later change the amount of your life insurance coverage.

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

Your life insurance premiums must be current at the time of the ABO application. If you are on sick leave and have allowed your coverage to default to the Company-provided amount, you are only eligible to receive ABO on that coverage amount. After an ABO payout, you are no longer permitted to change life insurance coverage levels. Employees who have irrevocably assigned their life insurance benefits and retirees or employees who have applied for retirement benefits are not eligible for ABO benefits. See [“Assignment of Benefits”](#).

Taxation of Life Insurance

If your Basic Life coverage is more than \$50,000, you may owe taxes on the value of your coverage over \$50,000. This value is called imputed income. IRS regulations require the Company to report employee federal wages and deduct Social Security taxes (FICA) on imputed income from your paycheck and report it on your Form W-2 each year.

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

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

An example of how imputed income works:

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

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

$$\$70,000 - \$50,000 = \$20,000$$

2. Divide that amount by \$1,000:

$$20,000 / \$1,000 = 20$$

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

$$20 \times \$0.08 = \$1.60$$

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

Conversion and Portability

Conversion

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

Your employment ends or you are no longer in a class that is eligible for Term Life Insurance coverage,

The coverage ends, and you have been covered under this insurance for at least five years, Coverage for your particular job classification ends, and you have been covered under this insurance for at least five years, or

You retire and your Retiree Life Insurance coverage is less than the coverage you had as an active employee.

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

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

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

\$10,000, whichever is less.

Spouse Term Life Insurance may also be converted to an individual life insurance policy (other than term life insurance).

Requesting Conversion

To convert to an individual policy, a Life Insurance Conversion Form and your first payment must be received by MetLife within 31 days of the date coverage terminates. Call MetLife at 1-877-275-6387 to discuss conversion and request a form. If you apply within this 31-day period, MetLife will not require you to provide a Statement of Health.

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

If you are a retiree and you die within the first 31 days of Retiree Life Insurance coverage, your beneficiary will receive a death benefit based on the amount of life insurance coverage you had as an active employee.

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

Portability

Voluntary Term Life Insurance is portable. This means you may continue your Voluntary Term Life Insurance coverage under a separate group policy if you leave the Company or retire. The rates for this continuing coverage are not the same as those you pay as an active employee, but they are preferred group rates based on your age. MetLife will provide the rate schedule if you apply for portability. The minimum amount of coverage you may continue is \$20,000 and the maximum amount is your current amount of Voluntary Term Life Insurance coverage. To apply for this continuing coverage, you must submit an application form to MetLife within 31 days after you leave or retire from the Company.

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

Assignment of Benefits

You may irrevocably assign the value of your life insurance coverage. 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 previously assigned your benefits, you are obligated to fulfill any conditions you have agreed to with your assignee. MetLife's only obligation is to pay the Life Insurance Benefits due at your death.

New

Beginning January 1, 2015, no new assignments on your life insurance coverage will be accepted by the Company. Any existing life assignments as of December 31, 2014 will continue to be recognized by the Company.

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

Total Control Account

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

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

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

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

Verbal Representation

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

Filing Claims

MetLife insures all Life Insurance Benefits under a group insurance policy. They also process all claims.

The life insurance claim will be processed after MetLife receives all necessary documentation.

Accidental Death & Dismemberment (AD&D) Insurance Benefits

This section includes:

Accidental Death & Dismemberment Insurance (AD&D)

What is Covered

Special Benefit Features

Exclusions

Filing a Claim

Conversion Rights

Insurance Policy

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

SRAI Benefit

SPAI Benefits

MPAI Benefits (For Management/Specialist and Officer employees only)

Policy Aggregates

Exclusions

Insurance Policy

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

- As an eligible employee, you may elect to purchase Accidental Death and Dismemberment (AD&D) Insurance for yourself and your family.
- Special Risk and Accident Insurance (SRAI) pays a benefit up to a maximum of \$500,000 if accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world.
- Special Purpose Accident Insurance (SPAI) coverage provides two types of insurance coverage:
 - Up to \$100,000 if injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device.
 - Pays up to \$100,000 for accidental death or dismemberment for non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft.

For Management/Specialist and Officer employees only:

- Company-provided Basic AD&D Insurance provides coverage equal to Basic Term Life Insurance coverage (typically, 2 times annual base pay up to \$70,000, unless the employee has elected a lesser amount of Basic Term Life Insurance coverage)
- Management Personal Accident Insurance provides a maximum of \$200,000 in coverage for Management employees while traveling on Company business and for non-occupational accidents involving any land or water vehicle.

LINA's and CIGNA's Roles

Accident coverage is provided under group insurance policies issued by the Life Insurance Company of North America (LINA). CIGNA processes and pays all claims for LINA. [Contact American Airlines Benefits Service Center for more information.](#)

Benefit Overview

Option	Key Features
Basic Accidental Death & Dismemberment (AD&D) Insurance – for Management & Support Staff employees only	<p>Benefit paid in the event of your covered accidental dismemberment or death</p> <p>Coverage is paid for by the Company.</p> <p>AD&D coverage equal to Basic Term Life Insurance coverage (typically, 2x annual base pay up to \$70,000, unless you have elected a lesser amount of Basic Term Life coverage)</p>
Voluntary Accidental Death & Dismemberment (AD&D) Insurance	<p>Benefit paid in the event of your covered accidental dismemberment or death. (Note: this insurance does NOT provide coverage for medical and other expenses associated with injuries due to an accident.)</p> <p>You pay premiums through before-tax payroll deduction.</p> <p>Coverage in \$10,000 increments up to \$500,000 for employee coverage and up to \$350,000 for spouse coverage. \$10,000 coverage for each dependent child, regardless of the number of children covered.</p>
Special Risk Accident Insurance (SRAI)	<p>Coverage is paid for by the Company</p> <p>Pays a benefit of five times your annual base salary, up to a maximum of \$500,000 if accidental death or dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world.</p>
Special Purpose Accident Insurance (SPAI)	<p>Coverage is paid for by the Company.</p> <p>Pays up to \$100,000 to each employee injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.</p> <p>Covers non-flight employees while riding as passengers, mechanics, observers or substitute flight attendants in a previously tried, tested, and approved aircraft, and pays up to \$100,000 for accidental death or dismemberment.</p>
Management Personal Accident Insurance (MPAI) - For Management/Specialist and Officer employees only	<p>Provides a maximum of \$200,000 in coverage for Management employees while traveling on Company business and for non-occupational accidents involving any land or water vehicle.</p>

New

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

Management and Support Staff employees are automatically eligible to receive Basic Accidental Death and Dismemberment Insurance (AD&D) from the Company, at no cost to you. The coverage is equal to your Basic Term Life Insurance coverage (typically, 2x pay up to \$70,000, unless you have elected a lesser amount of Basic Term Life coverage).

As an eligible employee, you may elect to purchase Voluntary Accidental Death and Dismemberment (AD&D) Insurance Benefits for yourself and your family. In the event of an accidental injury, AD&D insurance pays benefits to:

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

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

What Is Covered

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

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

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

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

If Injury Results in:	Benefit Is:
Loss of one hand, foot or eye	1/2 benefit amount
Loss of speech	1/2 benefit amount
Loss of hearing in both ears	1/2 benefit amount
Loss of thumb and index finger on the same hand	1/4 benefit amount

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

Injury	Benefit
Loss of use of two limbs	<i>2/3 benefit amount</i>
Loss of use of one limb	<i>1/2 benefit amount</i>

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

Special Benefit Features

Air bag benefit: If you or your covered dependent dies in a motor vehicle accident and the safety airbag (as defined by the Plan) is deployed as a result of such an accident, the participant will receive a benefit equivalent to 10% of the AD&D principal sum benefit, up to a maximum of \$10,000. A seat belt must be worn in order for the Air Bag Benefit to be payable.

Child care benefit: If you or your spouse dies as the result of an accident and your child is covered under the family AD&D, the coverage pays the surviving spouse an annual benefit of 5% of the total coverage amount (up to \$7,500 per year) for the cost of surviving children's care in a licensed child care facility. This benefit is payable up to five years or until the child enters first grade, whichever occurs first.

COBRA reimbursement: If you die as a result of an accident and your spouse and child are covered under the family AD&D, the coverage pays your dependents an additional annual benefit up to 3% of your AD&D coverage amount to assist them in paying for continuation of group medical coverage, up to a maximum of \$6,000 per year. This COBRA reimbursement benefit may be paid for up to three years or for the duration of your dependents' COBRA eligibility, whichever is longer. To be eligible for this benefit, your spouse and dependent child(ren) must be covered under the family AD&D, as well as your Medical Benefit Option.

Coma benefit: If you or a covered dependent becomes comatose as the result of an accident within 31 days of the accident, you receive 1% per month of the AD&D death benefit amount each month for up to 11 months. This benefit ends the earliest of:

The month the covered person dies,

The end of the 11th month for which the benefit is payable, or

The end of the month in which the covered person recovers.

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

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

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

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

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

Common disaster benefit: If you elect family AD&D coverage and, as the result of a common accident, you or your spouse dies within one year of the covered accident, the spouse's loss of life benefits will be increased to 100% of your amount of coverage. However, the combined benefits of you and your spouse will not be more than \$1 million.

Counseling and bereavement benefits: AD&D pays an additional benefit if you or an insured family member dies, becomes comatose or is paralyzed or suffers accidental dismemberment as a result of a covered accident. AD&D will pay for up to five sessions of medically necessary bereavement and trauma counseling, at a maximum of \$100 per session, for expenses incurred within one year of the date of the covered accident. Benefits are payable for the insured and any of the insured's immediate family members including mothers/fathers-in-law, and brothers/sisters-in-law.

Double benefit for dismemberment of children: If a covered child experiences a loss as the result of an accident, the benefit amount is double (to a maximum benefit of \$60,000). This provision does not apply if death occurs within 90 days of the accident.

Home/vehicle modification benefit: If, as the result of an accident, the participant's covered injury(ies) require use accommodations to his/her home or motor vehicle, the participant will receive a benefit equivalent to 10% of his/her principal sum benefit, up to a maximum benefit of \$10,000.

Escalator benefit: Your AD&D benefits will automatically increase by 3% of your elected benefit amount each year, up to a maximum of 15% after five continuous years. This increased coverage is provided at no additional cost. If coverage ends for any reason, such as layoff, unpaid sick leave of absence or termination of contributions, any previous escalator benefit is lost. A new five-year escalator benefit period starts if you decrease your coverage or re-enroll.

Seat belt benefit: If you or your covered dependent dies in an accident as the driver or passenger of any land vehicle (including Company-owned cars, pickups and commercial vehicles) and the covered person was properly wearing a seat belt at the time of the accident, the coverage pays an additional 20% of the benefit applicable to you or your dependent, to a maximum of \$25,000. If the vehicle was not equipped with seat belts or the accident report shows seat belts were not in proper use, no seat belt benefit is payable.

Rehabilitation benefit: If a participant suffers injury from an accident resulting in a loss for which benefits are payable under the AD&D insurance benefit, this coverage will reimburse the participant for covered rehabilitative expenses that are due to the injury causing the loss. These covered rehabilitative expenses must be incurred within two years after the date of the accident causing the loss, and will be payable up to a maximum of \$50,000 for all injuries caused by the same accident.

Covered rehabilitative expense means an expense that:

- Is charged for a medically necessary rehabilitative training session of the participant, performed under the care, supervision or order of a physician,
- Does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for hospital room and board charges, does not exceed the most common charge for hospital semi-private room and board in the hospital where the expense is incurred, and
- Does not include charges that would not have been made if no insurance existed.

Medically necessary rehabilitative training service means any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that:

- Is essential for physical rehabilitative training due to the injury for which it is prescribed or performed,
 - Meets generally accepted standards of medical practice, and
 - Is ordered by a doctor.
- Covered rehabilitative expense does not include any expenses for or resulting from any condition for which the participant is entitled to benefits under any Workers' Compensation Act or similar law.

Hospital means a facility that:

- Is operating according to law for the care and treatment of injured people,
- Has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a pre-arranged basis,
- Has 24-hour nursing service by registered nurses, and
- Is supervised by one or more physicians.

A hospital does not include:

- A nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care,
- A facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes, or
- Any military or veteran hospital or soldiers' home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

Special education benefit: If either you or your spouse dies as the result of an accident and your children are all covered by the family AD&D, the coverage pays 5% of that parent's total coverage amount (up to \$10,000 per year) to each dependent child for higher education. This benefit is payable for up to four consecutive years, as long as the child is enrolled in school beyond 12th grade. If coverage is in force but there are no children who qualify at the time of the accident, the coverage pays an additional \$1,000 to the designated beneficiary.

Spouse critical period: If you or your covered spouse dies as a result of an accident, AD&D pays the surviving spouse an additional monthly benefit of a half of a percent (0.5%) of the deceased person's coverage amount. This benefit, provided to help the surviving spouse cope with the difficult period immediately following a death, is paid monthly for 12 months.

Spouse retraining or refreshing skills benefit: If you die accidentally and your spouse is also covered by the family AD&D, the coverage pays up to a maximum of \$10,000 for your spouse to enroll as a student in an accredited school within 365 days of your death. This benefit is in addition to all other benefits.

Uniplegia benefit: If a participant is involved in an accident resulting in the loss of use of only one arm or one leg, the participant will receive a benefit equivalent to 50% of his/her principal sum benefit.

Waiver of premium: If you elect AD&D coverage for you and your dependents and you die as the result of an accident, any AD&D coverage you have elected for your spouse and children continues without charge for 24 months.

Travel Assistance Services

If you have Basic or Voluntary AD&D coverage for yourself, you may also take advantage of travel assistance services when you and your covered family members travel internationally. This package of valuable services and benefits is called CIGNA Secure Travel and is administered by Europ Assist.

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

CIGNA Secure Travel offers the following services for international travel:

Services before your departure, including:

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

Services available while traveling abroad (or within the US if 100 or more miles from home) include:

- Medical referrals to local physicians, dentists and medical treatment centers in the event of an emergency (accident or illness); you must follow your Medical Benefit Option rules to receive reimbursement for any eligible expenses
- Assistance with paying for medical services (if payment is required at the time services are rendered)
- Prescription assistance to refill a prescription that has been lost, stolen or depleted
- Assistance in replacing lost luggage, documents and personal items
- Legal referrals to local attorneys, embassies and consulates; you will need to pay for any professional services rendered
- Emergency message relay to notify friends, relatives or business associates if you have a serious accident or illness while traveling
- Emergency medical evacuation for transportation to the nearest adequate hospital or treatment facility, if medically necessary
- Repatriation of remains in the event of death overseas to cover the cost of returning remains to the place of residence and arranging necessary government authorizations to transfer remains

- Return of dependent children (who are under age 16) traveling with a covered member and who are left unattended when the covered member is hospitalized. CIGNA Secure Travel will arrange and pay for their transportation home. If someone is needed to accompany the children, a qualified escort will be arranged and expenses paid.
- If a covered member is traveling alone and must be hospitalized for more than 10 consecutive days, arrangements will be made and paid to provide round-trip economy class transportation for an immediate family member or friend designated by the covered member from his or her home to the place where the covered member is hospitalized.

CIGNA Secure Travel agents are available 24 hours per day and 7 days per week

- Call 1-888-226-4567 (in the U.S. and Canada)
- Call collect 202-331-7635 (in other countries)
- By fax at 202-331-1528
- By e-mail at cigna@europassistance-usa.com
- Please identify yourself as a member of CIGNA Secure Travel
 - Policyholder: American Airlines, Inc.
 - Policy #: COA 001312 (Basic AD&D); or
 - Policy #: OK 809974 (Voluntary AD&D)
 - Group #: 57

Exclusions

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

Intentionally self-inflicted injuries, suicide or attempted suicide

Declared or undeclared act of war within the U.S. or any nation of which you are a citizen

An accident that occurs while you are serving full-time active duty for more than 30 days in the armed forces of any country or international authority

Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound

Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from the vehicle or device while:

The vehicle is being used for experimental purposes

You are operating, learning to operate or serving as a member of the crew of an aircraft other than an aircraft operated by or under contract with the Company

Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed physician (accidental ingestion of a poisonous substance is covered, as well as accidents caused by use of legal, over-the-counter drugs)

Commission of a felony including, but not limited to: robbery, rape, arson, murder, kidnapping or burglary

Filing a Claim

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

- Contact Benefits Service Center to request a CIGNA AD&D Claim Form within 30 days of the death or injury. Complete the form according to accompanying directions. All claims must be submitted on CIGNA forms.

- In the event of your death, your manager/supervisor will notify Survivor Support Services, who will coordinate filing for benefits, similar to the procedures outlined for life insurance claims in Filing Claims.

- Send the completed claim form to Benefits Service Center along with documentation of the claim, such as a police report of an accident and a certified copy of the death certificate. Benefits Service Center sends the claim to CIGNA for processing.

- CIGNA processes claims within 90 days from the day they are received. In some cases, however, more time may be needed. If this is the case with your claim, CIGNA will notify you that an additional 90 days will be required. At any point during the claim review period, you may be asked to supply additional information and/or submit to a medical examination at LINA's expense.

- If your claim is approved, the insurance proceeds will be deposited into a CIGNA Resource Manager Account (similar to a money market checking account) that earns interest.

- If your claim is denied, you or your beneficiary will be notified in writing. Notification explains the reasons for the denial and specifies the provisions of the LINA group policy that prevent approval of the claim. The notification may also describe what additional information, if any, could change the outcome of the decision.

- If your claim is denied or you have not received a response by the end of the second 90-day review period, you may request a review of your claim.

- No one may take legal action regarding the claim until 60 days after filing the claim. No legal action may be taken more than three years after filing the claim (with the exception of five years in Kansas and six years in South Carolina). You must exhaust your administrative appeals before filing any legal action regarding a claim denial.

Conversion Rights

You can convert up to \$250,000 in Accidental Death and Dismemberment (AD&D) Insurance Benefits coverage for you and your spouse and up to \$10,000 in coverage for each eligible child to individual policies offered by LINA within 31 days of termination of coverage if coverage terminates for one of the following reasons:

- Your employment ends,

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

- The coverage ends.

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

Insurance Policy

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

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

The Company provides other accident insurance for certain situations described in this section. Other accident insurance programs include Special Risk Accident Insurance (SRAI) Benefit and Special Purpose Accident Insurance (SPAI) Benefit. These insurance coverages all have the following features:

- Premiums are paid by the Company.

- Coverage is provided without regard to your health history.

- The insurance provides 24-hour protection while you are traveling on Company business, from the time you leave until you return home or to your base, whichever occurs first.

- Benefits are payable in addition to any other insurance you may have.

- Covered losses include death or loss of limb, sight, speech or hearing. The insurance pays a benefit if you have a loss within one year of an accidental injury.

- No more than one Other Accident Insurance Benefit will be paid with respect to injuries resulting from one accident. If you have more than one loss from the same accident, you are entitled to the largest benefit amount for a single loss.

- Benefits payable under these other accident coverages do not reduce any accident benefits you may receive under the AD&D Insurance Benefits coverage.

SRAI Benefit

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

SRAI pays a benefit of five times your annual base salary, up to a maximum of \$500,000. This coverage only applies to employees on active payroll.

SPAI Benefits

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

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

MPAI Benefits (For Management/Specialist and Officer employees only)

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

Policy Aggregates

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

- \$10,000,000 under SRAI Benefit.

\$2,000,000 per aircraft accident under SPAI Benefit.

\$5,000,000 per aircraft accident under MPAl Benefit. (For Management/Specialists and Officer employees only)

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

Exclusions

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

- Suicide, attempted suicide or intentional self-inflicted injuries.

- Declared or undeclared act of war (Under SRAI Benefit, hostile acts of foreign governments are not covered within the U.S.)

- An accident that occurs while you are serving on full-time, active duty in the armed forces of any country or international authority.

- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity or any bacterial infection other than bacterial infection caused by an accidental cut or wound.

- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting, while:

 - The vehicle is used for test or experimental purposes.

 - You are operating, learning to operate or serving as a member of the crew except while riding solely as a passenger, mechanic, substitute flight attendant or acting as a crewmember on any aircraft owned by or under contract to American Airlines.

 - Being operated under the direction of any military authority other than transport-type aircraft operated by the Military Airlift Command (MAC) of the U.S. or a similar air transport service of any other country.

 - Commuting to and from work (SRAI Benefit).

Insurance Policy

The terms and conditions of the coverages are set forth in the group insurance policies issued by the Life Insurance Company of North America (LINA). The group policies are available for review from the Plan Administrator.

In the event of a conflict between the description and the provisions of the insurance policies, the insurance policies will govern.

Disability Benefits

Please note that additional details on your:

- Optional Short-Term Disability (OSTD)
- Short-Term Disability
- Voluntary Long-Term Disability
- Long-Term Disability

for the various workgroups noted below, are contained in supplemental insurance certificates. These supplemental insurance certificates are incorporated and are a part of this Guide. Please note that additional details on your Disability benefits may be contained in these documents.

This section includes:

Optional Short-Term Disability (OSTD) Insurance

This benefit applies to TWU-represented employees and Agents, Representatives and Planners

How the OSTD Insurance Benefit Works

Definition of Total Disability

Appropriate Care and Treatment

OSTD Insurance Benefits

Filing a Claim

Return-to-Work Program

Family Care Incentive

When Benefits Begin

Benefits from Other Sources

When Benefits End

Exclusions and Limitations

Short-Term (STD) Disability Insurance

This benefit applies to Management & Support Staff of American Airlines, Inc. and US Airways, Inc.

[Click here to view the insurance certificate for the Management and Support Staff Short-Term Disability Insurance plan.](#)

Voluntary Long-Term Disability Plan

This benefit applies to Agents, Representatives and Planners

- How the Plan Works
- Definition of Total Disability
- Appropriate Care and Treatment
- LTD Plan Benefits
- Severe Condition Benefit
- LTD Benefit Elimination Period
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Long-Term Disability Plan

This benefit applies to Management & Support Staff of American Airlines Inc. and US Airways, Inc.

- How the Plan Works
- Definition of Total Disability
- Appropriate Care and Treatment
- LTD Plan Benefits
- Severe Condition Benefit
- LTD Benefit Elimination Period
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- Benefits from Other Sources

The Company provides Optional Short-Term Disability (OSTD) Insurance, Short-Term (STD) Insurance as well as Voluntary Long-Term Disability (LTD) Plan, and Long-Term Disability (LTD) coverage in the event you are unable to return to work when your sick pay ends. Coverage varies by work group. Find your options below.

Agent, Representative, Planner (ARP) and TWU OSTD Coverage:

- Replaces a portion of your salary when you are unable to work as a result of a non-work related disability.
- Is a fully-insured benefit from MetLife. Eligibility ends when your employment terminates.

Agent, Representative, Planner Voluntary LTD Plan Coverage:

- LTD Plan coverage replaces a portion of your salary when you are unable to work as a result of a sickness or accidental bodily injury.
- LTD Plan coverage begins paying benefits on the later of the date you are disabled for four consecutive months, the latest day you received salary/pay from the Company or the last day you receive other benefits for this disability.

Severe Condition Benefit provides a one-time payment of \$5,000 if you are diagnosed with a qualifying critical illness.

Management & Support Staff STD Coverage:

- Replaces a portion of your salary when you are unable to work as of a non-work related disability.
- Is a fully-insured benefit from MetLife. Eligibility ends when your employment terminates.

Severe Condition Benefit provides a one-time payment of \$5,000 if you are diagnosed with a qualifying critical illness.

Management & Support Staff LTD Plan coverage:

- LTD Plan coverage replaces a portion of your salary when you are unable to work as a result of a sickness or accidental bodily injury.
- LTD Plan coverage begins paying benefits on the later of the date you are disabled for six consecutive months, the latest day you received salary/pay from the Company or the last day you receive other benefits for this disability.

MetLife's Role – OSTD/STD/LTD Pay

MetLife is the claims processor for Short-Term & Long-Term Disability. Visit the [MetLife website](#) or contact MetLife at 1-888-533-6287 for more information.

Overview

The following table helps you understand the benefits you may be eligible to receive in event of an illness or disability.

Program	When Benefits Begin	When Benefits End	Amount of Benefit
ARP, TWU Optional Short-Term Disability (OSTD) Coverage	The later of: Eighth day of your illness or disability; or When sick pay is exhausted.	The earlier of the date: The claims processor determines you are no longer disabled; or You become gainfully employed in any type of job except under the Return-to-Work Program (see Return-to-Work Program); or The 26-week maximum period ends; or You die.	The amount of benefit: 50% of adjusted monthly salary (reduced by any state disability benefits you are eligible to receive). If you are enrolled in Long-Term Disability (LTD) Plan coverage, you will receive the full OSTD Insurance coverage, plus you will receive a minimum benefit from LTD Plan coverage (to begin at 4 months from the date of disability or when sick pay is exhausted). Once the 26 weeks of

Program	When Benefits Begin	When Benefits End	Amount of Benefit
			OSTD Insurance are exhausted, the full LTD Plan benefit will be payable.
ARP Voluntary Long-Term Disability (LTD) Plan	<p>The latest of:</p> <p>The date you are disabled for four consecutive months; or</p> <p>The latest day you received salary/pay from the Company (both salary continuance or sick pay — sick pay must be exhausted); or</p> <p>The last day you receive other benefits for this disability.</p>	<p>The earlier of the date:</p> <p>The claims processor determines you are no longer disabled; or</p> <p>You become gainfully employed in any type of job for any employer, except under the Return-to-Work Program (see Return-to-Work Program); or</p> <p>The date you reach age 65 (unless disabled after age 60); or</p> <p>You reach the maximum benefit period (see Exclusions and Limitations); or</p> <p>You die.</p>	<p>The amount of benefit:</p> <p>Full-time employee: 60% of base monthly (reduced by benefits from other sources). Maximum covered salary up to the maximum allowed by federal law.</p> <p>Part-time employee: same as full-time, (reduced by benefits from other sources).</p>

Program	When Benefits Begin	When Benefits End	Amount of Benefit
Management & Support Staff Short-Term Disability (STD) Insurance	<p>The later of:</p> <p>Eighth day of your illness or disability; or</p> <p>When sick pay is exhausted.</p>	<p>The earlier of the date:</p> <p>The claims processor determines you are no longer disabled; or</p> <p>You become gainfully employed in any type of job.</p> <p>The 26-week</p>	<p>The amount of benefit:</p> <p>66.67% of adjusted monthly salary (reduced by any state disability benefits you are eligible to receive).</p> <p>Once the 26 weeks</p>

Program	When Benefits Begin	When Benefits End	Amount of Benefit
		maximum period ends; or You die.	of STD Insurance are exhausted, the full LTD Plan benefit will be payable.
Management & Support Staff Long-Term Disability (LTD) Plan	The latest of: The date you are disabled for six consecutive months; or The latest day you received salary/pay from the Company (both salary continuance or sick pay); or The last day you receive other benefits for this disability.	The earlier of the date: The claims processor determines you are no longer disabled; or You become gainfully employed in any type of job for any employer, except under the Return-to-Work Program (see Return-to-Work Program); or Disabled before 60-to normal retirement age; disabled after 60 (61-69) max decreases from 4 years to 1 year; or You reach the maximum benefit period (see Exclusions and Limitations); or You die.	The amount of benefit: Full-time employee: 66.67% of base monthly (reduced by benefits from other sources). Maximum covered salary up to the maximum allowed by federal law. Part-time employee: 66.67% of base monthly (reduced by benefits from other sources). Average monthly salary is based on average weekly earnings for the last six months.

ARP, TWU Optional Short-Term Disability (OSTD) Insurance - The Company offers a certain amount of paid sick time for salary continuance during disabilities. However, a gap may occur between the time accrued sick pay ends and Long-Term Disability (LTD) Plan benefits begin. In this case, the Company also offers Optional Short-Term Disability (OSTD) Insurance benefits to provide income protection until LTD Plan benefits begin.

How the OSTD Insurance Benefit Works

OSTD Insurance benefits replace a portion of your salary when you are unable to work as a result of a non-work related disability. Before electing OSTD Insurance coverage, you

should consider your accrued sick time because OSTD Insurance benefits are not payable until all of your accrued sick pay is used.

OSTD Insurance is insured through MetLife and is designed to supplement any other similar benefits to equal 50% of your adjusted monthly salary. For regular, full-time employees, "adjusted monthly salary" is defined as your annual base salary or annualized hourly pay, plus skill and license premiums and market differentials. It does not include profit sharing, bonus, overtime or incentive pay.

For converted and part-time employees, "adjusted monthly salary" is based on average weekly earnings for the last six months.

If you are enrolled LTD Plan coverage, you will receive the full OSTD Insurance benefit, plus you will receive a minimum benefit from LTD Plan coverage (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD Insurance are exhausted, the full LTD Plan benefit will be payable.

OSTD Insurance also offers a Return-to-Work Program that allows you to go back to work on a trial basis while recovering from a disability.

The cost of OSTD Insurance is collected through payroll deductions. If you enroll, your selection remains in effect for two calendar years. If you choose not to enroll when you are first eligible and decide to enroll later, proof of good health is required. Your OSTD Insurance will not become effective until you are actively at work and a payroll deduction has been taken.

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive OSTD Insurance benefits.

Definition of Total Disability

You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

Appropriate Care and Treatment

You will be required to receive Appropriate Care and Treatment (during your disability). Appropriate Care and Treatment means medical care and treatment that is:

- Given by a physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- Consistent with a physician's diagnosis of your disability; and
- Intended to maximize your medical and functional improvement.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

OSTD Insurance Benefits

If you have a qualifying disability, the OSTD Insurance benefit covers the difference between any state-provided benefit and 50% of your adjusted weekly salary on your last date worked. The maximum covered salary is \$200,000.

In some cases, OSTD Insurance benefits may be limited:

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island or Puerto Rico, you may be eligible for state disability benefits. Employees based in California, Hawaii and Rhode Island must apply directly to the state for benefits.
- If you have accrued a significant number of unused sick days, you would not be able to collect OSTD Insurance until you have used all those days.
- If you are enrolled in the Long-Term Disability (LTD) Plan, you will receive the full benefit of OSTD Insurance, plus you will receive a minimum benefit from LTD Plan coverage (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD Insurance are exhausted, the full LTD Plan benefit will be payable.

The OSTD Insurance benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

Filing a Claim

If your disability continues for eight or more days, you should file your disability claim immediately. Do not wait until your sick pay is used up; file by the eighth day of your disability. The sooner you file, the sooner your claim can begin processing. However, the latest you can file your claim is six months after your disability began. If you are covered under a state-mandated short-term disability plan and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim beyond the six-month deadline (or the state-mandated deadline, if sooner), your claim will not be accepted and you will not be eligible for benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance benefit, state disability plans (other than California, Rhode Island and Hawaii, which have their own forms that must be filed directly with the respective states) and LTD Plan. You or your supervisor should request the [Disability Claim Form](#) as soon as you become disabled.
- You, your supervisor and your attending physician must each complete part of the form:
 - Disability Claim Employer Statement: Your supervisor completes this page.
 - Disability Claim Employee Statement: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see Benefits from Other Sources).
 - Disability Claim Attending Physician Statement: Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

MetLife is the claims processor for the Optional Short-Term Disability Insurance Benefit. The OSTD Insurance and state disability coverages are insured plans (including state plans in

New Jersey, New York and Puerto Rico). The states of California, Hawaii and Rhode Island administer their own disability plans.

Return-to-Work Program

You will collect a 50% OSTD Insurance benefit that is adjusted for income from other sources, a 10% Return-to-Work Program incentive and the amount you earn from participating in the voluntary Return-to-Work Program while you are disabled. Your OSTD Insurance benefit will be adjusted to reflect income from other sources (such as state disability, income from another employer, no-fault auto, third party recovery) and any amount of your work earnings while participating in the Return-to-Work Program that causes your income from all sources to exceed 100% of your pre-disability earnings. In no event can the total amount you collect from all sources or income exceed 100% of your pre-disability earnings while you are disabled. Your pre-disability earnings are determined as of the date you become disabled. For part-time employees, pre-disability earnings are based on a 20-hour work week.

Family Care Incentive

If you work part-time or participate in the Return-to-Work Program while you are disabled, MetLife will reimburse you for up to \$100 for weekly expenses you incur for each child or family member incapable of independent living.

To provide care for your or your spouse's child, legally adopted child or a child for whom you or your spouse are legal guardian and who is:

- Living with you as part of your household;
- Dependent on you for support; and
- Under age 13,

Child care must be provided by a licensed child care provider who may not be member of your immediate family or living in your residence.

This benefit also includes care for your family member who is living with you as part of your household and who is

- Chiefly dependent on your for support; and
- Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.

Care to your family member may not be provided by a member of your immediate family.

When Benefits Begin

Provided you qualify, OSTD Insurance benefits are payable on the eighth day of disability or when your accrued paid sick time is exhausted, whichever occurs later. If you are collecting vacation pay when OSTD Insurance benefits become payable, OSTD Insurance benefits will not begin until your vacation pay ends. Benefits are payable for a maximum of 26 weeks.

There is no limit to the number of times you may receive these benefits for different periods of disability. However, successive periods of disability separated by less than 60 days of full-time active work are considered a single period of disability. Such disability will be considered to be a part of the original disability. MetLife will use the same pre-disability earnings and apply the same terms, provisions and conditions that were used for the original disability. This benefits you because if you become disabled again due to the same or related sickness or accidental injury, you will not be required to meet a new elimination period. The only exception is if the later disability is unrelated to the previous disability and begins after you return to full-time active work for at least one full day.

Benefits from Other Sources

Your OSTD Insurance benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- **No-Fault Auto Laws:** Periodic loss of income payments you receive under no-fault auto laws. Such payments will offset your OSTD Insurance benefit.
- **Third Party Recovery:** Recovery amounts that you receive from loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings may offset your OSTD Insurance benefit.

When Benefits End

Your OSTD Insurance benefit payments end automatically on the earliest of the following dates:

- The date the claims processor determines you are no longer disabled (e.g., you no longer meet the definition of total disability, you are no longer receiving Appropriate Care and Treatment, etc.); or
- The date you become gainfully employed in any type of job for any employer, except under the Return-to-Work Program; or
- The end of the maximum benefit period of 26 weeks; or
- The date you die.

If and when you return to work, you or your supervisor must notify MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repaying any overpayments you receive.

Exclusions and Limitations

The OSTD Insurance benefit has the following exclusions and limitations:

- **Preexisting conditions exclusion:** You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation of disability no longer applies, and you may receive benefits.
- If you are based in California, Hawaii, New York, New Jersey, Puerto Rico or Rhode Island, then OSTD Insurance benefits are offset. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. If the state benefit is less than the OSTD Insurance benefit, an OSTD Insurance benefit is payable. If the state benefit is more than the OSTD Insurance benefit, an OSTD Insurance benefit is not payable.
- Benefits are not payable if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered work-related for OSTD Insurance purposes if the claim is denied by Workers' Compensation.

- If you become disabled before the effective date, you are not covered under this insurance until you return to work and deductions are taken from your pay.
- Benefits are payable to employees. Dependents are not eligible for this benefit.
- Benefits are not payable if you are disabled as a result of committing or trying to commit a felony, assault or other serious crime.
- Benefits are not payable if you are disabled as a result of self-inflicted injuries or attempted suicide.
- Benefits are not payable if caused by a declared or undeclared act of war.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling condition from a duly qualified physician.
- Benefits may be reduced if you participate in the Return-to-Work program.

Management and Support Staff Short-Term Disability Insurance Plan

[Click here to view the insurance certificate for the Management and Support Staff Short-Term Disability Insurance Plan.](#)

Agent, Representative and Planner Voluntary Long-Term Disability Plan

How the Plan Works

The Company offers eligible employees the opportunity to participate in the Long-Term Disability (LTD) Plan.

LTD Plan benefits replace a portion of your salary when you are unable to work as a result of a disability. Most absences from work due to disability are generally of short duration and covered by paid sick time or Optional Short-Term Disability (OSTD) Insurance benefits. However, some absences may continue for longer periods. LTD Plan coverage provides you protection during these extended absences. LTD Plan benefits also provide you the opportunity to return to work on a trial basis and to participate in a rehabilitation program. You pay the cost of LTD Plan benefits through payroll deductions with after-tax contributions. If you choose not to enroll when you are first eligible and later decide to enroll, proof of good health is required.

MetLife is the claims processor. The LTD Plan is self-funded through employee contributions deposited to a Voluntary Employees Beneficiary Association (VEBA) trust established under Section 501(c)(9) of the Internal Revenue Code. Benefits are paid from trust assets.

The Company provides limited salary protection for non-work related disabilities through accrued sick pay and Optional Short-Term Disability (OSTD) Insurance benefits. OSTD Insurance benefits end after a maximum period of 26 weeks. If you also participate in the LTD Plan, your LTD Plan benefits begin after the latest of:

- The date you are disabled for four consecutive months; the latest day you received salary/pay from the Company (both salary continuance [if applicable] and sick pay); or
- The last day you receive other benefits for this disability.

Definition of Total Disability

During the elimination period and the first 24 months for which LTD Plan benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of

job for wage or profit and are unable to perform major and substantial duties of your own occupation because of sickness or accidental bodily injury.

Appropriate Care and Treatment

You will be required to receive Appropriate Care and Treatment during your disability. Appropriate Care and Treatment means medical care and treatment that is:

- Given by a physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- Consistent with a physician's diagnosis of your disability; and
- Intended to maximize your medical and functional improvement.

After 24 months during which benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for any employer and are unable to perform major and substantial duties of any occupation or employment for wage or profit for which you have become reasonably qualified by training, education or experience.

The only conditions under which you may be gainfully employed in any type of job for wage or profit and still be considered totally disabled are described under the Return-to-Work Program.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

LTD Plan Benefits

LTD Plan benefits are not taxable income because you pay for this coverage with after-tax contributions.

Full-time employees: Your monthly LTD Plan benefit, together with benefits from other sources, equals 60% of your base monthly salary (up to \$6,666.67) on your last day worked, plus 50% of the portion of your base monthly salary that is greater than \$6,666.67, up to a maximum covered salary of \$200,000.

Part-time employees: Your monthly LTD Plan benefit, together with benefits from other sources, is 60% of your base monthly salary. (Average monthly salary is based on average weekly earnings for the last six months.)

The minimum LTD Plan benefit for both full-time and part-time employees is the greater of 10% of your pre-disability base monthly salary on your last day worked or \$100 per month.

Whether you are a full-time or part-time employee, the amount you receive from LTD Plan is reduced by your income from other sources, including, but not limited to, other disability plans, unemployment benefits, Social Security Disability Benefits and benefits from Workers' Compensation, occupational disease law or other similar law. If you have a family and are eligible for family Social Security Disability Benefits, total payments from all sources will not be more than 80% of your base monthly salary on your last day paid.

The LTD Plan may provide you the opportunity to return to work or enter a Company-paid rehabilitation program without losing your LTD Plan benefits. However, if you are approved to participate in the Return-to-Work Program, your monthly LTD Plan benefit is decreased by 50% of your earnings during the return-to-work period.

The Return-to-Work Program is separate from the Workers' Compensation Transitional Duty program for employees with a work-related injury or illness. Employees participating in the Transitional Duty program are not eligible for this MetLife program. For details, see the Return-to-Work Program and Vocational Rehabilitation Benefit.

Severe Condition Benefit

(This is a new benefit in the LTD Plan, and is effective for disabilities beginning on or after January 1, 2011 with additional updates January 2, 2015.)

LTD Plan participants who are receiving LTD Plan benefits due to a Severe Condition often incur additional expenses that their health coverage and LTD Plan benefits don't cover — for example, living expenses, lodging expenses, household costs, medical expenses not covered by the medical coverage, etc. The LTD Plan now provides some financial help to those LTD Plan participants with Severe Conditions.

Severe Condition refers to only the following medical conditions:

- Cancer
- Heart attack
- Kidney failure
- Major organ failure requiring transplant
- Paraplegia
- Quadriplegia
- Stroke
- Alzheimer's Disease (AD) - *date of disability on or after January 1, 2015

Effective January 1, 2011, the LTD Plan will provide a tax-free \$5000 lump sum Severe Condition Benefit (SCB) to LTD Plan participants who meet the eligibility requirements. This SCB is payable only one time during the entire time you are covered under the LTD Plan, irrespective of how many Severe Conditions you may have. To be eligible to receive this benefit, you must meet all of the following criteria:

- Be an LTD Plan participant with LTD Plan coverage in force
- Be totally disabled (as defined by the LTD Plan) and be receiving LTD Plan benefits
- Your Severe Condition begins on or after January 1, 2011, as documented by a board-certified physician certified in the appropriate medical specialty applicable to your Severe Condition

This \$5000 SCB is payable only one time during the entire time you are covered under the LTD Plan, irrespective of how many Severe Conditions you may have. Your SCB benefit is tax-free, and is not reduced by your LTD benefit or by any other benefit sources that reduce your LTD benefit.

Severe Conditions are defined as follows:

Severe Condition	Definition/Documentation
Cancer	<p>Presence of one or more invasive malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue that requires the following:</p> <ul style="list-style-type: none"> • Medically necessary surgery, radiotherapy or chemotherapy; OR • Metastasis(es) has occurred (or is occurring); OR • The diagnosed cancer has a terminal prognosis, and the patient is not expected to live beyond 24 months from the date of diagnosis, and will not benefit from or has exhausted curative therapy; OR • Carcinoma <i>in situ</i> classified by the TNM Staging classification as TisN0M0 and requires medically necessary surgery, radiotherapy or chemotherapy; OR • Malignant tumors classified by the TNM Staging classification as T1N0M0 or greater, which are treated by endoscopic means; OR • Malignant melanoma(s) classified by the TNM Staging classification as T1N0M0, with a pathology report documenting a Breslow tumor thickness of 0.75 mm or less; OR • Tumors of the prostate classified by the TNM Staging classification as T1bN0M0 or T1cN0M0 and treated with radical prostatectomy or external beam radiotherapy.
Heart Attack (Myocardial infarction)	<p>The death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus(i) or embolus(i)</p>
Stroke	<p>Cerebrovascular accident or incident producing measureable, functional, and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue:</p> <ul style="list-style-type: none"> • Hemorrhage • Thrombus • Embolus from an extra-cranial source • Stroke does not include transient ischemic attack(s) or prolonged reversible ischemic attacks.
Kidney Failure	<p>Total, end-stage irreversible failure of both kidneys' function, that requires the following:</p> <ul style="list-style-type: none"> • Medically necessary immediate and regular (weekly) kidney dialysis that is expected to continue for at least 6 months; OR • Medically necessary kidney transplant
Major Organ Failure Requiring Transplant	<ul style="list-style-type: none"> • Irreversible failure of the participant's entire: • Heart, lung, kidney, pancreas, small intestine or any combination thereof, that requires medically necessary replacement with an entire organ(s) from a human donor, and the patient has been placed on the transplant list or the transplant has been performed; OR • Liver, that requires medically necessary complete or partial replacement with an entire liver or liver tissue from a human donor, and the patient has been placed on the transplant list or the transplant has been performed; OR • Bone marrow that requires medically necessary replacement with the bone marrow from either the patient himself or from a human

Severe Condition	Definition/Documentation
	donor
Paraplegia	Paralysis of the lower portion of the body (from waist or hip level), including both lower limbs
Quadriplegia	Paralysis of the upper and lower portions of the body (from neck, shoulder or chest level), including all four limbs
Alzheimer 's Disease	<p>The development of multiple, progressive cognitive deficits manifested by memory impairment (impaired ability to learn new information or to recall previously learned information) and one or more of the following cognitive disturbances:</p> <ul style="list-style-type: none"> • aphasia (language disturbance); • apraxia (impaired ability to carry out motor activities despite intact motor function); • angosia (failure to recognize or identify objects despite intact sensory function); and • disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting). <p>Proof of Alzheimer's Disease requires a Diagnosis made in Writing by a Neurologist, Geriatrician, or Neuropsychologist and supported by all of the following:</p> <ul style="list-style-type: none"> • formal neuropsychological testing performed by a Neuropsychologist confirming dementia; • laboratory tests have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease; and • magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease. <p>The Covered Condition for Alzheimer's Disease will be deemed to Occur on the date that the Diagnosis of Alzheimer's Disease is made and all other etiologies have been ruled out.</p> <p>We will not pay benefits for a Diagnosis of Alzheimer's Disease for: other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, normal-pressure hydrocephalus);</p> <ul style="list-style-type: none"> • systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis); • substance-induced conditions; or • any form of dementia that is not diagnosed as Alzheimer's Disease.

Severe Condition	Definition/Documentation

To apply for this benefit, you must submit to the claim processor proof that you've been diagnosed with a Severe Condition and the date of such diagnosis, and this proof must be signed and certified by your treating board-certified physician certified in the appropriate medical specialty applicable to your Severe Condition. You may also be asked to have your physician submit copies of his/her clinical records of your diagnosis and treatment for your Severe Condition, including one or more of the following:

- **Cancer:** Pathology reports confirming the diagnosis.
- **Heart Attack:** Proof of inpatient hospitalization, laboratory reports of elevated cardiac enzymes, toponins or cardiac markers, EKG changes reflecting an acute myocardial infarction, cardiac imaging studies reflecting an acute myocardial infarction.
- **Kidney Failure:** Nephrologist's confirmed diagnosis of kidney failure.
- **Recipient of Major Organ Transplant:** Specialist's confirmation of major organ failure, proof that patient has been placed on the transplant list, documentation that the transplant has occurred.
- **Paraplegia:** Successive neurological examinations with demonstrations of weakness of both lower limbs, usually accompanied by impairment of bladder/bowel control, motor weakness, muscle atrophy, abnormal deep tendon reflexes, radioimaging confirmation of neurological deficit.
- **Quadriplegia:** Successive neurological examinations with demonstrations of weakness of all four limbs, usually accompanied by impairment of bladder/bowel control, motor weakness, muscle atrophy, abnormal deep tendon reflexes, radioimaging confirmation of neurological deficit.
- **Stroke:** Clinical confirmation of the diagnosis of Stroke based on clinical evidence of significant neurological impairment that is functional, measureable, and permanent based on MRI, CT or other reliable imaging techniques demonstrating the affected areas of the brain. Such neurological impairment must be documented in the clinical records 30 or more days after the cerebrovascular accident/incident by the neurologist, and be based on clinical evidence of significant neurological, motor or sensory impairment.
- **Alzheimer's Disease:** formal neuropsychological testing performed by a Neuropsychologist confirming dementia; laboratory tests have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease; and magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease.

The claim processor will review your claim, and if approved, will make the \$5000 SCB payment to you, in one lump sum. This SCB is paid *in addition to* your monthly LTD Plan benefit, and the \$5000 benefit is tax-free.

Benefits will not be paid for any Severe Condition that is:

- Caused by, contributed by or resulting from your voluntarily taking or using any drug, medication, sedative or other substance unless it is:
 - Taken or used as prescribed by your physician, or
 - An 'over the counter' drug, medication, sedative or other substance taken according to package directions.
- One for which diagnosis is made outside the United States, unless the diagnosis is confirmed in the United States.
- Does not first occur while you are covered under this LTD Plan.
- A diagnosis of stroke for cerebral symptoms due to migraine; cerebral injury resulting from hypoxia or trauma; or vascular disease affecting the eye, optic nerve, middle or inner ear or vestibular function.
- Cancer classified by the TNM Staging classification as less than T1N0M0, papillary tumor of the bladder classified as Ta, tumors of the prostate classified as T1N0M0 or T1aN0M0 or papillary tumors of the thyroid classified as T1N0M0 or less and are one centimeter or less in diameter.
- Tumor(s) in the presence of the human immunodeficiency virus.
- Any non-melanoma skin cancer unless there is metastasis or melanoma *in situ* classified as T1sN0M0.
- Chronic Lymphocytic Leukemia, classified by RAI classification as less than Stage III.
- Melanoma in situ classified by the TNM Staging classification as TisN0M0.
- Any form of dementia that is not diagnosed as Alzheimer's Disease.

LTD Benefit Elimination Period

The elimination period is the waiting period before LTD Plan benefits are payable. It extends until the latest of the following:

- The date you have been continuously totally disabled for four consecutive months or
- The last day of salary continuation (injury-on-duty pay or sick pay) during total disability.

Duration of LTD Benefits

After you qualify for LTD Plan benefits, if you remain disabled, you receive a monthly benefit for the following maximum period:

Age at Which Disability Begins	Maximum Duration of Benefits
Under age 60 or the day you turn age 60	To age 65
After your 60 th birthday	5 years

During your disability, you may be required to provide additional medical information or submit to periodic physical exams to confirm your continuing disability. LTD Plan benefits end if you do not agree to undergo a physical exam or provide the required information.

For age 60 or over employees who become disabled, the five-year maximum duration of benefits may allow your LTD Plan benefits to continue after you begin receiving your pension. If this occurs, your LTD Plan benefit will be offset by the amount of pension benefit you receive (or you are entitled to receive).

Filing a Claim for LTD Benefits

You should file LTD Plan claim as soon as you become disabled. Do not wait until your sick pay is used up or until your four-month elimination period expires — file your claim immediately. The latest you can file your LTD Plan claim is one year after your disability began. If you file your disability claim beyond this one-year deadline, your claim will not be accepted and you will not be eligible for LTD Plan benefits.

MetLife is the claims processor for the LTD Plan. The LTD Plan is funded by employee contributions and managed by the Company through a trust. Benefits are paid from trust assets.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance, state disability plans (other than California, Rhode Island and Hawaii, which have their own forms that must be filed directly with the respective states) and LTD Plan programs. You or your supervisor should request the [Disability Claim Form](#) as soon as you become disabled.
- You, your supervisor and your attending physician must each complete part of the form:
 - Disability Claim Employer Statement: Your supervisor completes this page.
 - Disability Claim Employee Statement: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see Benefits from Other Sources).
 - Disability Claim Attending Physician Statement: Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

When LTD Benefits Begin

Provided you qualify, LTD Plan benefits are payable at the end of the elimination period.

- The date you are disabled for four consecutive months;
- The latest day you received salary/pay from the Company (both salary continuance and sick pay) — sick pay must be exhausted; or
- The last day you receive other benefits for your disability.

If you are collecting vacation pay when LTD Plan benefits become payable, your LTD Plan benefits will not begin until your vacation pay ends. If you return to work in a capacity comparable to your pre-disability status during the elimination period, you are still considered continuously disabled if you become totally disabled again due to the same or related sickness or injury within 60 days after returning to work in your pre-disability

occupation or other comparable work. However, days worked do not count toward your elimination period.

If you have received LTD Plan benefits for an earlier disability and become totally disabled again, your most recent disability is considered part of the previous disability. However, this provision does not apply if you have returned to work in a capacity comparable to your pre-disability status for at least three months or, if the cause of the later disability is totally unrelated to the earlier disability. If it is considered a separate period of disability, you must satisfy a new elimination period.

When LTD Benefits End

Your LTD Plan benefits automatically end on the earliest of the following dates:

- The date your benefits expire, as explained in Duration of Benefits;
- The date you reach age 65 (unless disabled after age 60);
- The date you are no longer disabled (e.g., you no longer meet the definition of total disability, you are no longer receiving Appropriate Care and Treatment, etc.);
- The date you become gainfully employed in any type of job, except under the Return-to-Work Program;
- The date benefits end, if disability is due to a mental health disorder or neuromuscular, musculoskeletal or soft tissue disorder — see Exclusions and Limitations; or
- The date you die.

If and when you return to work, you or your supervisor must contact MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repaying any overpayments you receive.

If your employment terminates from a sickness or injury Leave of Absence and you are receiving LTD Plan benefits, these LTD Plan benefits will continue until you meet one or more of the conditions listed above. However, when you meet one or more of these conditions and your LTD Plan benefits terminate, your LTD Plan coverage also terminates at the same time. After your LTD Plan benefits and LTD Plan coverage terminate, any later recurrence or relapse of your disabling condition or your development of any other disabling condition, will not reactivate your LTD Plan coverage, will not result in any reinstatement of LTD Plan benefits and will not cause any LTD Plan benefits to resume.

LTD Exclusions and Limitations

The LTD Plan has the following exclusions and limitations:

If you become disabled before the effective date, you are not covered under the LTD Plan until you return to work and deductions are taken from your pay.

You are not covered under the LTD Plan for a disability if you received medical care or treatment for the disability within the three months before the effective date of coverage. However, after you have been covered for 12 months, this limitation on disability no longer applies and you may receive benefits.

If you are disabled due to a mental health disability (this includes mental health disorders, emotional disease and/or alcohol/chemical/substance abuse/dependency), disability benefits under this coverage will end when you have received a maximum of 24 months of LTD Plan benefits for the entire time you are covered under the LTD Plan. This maximum benefit applies to the duration of your participation in this coverage. As part of a mental health

disability, chemical abuse/dependency includes, but is not limited to, both prescription and over-the-counter medications, as well as illicit/illegal drugs; substance abuse/dependency includes, but is not limited to, any other non-drug substances such as aerosol propellants, glue, etc.

This 24-month maximum disability benefit applies whether or not you have been hospitalized, with the following exceptions:

- If you are confined in a hospital at the end of this 24-month maximum benefit period, benefits continue as long as you are confined.
- To enable a necessary recovery period, benefits also continue for up to 90 days following your release from hospital confinement, provided you were confined for at least 14 consecutive days.
- If you are reconfined during this 90-day recovery period, benefits continue during your reconfinement, together with another 90-day recovery period, provided you are reconfined for at least 14 consecutive days.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling conditions from a duly-qualified physician.
- Benefits are not payable if the Plan Administrator determines in its sole discretion that you are disabled as a direct or indirect result of committing or trying to commit a felony, assault or other serious crime or are engaged in an illegal occupation, regardless of whether or not you are ever charged with a crime or for engaging in an illegal occupation.
- Benefits are not payable if you are disabled as a result of intentionally self-inflicted injuries or an attempted suicide.
- Benefits are not payable if you are disabled as a result of a declared or undeclared act of war.
- Benefits are payable only to employees. Dependents are not eligible for this benefit.
- Preexisting Conditions Exclusion: You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for 12 months, this limitation on disability no longer applies and you may receive benefits. (See Glossary for the OSTD Insurance benefit definition of a preexisting condition.)
- If you are disabled due to a neuromuscular, musculoskeletal and/or soft tissue disorder disability, the disability benefits under the LTD Plan will end when you have received a maximum of 24 months of disability benefits for the entire time you are covered under the LTD Plan. This 24-month maximum benefit applies to the duration of your participation in this coverage. Neuromuscular, musculoskeletal and/or soft tissue disorders include, but are not limited to any disease, injury or disorder of the spine, the vertebrae, their supporting structures, muscles and/or soft tissue; bones, nerves, supporting body structures, muscles and/or soft tissue of all joints, extremities and/or major body complexes of movement; sprains/strains of all joints and muscles. This 24-month maximum benefit does not apply to disabilities, if such disabilities have documented objective clinical evidence of:
 - Seropositive arthritis (inflammatory disease of the joints), supported by clinical findings of arthritis and positive serological tests for connective tissue disease;
 - Spinal (referring to the bony spine and/or spinal cord tumor(s) — abnormal growths — whether benign or malignant), malignancy or vascular malformations (abnormal development of blood vessels);
 - Radiculopathies (disease of the peripheral nerve roots) supported by objective clinical evidence of nerve pathology;

- Myelopathies (disease of the spinal cord and/or nerves) supported by objective clinical evidence of spinal cord/nerve pathology;
- Traumatic spinal cord necrosis (injury or disease of the spinal cord) resulting from traumatic injury with paralysis; or
- Musculopathies (disease of the muscle/muscle fibers) supported by objective pathological evidence on muscle biopsy or electromyography.
- Disabilities caused by the aforementioned conditions — provided objective evidence confirms the diagnosis — will not be subject to the 24-month limitation, but will be benefited according to all other applicable LTD Plan provisions.

The Plan Administrator in its sole discretion shall determine whether any exclusion or limitation applies.

Benefits from Other Sources

If you qualify for disability benefits from other sources, your LTD Plan benefits are reduced by the amount of the following periodic benefits. Your LTD Plan benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- Periodic benefits for loss of time because of this disability under:
 - Any employee benefit coverage for which the Company has paid any part of the cost or made payroll deductions, including a Company-sponsored annuity contract or disability retirement benefits plan
 - Any government law including no-fault motor vehicle insurance, other than a law providing benefits for military services.
- Periodic benefits for loss of time due to a work-related injury or illness or by reason of any Workers' Compensation, occupational disease law or other similar law.
- Unemployment benefits.
- Social Security Disability Benefits (SSDB) based on the amount of SSDB in effect as of the LTD Plan benefit start date. This may not apply if your disability is a result of a pregnancy or if your disability lasts less than one year. Periodic increases in monthly SSDB income (through cost-of-living increases) and additional Social Security retirement and survivor benefits are not subtracted from LTD Plan benefits.
- Earnings from employment activity not approved under return-to-work guidelines.
- Any LTD Plan benefit a participant receives while disabled may be offset by the amount of Retiree Benefit Plan pension benefits the participant is receiving (or is entitled to receive).

To alleviate potential financial hardship while waiting for a determination on a claim for Social Security, Workers' Compensation or other such benefits described above, you may request that such benefits not be deducted from your LTD Plan benefits. The Reimbursement Agreement is in the [Disability Claim Form](#). It states that you agree to reimburse the appropriate amount of LTD Plan benefits paid if Social Security, Workers' Compensation or other such benefits are later payable.

Social Security Disability Benefits

Because the amount of LTD Plan benefits you receive is influenced by Social Security Disability Benefits (SSDB), you must apply for SSDB as soon as possible.

Within six months after your LTD Plan claim is approved, you must provide evidence to the claims processor that you have filed for SSDB or that your application has been denied. This does not apply if your disability is the result of pregnancy or is expected to last less than one year. Otherwise, your SSDB benefits will be estimated and your LTD Plan benefits will be reduced by the estimated amount.

Evidence may include a denial of benefits by the Social Security Administration, failure to qualify because of the length of your disability or a copy of the Receipt of Claim Form given to you by the Social Security Administration at the time of application. Please note that if your initial application is denied, you must file for reconsideration and/or appeal to the Social Security Administration.

Former Pension Benefit Supplement

Effective January 1, 2004, the Pension Supplement Benefit in the Long-Term Disability Plan Ended

The Pension Benefit Supplement only applies to employees who are eligible to receive benefits from the defined benefit pension plan and were disabled prior to January 1, 2004. You are not accruing credited service toward your pension benefit. The LTD Plan pension supplement (also known as the “Deferred Benefit”) makes up for this loss of credited service. Your pension supplement benefit is payable to you when you begin taking your pension. However, this benefit is paid separately from your pension benefit. If you choose to take your pension early, your pension supplement begins paying at the same time with the same reduction, if any, as your early pension benefit.

The amount of your pension supplement benefit is determined by placing the number of months of LTD Plan benefits you received before your 65th birthday into the applicable benefit formula under your Retirement Benefit Plan. No additional months will be credited after age 65. The formulas are:

- Minimum Benefit formula
- Career Average formula
- Final Average Salary formula
- Social Security Offset formula

If you elected an optional form of payment under your Retirement Benefit Plan, your pension supplement benefit is computed and paid the same way.

When your pension supplement benefit begins, if your monthly benefit is less than \$20, a lump sum payment may be made, rather than monthly benefit payments. The claims processor determines whether this is an option.

Freeze of Pension Supplement Benefit

As part of the Company’s restructuring, American Airlines Inc. froze its defined benefit pension plans for all work groups. This freeze was effective November 1, 2012. This pension plan freeze prohibits participants from accruing additional Credited Service on or after November 1, 2012.

The LTD Plan’s Former Pension Supplement Benefit calculation uses Credited Service and number of months the LTD benefit was paid. Because the defined benefit pension plans have been frozen, it is necessary to freeze this Former Pension Supplement Benefit as well. Therefore, employees who accrued this benefit will still be eligible, but the accrual of

Credited Service and number of LTD payments made will cease on the earlier of the following:

- Your attaining age 65, or
- The date your LTD payments stop, or
- The date of the defined benefit pension plan freeze - November 1, 2012

Return-to-Work Program

The Return-to-Work Program, administered by MetLife, is a voluntary program that allows you, as a disabled employee collecting LTD Plan benefits, to work in an occupation or job for wage or profit for a trial period without losing your LTD Plan benefits. Your return to work must be approved by the claims processor and may not exceed one year. The claims processor will monitor your progress under this program. If you fully recover and are no longer disabled before the end of that year, you will no longer be eligible for the program.

During your trial work periods, you continue to receive LTD Plan benefits. However, your benefits are reduced by 50% of your earnings from employment. If your attempt to return to work is unsuccessful, you may return to your former LTD Plan status and receive your former benefit, provided you remain disabled and satisfy all other coverage provisions.

Employees who are participating in the Workers' Compensation Transitional Duty program are not eligible for this Return-to-Work Program and vice versa.

Following are the steps required to participate in the Return-to-Work Program:

- A request for consideration is initiated either by you, your supervisor, your physician or the claims processor.
- The request is distributed to all parties above and all must agree that you may return to work on a trial basis.
- When your return-to-work plan has been approved by all parties, MetLife will document the plan for signature. Documentation will include the following:
 - Written agreement from your physician, supervisor and you that you may return to work
 - Statement of approximate length of time for the trial work period
 - Statement of hours to be worked per day and rate of pay. (If hours per day vary, the claims processor will need regular bi-weekly or semi-monthly reports of earnings and hours worked.)
- The claims processor notifies you or your supervisor whether your return-to-work request has been approved.

If you are allowed to participate in the Return-to-Work Program, your supervisor must notify the claims processor of the date you return to work. In addition, if and when you can no longer work, both your supervisor and physician must send written notification to the claims processor of this change. If you return to work for the Company under this program, your supervisor should indicate "Returning to Work" on your Payroll Transaction Request (PTR).

Your LTD Plan payroll deductions will not resume until you are actively at work under the Return-to-Work Program for one consecutive year or when you are no longer disabled.

Vocational Rehabilitation Program

If you are receiving LTD Plan benefits, you may be eligible to receive assistance through the Vocational Rehabilitation Benefit if approved by the claims processor. This benefit is not available for participants receiving OSTD.

Vocational Rehabilitation Benefits may cover expenses such as:

- Vocational counseling
- Job search assistance
- Occupational training
- Vocational education
- Prosthetic devices
- Psychotherapy
- Physiotherapy

You may request consideration for this benefit by writing to MetLife. See [“Contact Information”](#) in the *Reference Information* section.

After reviewing your request, the claims processor may require an in-depth field evaluation of your potential to return to work. If so, your supervisor will be notified with the necessary details. The claims processor may also request a complete job description and other documentation. After reaching a decision, the claims processor notifies you of the rehabilitation benefits to which you are entitled.

New

Management & Support Staff Long-Term Disability Plan

How the Plan Works

The Company offers eligible employees the opportunity to participate in the Long-Term Disability (LTD) Plan.

LTD Plan benefits replace a portion of your salary when you are unable to work as a result of a Disability. Most absences from work due to disability are generally of short duration and covered by paid sick time or Short-Term Disability (STD) Insurance benefits. However, some absences may continue for longer periods. LTD Plan coverage provides you protection during these extended absences. LTD Plan benefits also provide you the opportunity to return to work on a trial basis and to participate in a rehabilitation program. The Company pays the cost of LTD Plan benefits with before-tax contributions. The LTD Plan is self-funded through a Voluntary Employees Beneficiary Association (VEBA) trust established under Section 501(c)(9) of the Internal Revenue Code. Benefits are paid from trust assets. The Company provides limited salary protection for non-work related disabilities through sick pay and Short-Term Disability (STD) Insurance benefits. STD Insurance benefits end after a maximum period of 180 days. Your LTD Plan benefits begin the later of the date you have been continuously totally disabled for 180 days or the end of STD.

Definition of Total Disability

During the elimination period and the first 24 months for which LTD Plan benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of

job for wage or profit and are unable to perform major and substantial duties of your own occupation because of sickness or accidental bodily injury.

Appropriate Care and Treatment

You will be required to receive Appropriate Care and Treatment during your disability. Appropriate Care and Treatment means medical care and treatment that is:

- Given by a physician whose medical training and clinical specialty are appropriate for treating your disability;
- Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;
- Consistent with a physician's diagnosis of your disability; and
- Intended to maximize your medical and functional improvement.

After 24 months during which benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for any employer and are unable to perform major and substantial duties of any occupation or employment for wage or profit for which you have become reasonably qualified by training, education or experience.

The only conditions under which you may be gainfully employed in any type of job for wage or profit and still be considered totally disabled are described under the Return-to-Work-Program.

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

LTD Plan Benefits

LTD Plan benefits are taxable income because coverage is provided for you on a non-contributory basis.

Full-time employees: Your monthly LTD Plan benefit, together with benefits from other sources, equals 66.67% of your base monthly salary on your last day worked, to a maximum benefit of \$21,666 per month, subject to the BENEFITS FROM OTHER SOURCES section, up to the maximum allowed by federal law.

Part-time employees: Your monthly LTD Plan benefit, together with benefits from other sources, equals 66.67% of your base monthly salary on your last day worked, to a maximum benefit of \$21,666, subject to the BENEFITS FROM OTHER SOURCES section, up to the maximum allowed by federal law. (Average monthly salary is based on average weekly earnings for the last six months.)

The minimum LTD Plan benefit for both full-time and part-time employees is \$100 per month. This does not apply if you are in an Overpayment situation or are receiving income from employment.

Whether you are a full-time or part-time employee, the amount you receive from LTD Plan is reduced by your income from other sources, including, but not limited to, other disability plans, unemployment benefits, Social Security Disability Benefits and benefits from Workers' Compensation, occupational disease law or other similar law.

The LTD Plan may provide you the opportunity to return to work or enter a Company-paid rehabilitation program without losing your LTD Plan benefits.

The Return-to-Work Program is separate from the Workers' Compensation Transitional Duty program for employees with a work-related injury or illness. Employees participating in the Transitional Duty program are not eligible for this MetLife program. For details, see the Return to-Work Program and Vocational Rehabilitation Benefit.

Severe Condition Benefit (This is a new benefit in the LTD Plan, and is effective for disabilities beginning on or after January 1, 2011 with additional updates January 1, 2015.)

LTD Plan participants who are receiving LTD Plan benefits due to a Severe Condition often incur additional expenses that their health coverage and LTD Plan benefits don't cover — for example, living expenses, lodging expenses, household costs, medical expenses not covered by the medical coverage, etc. The LTD Plan now provides some financial help to those LTD Plan participants with Severe Conditions.

Severe Condition refers to only the following medical conditions:

- Cancer
- Heart attack
- Kidney failure
- Major organ failure requiring transplant
- Paraplegia
- Quadriplegia
- Stroke
- Alzheimer's Disease (AD) – *date of disability on or after January 1, 2015

Effective January 1, 2011, the LTD Plan will provide a \$5,000 lump sum Severe Condition Benefit (SCB) to LTD Plan participants who meet the eligibility requirements. This SCB is payable only one time during the entire time you are covered under the LTD Plan, irrespective of how many Severe Conditions you may have.

To be eligible to receive this benefit, you must meet all of the following criteria:

- Be an LTD Plan participant with LTD Plan coverage in force
- Be totally disabled (as defined by the LTD Plan) and be receiving LTD Plan benefits
- Your Severe Condition begins on or after January 1, 2011, as documented by a board certified physician certified in the appropriate medical specialty applicable to your Severe Condition

This \$5,000 SCB is payable only one time during the entire time you are covered under the LTD

Plan, irrespective of how many Severe Conditions you may have. Your SCB benefit is taxable, and is not reduced by your LTD benefit or by any other benefit sources that reduce your LTD benefit.

Severe Conditions are defined as follows:

Severe Condition Definition/Documentation

Cancer Presence of one or more invasive malignant tumors characterized by the uncontrollable and abnormal growth and spread of malignant cells with invasion of normal tissue that requires the following:

- Medically necessary surgery, radiotherapy or chemotherapy; OR
- Metastasis(es) has occurred (or is occurring); OR
- The diagnosed cancer has a terminal prognosis, and the patient is not expected to live beyond 24 months from the date of diagnosis, and will not benefit from or has exhausted curative therapy; or
- Carcinoma *in situ* classified by the TNM Staging classification as TisN0M0 and requires medically necessary surgery, radiotherapy or chemotherapy; or
- Malignant tumors classified by the TNM Staging classification as T1N0M0 or greater, which are treated by endoscopic means; or
- Malignant melanoma(s) classified by the TNM Staging classification as T1N0M0, with a pathology report documenting a Breslow tumor thickness of 0.75 mm or less; or
- Tumors of the prostate classified by the TNM Staging classification as T1bN0M0 or T1cN0M0 and treated with radical prostatectomy or external beam radiotherapy.

Heart Attack (Myocardial infarction)

The death of a portion of the heart muscle as a result of obstruction of one or more coronary arteries due to atherosclerosis, spasm, thrombus(i) or embolus(i)

Stroke

Cerebrovascular accident or incident producing measureable, functional, and permanent neurological impairment caused by any of the following which result in an infarction of brain tissue:

- Hemorrhage
- Thrombus
- Embolus from an extracranial source
- Stroke does not include transient ischemic attack(s) or prolonged reversible ischemic attacks.

Kidney Failure

Total, end-stage irreversible failure of both kidneys' function that requires the following:

- Medically necessary immediate and regular (weekly) kidney dialysis that is expected to continue for at least 6 months; or
- Medically necessary kidney transplant

Severe Condition Definition/Documentation

Major Organ Failure Requiring Transplant

- Irreversible failure of the participant's entire:
- Heart, lung, kidney, pancreas, small intestine or any combination thereof, that requires medically necessary replacement with an entire organ(s) from a human donor, and the patient has been placed on the transplant list or the transplant has been performed; or

- Liver, that requires medically necessary complete or partial replacement with an entire liver or liver tissue from a human donor, and the patient has been placed on the transplant list or the transplant has been performed; or
- Bone marrow that requires medically necessary replacement with the one marrow from either the patient himself or from a human donor

Paraplegia

Paralysis of the lower portion of the body (from waist or hip level), including both lower limbs

Quadriplegia

Paralysis of the upper and lower portions of the body (from neck, shoulder or chest level), including all four limbs

Alzheimer's Disease

The development of multiple, progressive cognitive deficits manifested by memory impairment (impaired ability to learn new information or to recall previously learned information) and one or more of the following cognitive disturbances:

- aphasia (language disturbance);
- apraxia (impaired ability to carry out motor activities despite intact motor function);
- angosia (failure to recognize or identify objects despite intact sensory function); and
- disturbance in executive functioning (i.e. planning, organizing, sequencing, abstracting).

Proof of Alzheimer's disease requires a Diagnosis made in Writing by a Neurologist, Geriatrician, or Neuropsychologist and supported by all of the following:

- formal neuropsychological testing performed by a Neuropsychologist confirming dementia;
- laboratory tests have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease; and
- magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease.

The Covered Condition for Alzheimer's disease will be deemed to Occur on the date that the Diagnosis of Alzheimer's Disease is made and all other etiologies have been ruled out.

We will not pay benefits for a Diagnosis of Alzheimer's Disease for: other central nervous system conditions that may cause deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, normal-pressure hydrocephalus);

- systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B12 or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis);
- substance-induced conditions; or
- any form of dementia that is not diagnosed as Alzheimer's Disease.

To apply for this benefit, you must submit to the claim processor proof that you've been diagnosed with a Severe Condition and the date of such diagnosis, and this proof must be signed and certified by your treating board-certified physician certified in the appropriate medical specialty applicable to your Severe Condition. You may also be asked to have your

physician submit copies of his/her clinical records of your diagnosis and treatment for your Severe Condition, including one or more of the following:

- Cancer: Pathology reports confirming the diagnosis.
- Heart Attack: Proof of inpatient hospitalization, laboratory reports of elevated cardiac enzymes, troponins or cardiac markers, EKG changes reflecting an acute myocardial infarction, cardiac imaging studies reflecting an acute myocardial infarction.
- Kidney Failure: Nephrologist's confirmed diagnosis of kidney failure.
- Recipient of Major Organ Transplant: Specialist's confirmation of major organ failure, proof that patient has been placed on the transplant list, documentation that the transplant has occurred.
- Paraplegia: Successive neurological examinations with demonstrations of weakness of both lower limbs, usually accompanied by impairment of bladder/bowel control, motor weakness, muscle atrophy, abnormal deep tendon reflexes, radioimaging confirmation of neurological deficit.
- Quadriplegia: Successive neurological examinations with demonstrations of weakness of all four limbs, usually accompanied by impairment of bladder/bowel control, motor weakness, muscle atrophy, abnormal deep tendon reflexes, radioimaging confirmation of neurological deficit.
- Stroke: Clinical confirmation of the diagnosis of Stroke based on clinical evidence of significant neurological impairment that is functional, measureable, and permanent based on MRI, CT or other reliable imaging techniques demonstrating the affected areas of the brain. Such neurological impairment must be documented in the clinical records 30 or more days after the cerebrovascular accident/incident by the neurologist, and be based on clinical evidence of significant neurological, motor or sensory impairment.
- Alzheimer's: formal neuropsychological testing performed by a Neuropsychologist confirming dementia; laboratory tests have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease; and magnetic resonance imaging, computerized tomography or other reliable imaging techniques that have been completed as part of the evaluation to rule out etiologies other than Alzheimer's Disease.

The claim processor will review your claim, and if approved, will make the \$5,000 SCB payment to you, in one lump sum. This SCB is paid *in addition to* your monthly LTD Plan benefit.

Benefits will not be paid for any Severe Condition that is:

- Caused by, contributed by or resulting from your voluntarily taking or using any drug, medication, sedative or other substance unless it is:
- Taken or used as prescribed by your physician, or
- An 'over the counter' drug, medication, sedative or other substance taken according to package directions.
- One for which diagnosis is made outside the United States, unless the diagnosis is confirmed in the United States.
- Does not first occur while you are covered under this LTD Plan.
- A diagnosis of stroke for cerebral symptoms due to migraine; cerebral injury resulting from hypoxia or trauma; or vascular disease affecting the eye, optic nerve, middle or inner ear or vestibular function.
- Cancer classified by the TNM Staging classification as less than T1N0M0, papillary tumor of the bladder classified as Ta, tumors of the prostate classified as T1N0M0 or

T1aN0M0 or papillary tumors of the thyroid classified as T1N0M0 or less and are one centimeter or less in diameter.

- Tumor(s) in the presence of the human immunodeficiency virus.
- Any non-melanoma skin cancer unless there is metastasis or melanoma *in situ* classified as T1sN0M0.
- Chronic Lymphocytic Leukemia, classified by RAI classification as less than Stage III.
- Melanoma in situ classified by the TNM Staging classification as TisN0M0.
- Any form of dementia that is not diagnosed as Alzheimer's Disease.

LTD Benefit Elimination Period

The elimination period is the waiting period before LTD Plan benefits are payable. It extends until the later of the date you have been continuously totally disabled for 180 days or the end of STD.

Duration of LTD Benefits

After you qualify for LTD Plan benefits, if you remain disabled, you receive a monthly benefit for the following maximum period:

- Your Normal Retirement Age defined by the federal Social Security Administration on the date Your Disability starts; or
- the period shown below:

Age on Date of Your Disability	Benefit Period
Less than 61	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

* The Maximum Benefit Period is subject to the Limited Disability Benefits and DATE BENEFIT PAYMENTS END sections.

During your disability, you may be required to provide additional medical information or submit to periodic physical exams to confirm your continuing disability. LTD Plan benefits end if you do not agree to undergo a physical exam or provide the required information.

For employees who become disabled, the maximum duration of benefits may allow your LTD Plan benefits to continue after you begin receiving your pension. If this occurs, your LTD Plan benefit will be offset by the amount of pension benefit you receive (or you are entitled to receive).

Filing a Claim for LTD Benefits

You should file LTD Plan claim as soon as you become disabled. Do not wait until your 180 day elimination period expires — file your claim immediately.

The latest you can file your LTD Plan claim is one year after your disability began. If you file your disability claim beyond this one-year deadline, your claim will not be accepted and you will not be eligible for LTD Plan benefits.

MetLife is the claims processor for the LTD Plan. The LTD Plan is funded and managed by the Company through a trust. Benefits are paid from trust assets.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the STD Insurance, state disability plans (other than California, Rhode Island and Hawaii, which have their own forms that must be filed directly with the respective states) and LTD Plan programs. You should submit your Disability Claim Form as soon as you become disabled.
- You, your supervisor and your attending physician must each complete part of the form:
- Disability Claim Employer Statement: Your supervisor completes this page.
- Disability Claim Employee Statement: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see Benefits from Other Sources).
- Disability Claim Attending Physician Statement: Your physician completes this page.
- Direct Deposit Agreement is required (Electronic Fund Transfer)

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

When LTD Benefits Begin

Provided you qualify, LTD Plan benefits are payable at the end of the elimination period. The later of the date you are totally disabled for 180 consecutive days, or the end of STD.

If you return to work in a capacity comparable to your pre-disability status during the elimination period or after receiving LTD benefits, you are still considered continuously disabled if you become totally disabled again due to the same or related sickness or injury within 90 days after returning to work in your pre-disability occupation or other comparable work. However, days worked do not count toward your elimination period.

If you have received LTD Plan benefits for an earlier disability and become totally disabled again, your most recent disability is considered part of the previous disability. However, this provision does not apply if you have returned to work in a capacity comparable to your pre-disability status for at least three months or, if the cause of the later disability is totally unrelated to the earlier disability. If it is considered a separate period of disability, you must satisfy a new elimination period.

When LTD Benefits End

Your LTD Plan benefits automatically end on the earliest of the following dates:

- If capable of returning to work and limitations can be accommodated, and you choose not to, your benefit will cease;

- During the first 24 months of benefit payments, when you are able to work in your own occupation by using adaptive equipment or a worksite modification that we consider appropriate for your situation and that is approved by an independent Doctor, but you choose not to; your benefit will cease;
- The date you cease or choose not to participate in a Rehabilitation Program that we consider appropriate for your situation and is approved by an independent Doctor;
- The date your benefits expire, as explained in Duration of Benefits;
- The date you reach your maximum period, as explained in the Duration of LTD Benefits.
- The date you are no longer disabled (e.g., you no longer meet the definition of total disability, you are no longer receiving Appropriate Care and Treatment, etc.);
- The date you become gainfully employed in any type of job, except under the Return-to-Work Program;
- The date benefits end, if disability is due to a mental health disorder or neuromuscular, musculoskeletal or soft tissue disorder — see Exclusions and Limitations; or
- The date you die.

If and when you return to work, you or your supervisor must contact MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repaying any overpayments you receive.

If your employment terminates from a sickness or injury Leave of Absence and you are receiving LTD Plan benefits, these LTD Plan benefits will continue until you meet one or more of the conditions listed above. However, when you meet one or more of these conditions and your LTD Plan benefits terminate, your LTD Plan coverage also terminates at the same time. After your LTD Plan benefits and LTD Plan coverage terminate, any later recurrence or relapse of your disabling condition or your development of any other disabling condition, will not reactivate your LTD Plan coverage, will not result in any reinstatement of LTD Plan benefits and will not cause any LTD Plan benefits to resume.

LTD Exclusions and Limitations

The LTD Plan has the following exclusions and limitations:

- If you become disabled before the effective date, you are not covered under the LTD Plan until you return to work.
 - If you are disabled due to a mental health disability (this includes mental health disorders, emotional disease and/or alcohol/chemical/substance abuse/dependency), disability benefits under this coverage will end when you have received a maximum of 24 months of LTD Plan benefits for the entire time you are covered under the LTD Plan. This maximum benefit applies to the duration of your participation in this coverage. As part of a mental health disability, chemical abuse/dependency includes, but is not limited to, both prescription and over-the-counter medications, as well as illicit/illegal drugs; substance abuse/dependency includes, but is not limited to, any other non-drug substances such as aerosol propellants, glue, etc.

This 24-month maximum disability benefit applies whether or not you have been hospitalized, with the following exceptions:

- If you are confined in a hospital at the end of this 24-month maximum benefit period, benefits continue as long as you are confined.
- To enable a necessary recovery period, benefits also continue for up to 90 days following your release from hospital confinement, provided you were confined for at least 14 consecutive days.
- If you are reconfined during this 90-day recovery period, benefits continue during your reconfinement, together with another 90-day recovery period, provided you are reconfined for at least 14 consecutive days.
- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling conditions from a duly-qualified physician.
- Benefits are not payable if the Plan Administrator determines in its sole discretion that you are disabled as a direct or indirect result of committing or trying to commit a felony, assault or other serious crime or are engaged in an illegal occupation, regardless of whether or not you are ever charged with a crime or for engaging in an illegal occupation.
- Benefits are not payable if you are disabled as a result of intentionally self-inflicted injuries or an attempted suicide.
- Benefits are not payable if you are disabled as a result of a declared or undeclared act of war.
- Benefits are payable only to employees. Dependents are not eligible for this benefit.
- Pre-existing Conditions Exclusion: Pre-existing Condition Exclusion means a Sickness or accidental injury for which you:
 - received medical treatment, consultation, care, or services; or
 - took prescribed medication or had medications prescribed;
 in the 3 months before Your insurance, or any increase in the amount of insurance under this plan takes effect. However, a Pre-existing Condition does not include any condition for which You had tests if the condition was found not to exist.

We will not pay benefits for a Disability that results from a Pre-existing Condition if you have been Actively at Work for less than 12 consecutive months after the date your Disability insurance takes effect under this plan.

If you were hired on or after January 1, 2015, the pre-existing provision will apply to your LTD coverage, and *it is waived for all covered employees hired prior to January 1, 2015.*

- If you are disabled due to a neuromuscular, musculoskeletal and/or soft tissue disorder disability, the disability benefits under the LTD Plan will end when you have received a maximum of 24 months of disability benefits for the entire time you are covered under the LTD Plan. This 24-month maximum benefit applies to the duration of your participation in this coverage. Neuromuscular, musculoskeletal and/or soft tissue disorders include, but are not limited to any disease, injury or disorder of the spine, the vertebrae, their supporting structures, muscles and/or soft tissue; bones, nerves, supporting body structures, muscles and/or soft tissue of all joints, extremities and/or major body complexes of movement; sprains/strains of all joints and muscles. This 24-month maximum benefit does not apply to disabilities, if such disabilities have documented objective clinical evidence of:
 - Seropositive arthritis (inflammatory disease of the joints), supported by clinical findings of arthritis and positive serological tests for connective tissue disease;

- Spinal (referring to the bony spine and/or spinal cord tumor(s) — abnormal growths — whether benign or malignant), malignancy or vascular malformations (abnormal development of blood vessels);
- Radiculopathies (disease of the peripheral nerve roots) supported by objective clinical evidence of nerve pathology;
- Myelopathies (disease of the spinal cord and/or nerves) supported by objective clinical evidence of spinal cord/nerve pathology;
- Traumatic spinal cord necrosis (injury or disease of the spinal cord) resulting from traumatic injury with paralysis; or
- Musculopathies (disease of the muscle/muscle fibers) supported by objective pathological evidence on muscle biopsy or electromyography.
- Disabilities caused by the aforementioned conditions — provided objective evidence confirms the diagnosis — will not be subject to the 24-month limitation, but will be benefited according to all other applicable LTD Plan provisions.
- The Plan Administrator in its sole discretion shall determine whether any exclusion or limitation applies.

Benefits from Other Sources

If you qualify for disability benefits from other sources, your LTD Plan benefits are reduced by the amount of the following periodic benefits. Your LTD Plan benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

Periodic benefits for loss of time because of this disability under:

- Any employee benefit coverage for which the Company has paid any part of the cost or made payroll deductions, including a Company-sponsored annuity contract or disability retirement benefits plan
- Any government law including no-fault motor vehicle insurance, other than a law providing benefits for military services.
- Periodic benefits for loss of time due to a work-related injury or illness or by reason of any Workers' Compensation, occupational disease law or other similar law.
- Unemployment benefits.
- Social Security Disability Benefits (SSDB) based on the amount of SSDB in effect as of the LTD Plan benefit start date. This includes SSDB benefits for you, your spouse or children that you receive because of your disability. This may not apply if your disability is a result of a pregnancy or if your disability lasts less than one year. Periodic increases in monthly SSDB income (through cost-of-living increases) and survivor benefits are not subtracted from LTD Plan benefits.
- The gross amount that You, Your spouse and/or children receive as retirement payments because You are receiving payments under the United States Social Security Act (Social Security Retirement/Old Age Benefits)
- Earnings from employment activity not approved under the return-to-work guidelines.
- Any LTD Plan benefit a participant receives while disabled may be offset by the amount of Retiree Benefit Plan pension benefits the participant is receiving (or is entitled to receive).
- Third Party Recovery: Recovery amounts that you receive from loss of income as a result of claims against a third party by judgment, settlement or otherwise including future earnings.

To alleviate potential financial hardship while waiting for a determination on a claim for Social Security, Workers' Compensation or other such benefits described above, you may request that such benefits not be deducted from your LTD Plan benefits. The Reimbursement Agreement is in the Disability Claim Form. It states that you agree to reimburse the appropriate amount of LTD Plan benefits paid if Social Security, Workers' Compensation or other such benefits are later payable.

Social Security Disability Benefits

Because the amount of LTD Plan benefits you receive is influenced by Social Security Disability Benefits (SSDB), you must apply for SSDB as soon as possible.

Within six months after your LTD Plan claim is approved, you must provide evidence to the claims processor that you have filed for SSDB or that your application has been denied. This does not apply if your disability is the result of pregnancy or is expected to last less than one year. Otherwise, your SSDB benefits will be estimated and your LTD Plan benefits will be reduced by the estimated amount.

Evidence may include a denial of benefits by the Social Security Administration, failure to qualify because of the length of your disability or a copy of the Receipt of Claim Form given to you by the Social Security Administration at the time of application. Please note that if your initial application is denied, you must file for reconsideration and/or appeal to the Social Security Administration.

Single Sum Payment

If you receive other income in the form of a single sum payment, you must, within 10 days after receipt of such payment, give written proof satisfactory to MetLife of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When MetLife receives such Proof, they will adjust the amount of Your Disability benefit by pro-rating such single sum amount on a monthly basis over the time period for which the sum was given.

If they do not receive the written proof of the single sum amount as indicated above, They may reduce Your Disability benefit by pro-rating the sum over a 60 month period starting with the date Your Monthly Benefit is first payable.

If they adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment or additional income from other employment.

Former Pension Benefit Supplement

Effective January 1, 2004, the Pension Supplement Benefit in the Long-Term Disability Plan Ended.

The Pension Benefit Supplement only applies to employees who are eligible to receive benefits from the defined benefit pension plan and were disabled prior to January 1, 2004. You are not accruing credited service toward your pension benefit. The LTD Plan pension supplement (also known as the “Deferred Benefit”) makes up for this loss of credited service. Your pension supplement benefit is payable to you when you begin taking your pension. However, this benefit is paid separately from your pension benefit. If you choose to take your pension early, your pension supplement begins paying at the same time with the same reduction, if any, as your early pension benefit.

The amount of your pension supplement benefit is determined by placing the number of months of LTD Plan benefits you received before your 65th birthday into the applicable benefit formula under your Retirement Benefit Plan. No additional months will be credited after age 65. The formulas are:

- Minimum Benefit formula
- Career Average formula
- Final Average Salary formula
- Social Security Offset formula

If you elected an optional form of payment under your Retirement Benefit Plan, your pension supplement benefit is computed and paid the same way.

When your pension supplement benefit begins, if your monthly benefit is less than \$20, a lump sum payment may be made, rather than monthly benefit payments. The claims processor determines whether this is an option.

Freeze of Pension Supplement Benefit

As part of the Company’s restructuring, American Airlines Inc. froze its defined benefit pension plans for all work groups. This freeze was effective November 1, 2012. This pension plan freeze prohibits participants from accruing additional Credited Service on or after November 1, 2012.

The LTD Plan’s Former Pension Supplement Benefit calculation uses Credited Service and number of months the LTD benefit was paid. Because the defined benefit pension plans have been frozen, it is necessary to freeze this Former Pension Supplement Benefit as well. Therefore, employees who accrued this benefit will still be eligible, but the accrual of Credited Service and number of LTD payments made will cease on the earlier of the following:

- Your attaining age 65, or
- The date your LTD payments stop, or
- The date of the defined benefit pension plan freeze - November 1, 2012

Return-to-Work Program

The Return-to-Work Program, administered by MetLife, is a program that allows you, as a disabled employee collecting LTD Plan benefits, to work in an occupation or job for wage or profit without losing your LTD Plan benefits. Your return to work must be approved by the claims processor and may not exceed one year. The claims processor will monitor your

progress under this program. If you fully recover and are no longer disabled before the end of that year, you will no longer be eligible for the program.

If you work while you are Disabled and receiving Monthly Benefits, including self-employment, your monthly benefit will be adjusted as follows:

1. Add your monthly Work Earnings to your Gross Monthly Benefit payment.
2. Compare the answer in item 1 to your Pre-disability Base monthly Income

If the answer from item 1 is less than or equal to 100% of your Pre-disability Base monthly Income, we will not further reduce your Net monthly Benefit payment. If the answer from item 1 is more than 100% of your Pre-disability Base monthly Income, We will subtract the amount over 100% from your Net monthly Benefit payment. We may require you to send proof of your monthly Work Earnings.

In addition, the Minimum monthly Benefit will not apply.

Employees who are participating in the Workers' Compensation Transitional Duty program are not eligible for this Return-to-Work Program and vice versa.

Following are the steps required to participate in the Return-to-Work Program:

- A request for consideration is initiated either by you, your supervisor, your physician or the claims processor.
- The request is distributed to all parties above and all must agree that you may return to work on a trial basis.
- When your return-to-work plan has been approved by all parties, MetLife will document the plan for signature. Documentation will include the following:
- Written agreement from your physician, supervisor and you that you may return to work
- Statement of approximate length of time for the trial work period
- Statement of hours to be worked per day and rate of pay. (If hours per day vary, the claims processor will need regular bi-weekly or semi-monthly reports of earnings and hours worked.)
- The claims processor notifies you or your supervisor whether your return-to-work request has been approved.

If you are allowed to participate in the Return-to-Work Program, your supervisor must notify the claims processor of the date you return to work. In addition, if and when you can no longer work, both your supervisor and physician must send written notification to the claims processor of this change. If you return to work for the Company under this program, your supervisor should indicate "Returning to Work" on your Payroll Transaction Request (PTR).

Vocational Rehabilitation Program

If you are receiving LTD Plan benefits, you may be eligible to receive assistance through the Vocational Rehabilitation Benefit if approved by the claims processor. This benefit is not available for participants receiving STD.

Vocational Rehabilitation Benefits may cover expenses such as:

- Vocational counseling
- Job search assistance
- Occupational training
- Vocational education
- Prosthetic devices
- Psychotherapy
- Physiotherapy

You may request consideration for this benefit by writing to MetLife. See “Contact Information” in the *Reference Information* section.

After reviewing your request, the claims processor may require an in-depth field evaluation of your potential to return to work. If so, your supervisor will be notified with the necessary details.

The claims processor may also request a complete job description and other documentation. After reaching a decision, the claims processor notifies you of the rehabilitation benefits to which you are entitled.

How do I enroll?

This section covers General Enrollment and when Coverage Begins and Ends.

Annual Enrollment

How to Enroll

New Employee Enrollment

When Coverage Begins as a Newly Hired Employee

When Coverage Begins as a Current Employee

Waiving Coverage

Default Coverage

HIPAA Special Enrollment Rights – Medical Benefit Option

When Coverage Ends

You have the opportunity to select benefits tailored to your individual needs and preferences each year during annual enrollment. The annual enrollment period occurs in the Fall of each year. Employees must enroll online using the [American Airlines Benefits Service Center](#). After annual 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.

The Plan year is January 1 through December 31.

If your current medical option is no longer available and you do not make another selection, you will default into the CORE Medical Benefit Option. If the CORE Medical Benefit Option is not available, you will default into another Medical Benefit Option designated by the Plan Administrator.

If you are adding new dependents to your benefits during the year due to marriage, birth, adoption, or placement for adoption, you must request enrollment within 31 days of the event AND submit to the Benefits Service Center proof that these dependents qualify as your eligible dependents within 31 days of the date you request enrollment.

The American Airlines Benefits Service Center

The [American Airlines Benefits Service Center](#) (the online enrollment tool) on my.aa.com reflects the current benefits coverages available to you and the rates for those coverages. The [American Airlines Benefits Service Center](#) is updated by annual enrollment with your benefits Options and the new rates for the upcoming Plan year – January 1 through December 31.

Annual Enrollment

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

- Enroll for coverage,
- Add or remove a dependent from coverage - you have 31 days after enrolling to submit required documentation to the American Airlines Benefits Service Center,
- Make changes to your prior elections, or
- Continue your previous elections at the applicable new rates (if available).

New rates are shown on [American Airlines Benefits Service Center](#) when you enroll. With the exception of Life Events, annual enrollment is the only time you can change your coverage elections.

Any elections you make during annual enrollment are generally effective the following January 1. If proof of good health is required, the effective date for coverage, if approved, may be delayed to allow for review of your proof of good health, (e.g., to add or increase life insurance coverage).

Once annual 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 until the following year unless you experience a Life Event that would enable you to make such changes.

How to Enroll

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

IMPORTANT NOTICE: During the last two months of the current benefit year an employee cannot change or enroll in his/her HCFA, DCFA, or LPFA elected amounts. This does not include the elections you make during the Annual Enrollment period for the next benefit year.

New Employee Enrollment

As a new employee, you will receive information shortly after you begin working regarding enrollment in the Benefit Options. You may elect coverage for yourself and your eligible dependents (see the [General Eligibility](#) section) and have a one-time opportunity to enroll in the Employee Voluntary Term Life Insurance Benefit without having to provide proof of good health (coverage levels in excess of 1 times your salary require a Statement of Health).

Proof of good health is required if you wish to enroll in the Voluntary Term Life Insurance benefit at any level, at any time after you were first eligible, or to increase life insurance coverage levels. The employee can complete a form online via a Single Sign On to MetLife’s site when he/she elects the Voluntary coverage or increase. If you would like coverage on the life of your spouse, he/she will need to mail a completed, dated and signed Statement of Health form to [MetLife](#), postmarked within 30 days after your enrollment deadline. If your Statement of Health is not postmarked within 30 days after the close of your new employee enrollment window, your application for this coverage will not be considered, and you must wait until the next annual enrollment (or your next Life Event) to apply for this benefit.

FAQ: When can I enroll for benefits?

As a new employee, you can enroll shortly after you begin working. As an existing employee, you can enroll during the annual enrollment period or if you experience a Life Event during the year.

When Coverage Begins as a Newly Hired Employee

If you enroll by the enrollment deadline, your selected coverage (if different from default coverage) is retroactive to your enter-on-duty date and your paycheck is adjusted as necessary. However, if a death or accident occurs before your enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance coverage that will be paid is the amount under “Default Coverage”.

When Coverage Begins as a Current Employee

When you enroll during the annual enrollment period, your selected coverage (or default coverage) begins on January 1 and continues through December 31 (the Plan year).

If you want to add new dependents to your benefits, you must request enrollment within 31 days of the event and, within 31 days of the date you request their enrollment, submit to the Benefits Service Center proof that these dependents qualify as your eligible dependents. 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 [Dependent Eligibility Criteria](#).

Waiving Coverage

You may choose to waive medical coverage if you wish. Your dependents will not receive medical coverage if you waive such coverage. If you waive coverage, you can enroll in coverage later in the year only if you experience a Life Event, such as marriage, divorce or the birth or adoption of a child.

Default Coverage

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

NEW EMPLOYEE DEFAULT TABLE		
Benefit	Default	Comments
Medical Benefit Option	CORE Medical Option (Employee only)	
Dental Benefit Option	No coverage	N/A
Vision Insurance Benefit	No coverage	N/A
Optional STD	No coverage	This plan only applies to TWU and Agents, Representatives and Planners
Voluntary LTD Plan	No coverage	This plan applies only to Agents Representatives and Planners
STD/LTD Plan	STD/LTD Coverage	This plan applies only to Officer, Management, Specialist and Support Staff workgroups
Basic Term Life Insurance Benefit	2 times pay	Up to a maximum of \$70,000 This does not apply to Home-Based Representatives or Level 84 Premium Services Representatives
Basic AD&D Insurance Benefit	2 times pay	Up to a maximum of \$70,000 This plan applies only to Officer, Management, Specialist and Support Staff workgroups
Voluntary Term Life Insurance Benefit	No coverage	N/A
Voluntary AD&D	No coverage	N/A

NEW EMPLOYEE DEFAULT TABLE		
Benefit	Default	Comments
Insurance Benefit		
Spouse Life Insurance	No coverage	N/A
Child Life Insurance	No coverage	N/A
Flexible Spending Accounts (FSAs) (Health Care FSA and Dependent Day Care FSA and Limited Purpose Health Spending Account)	No coverage	Your FSA accounts will default to \$0.00 unless you take action to establish the accounts and enter a dollar amount for the accounts

Default Medical coverage:

If you do not affirmatively make an election during the New Hire enrollment period or the Annual Enrollment period:

- For New Hires, you will automatically default into the CORE Medical Benefit Option, if available. If the CORE Medical Benefit Option is not available, you will automatically default into another Medical Benefit Option selected by the Plan Administrator.
- For all other employees who previously elected benefits coverage during a prior Annual Enrollment, you will default into your previous elections (if still available) or the Core option for the following year, at the applicable rates for the following year. If the CORE Medical Benefit Option or your previous election is not available, you will automatically default into another Medical Benefit Option selected by the Plan Administrator.
- **Flexible Spending Accounts (FSAs):** If you do not elect an FSA, you will not have FSA accounts for the following year. You may not elect an FSA if you enroll within the last 60 days of the plan year. Employees enrolled in the Core option are only eligible to elect the Limited Purpose FSA.

New

HIPAA Special Enrollment Rights – Medical Benefit Option Only

If you declined coverage for you or your dependents under the Medical Benefit Option because you or they have medical coverage elsewhere and one of the following events occurs, you have 31 days from the date of the event to enroll yourself and/or your dependents in the Medical Benefit Option:

- You and/or your dependents lose eligibility for other medical coverage for reasons that include legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
- The employer contributions to the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.

- You and/or one of your dependents exhaust a lifetime maximum in another employer's health plan or other health insurance coverage.
- You and/or one of your dependents' employers cease to offer benefits to the class of employees through which you (or one of your dependents) had coverage.
- You and/or one of your dependents were enrolled under an HMO or other group or individual plan or arrangement that will no longer cover you (and/or one of your dependents) because you and/or one of your dependents no longer reside, live or work in its service area.
- You have a new dependent as a result of your marriage, common law marriage, or declaration of a Company-recognized Domestic Partner, your child's birth, adoption or placement for adoption with you. In that event, coverage is retroactive to the date of birth, adoption or placement for adoption.

As an employee, you may enroll yourself and request enrollment for your new spouse, common law spouse, or Company-recognized Domestic Partner and any new dependents within 31 days of your marriage or declaration. You may request enrollment for a new child within 31 days of his or her birth, adoption or placement for adoption. If you miss the 31 day deadline, you are not able to enroll and you will have to wait until the next annual enrollment period to enroll your dependent.

You must enroll in the benefits in order to elect coverage for your dependents. If your spouse is not enrolled in medical benefits on the date of birth, adoption, or placement for adoption, you may enroll yourself and request enrollment for your spouse, common law spouse, or Company-recognized Domestic Partner in the medical benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage, common law marriage, or declaration of a Company-recognized Domestic Partner, coverage will be effective no later than the first day of the month following the date enrollment is requested along with proof of eligibility. To request special enrollment or obtain more information, contact Benefits Service Center (see "[Contact Information](#)" in the *Reference Information* section).

Special Enrollment for Medicaid and CHIP

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

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

When Coverage Ends

Coverage for you and your dependents ends when you terminate employment, cancel coverage, stop paying for coverage or if you become ineligible for coverage (for example, due to a change in your job classification or if the Company terminates the Plan). See

[“Continuation of Coverage – COBRA Continuation”](#) in the *Additional Health Benefit Rules* section. In addition, your dependent’s coverage ends if the dependent no longer meets the eligibility requirements, as explained in the [“Dependent Eligibility Requirements”](#) in the *General Eligibility* section.

If you die as an active employee, your covered dependents continue to receive the same medical coverage they had before you died in the form of COBRA Continuation Coverage that continues for 90 days at no cost to your dependent. At the end of 90 days, your eligible dependents can continue medical coverage for up to 36 months under the full COBRA rate. The 90 days of coverage immediately following your death is included in the 36 months. Dental and Vision coverage is available for purchase through COBRA Continuation Coverage on day one. All other coverages end at the time of your death. Please note that not all of your coverages are COBRA-eligible.

If you are over age 55 and working as an active employee, and were eligible to retire on your date of death, your “under age 65” surviving spouse is eligible for the Retiree Medical Benefit when you die.

While you are receiving paid sick time and during the first year (12 months) of an unpaid sick or injury-on-duty leave of absence, you may keep the same benefits you elected for the current plan year. You cannot have more than 12 months of Company-subsidized health benefits while you are on an unpaid sick or injury-on-duty leave of absence. You are responsible for paying your share of the cost for coverage. When you begin a leave of absence (when your payroll transaction record is changed to reflect that you’re on a leave of absence), the Benefits Service Center sends you a notification acknowledging your leave and instructing you to access The American Airlines Benefits Service Center to register your Leave of Absence Life Event and decide whether or not to continue your benefits while on your leave. When you register your Life Event and benefit elections on The American Airlines Benefits Service Center, it will display a confirmation statement showing your choices, the monthly cost of benefits, etc. If you have not received the American Airlines Benefits Service Center notification within 10 days of being placed on leave, contact them immediately so you may continue your benefits while on leave (see [“Contact Information”](#) in the *Reference Information* section). Also, refer to [Leave of Absence \(LOA\)](#) on Jetnet for more information and/or contact your manager.

Important: If you elect not to continue payment for your benefits during your leave of absence, your benefits will terminate while you are on leave. When you return to active status, you may reactivate most of your benefits; however, the Voluntary Term Life Insurance Benefit and Disability benefits will require you to supply proof of good health with approval from MetLife, in order to reactivate.

Making Changes During the Year: Life Events

Life Events

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

Special Life Event Considerations

Benefit Coverages Affected by Life Events
Benefit Coverages Not Affected by Life Events

HIPAA Special Enrollment Rights – Medical Benefit Option

After Annual Benefits 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.

New

Life Event changes must be made within the 31 day time frame. If you miss the 31 day deadline, your Life Event change will not be processed. You will have to wait until the next Annual Benefits Enrollment period to make changes to your benefits.

New

Life Events

Certain circumstances or changes that occur during your life allow you or your dependents to make specific changes in coverage Options outside the Annual Benefits Enrollment period. The Internal Revenue Service dictates what constitutes Life Events.

When you experience a Life Event, remember these guidelines:

- Most Life Events are processed online through the [American Airlines Benefits Service Center](#). Visit Life Events on [my.aa.com](#) for a complete list of all Life Events and the correct procedures for processing your changes.
- If you process your Life Event within 31 days of the event, your changes are retroactive to the date the Life Event occurred (or the date proof of good health is approved, as applicable).
- You must provide acceptable proof of eligibility to American Airlines Benefits Service Center within 31 days of the date you request dependent enrollment before your dependent(s) can be enrolled in benefits
- American Airlines Group and its affiliates reserve the right to request documented proof of dependent eligibility criteria for benefits at any time. If you do not provide proof of eligibility when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the [Rules of Conduct](#) and may result in termination of employment and termination of benefits coverage.
- Any change in your cost for coverage applies on the date the change is effective. Retroactive contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.
- You may start or increase a Flexible Spending Account during the Plan year only if you have enrolled a dependent that was not previously covered. You cannot make changes within the last 60 days of the calendar year.
- Starting or increasing either Life, Accident or Disability Benefits may require proof of good health and coverage will only be effective after the applicant is approved. If death occurs before a Life Event is processed, the amount of coverage payable is your current amount of Life and/or Accident Insurance.

Glossary Term: Life Event

A circumstance or change that happens during the year that allows you and/or your dependents to make changes to your coverage Options outside the Annual Benefits Enrollment period.

- When you add Life or Accident Insurance Benefits, you must designate a beneficiary. Periodically thereafter, you may want to update your beneficiary designations. You can make beneficiary changes on the [American Airlines Benefits Service Center](#). Once you complete and submit the online beneficiary designation form, it supersedes all previous designations.
- If a death or accident occurs before your first-time enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Benefits that will be paid is your first time enrollment announcement. If you have coverage and you are requesting an increase, the amount payable is your current amount of coverage.
- You may only increase your Life Insurance Benefit by one level per year, with proof of good health.
- If you elect to enroll in any coverage requiring proof of good health, you must submit a Statement of Health from [MetLife](#) within 30 days after your enrollment/election date. If your Statement of Health is not submitted within 30 days after your enrollment/election date, your application for these coverages will not be considered, and you must wait until the next Annual Benefits Enrollment (or your next Life Event) to apply for any of these coverages.
- Losing Medicaid or CHIP coverage enables you to enroll in medical, dental and/or vision benefits. See *Special Enrollment for Medicaid or CHIP* Section above.
- Becoming eligible for a state premium subsidy program enables you to enroll in medical, dental and/or vision benefits. See *Special Enrollment for Medicaid or CHIP* Section above.

For all life events, you must register the event within 31 days with the American Airlines Benefits Service Center; you will then have 31 days from the date registered to supply the appropriate proofs of eligibility.

If You Experience the Following Life Event...	Then, You Can...
You become eligible for Company-provided benefits for the first time	Enroll online through the American Airlines Benefits Service Center .
Your spouse, Company-recognized Domestic Partner or dependent dies	Medical, Dental, and Vision: <ul style="list-style-type: none"> • Start/Stop coverage for yourself, your Spouse/Company recognized Domestic Partner (DP), and/or your eligible dependent (dependent coverage may be subject to QMCSO). • You may change Medical Benefit Options; your deductible and out-of-pocket maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO. Optional Short-Term Disability Benefit (FA, TWU, ARP):
You, your spouse/common law spouse/Company-recognized Domestic Partner or your dependent child gives birth to or adopts a child or has a child placed with you for adoption or you add eligible dependent(s) to your household or your dependent regains eligibility for coverage under the Plan	
You get legally married (including common law marriage), divorced or legally separated Or Declare a Company-recognized	

New

If You Experience the Following Life Event...	Then, You Can...
<p>Domestic Partner or that relationship ends</p> <p>Change in spouse's/Company-recognized Domestic Partner's employment or other health coverage</p> <p>OR</p> <p>Your spouse's/Company-recognized Domestic Partner's employer no longer contributes toward health coverage</p> <p>OR</p> <p>Your spouse's/Company-recognized Domestic Partner's employer no longer covers employees in your spouse's position</p>	<ul style="list-style-type: none"> • Start/Stop coverage for yourself only. If you enroll for the first time, coverage is for a duration of 2 years <p>Company-provided Short-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Long-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Long-Term Disability Plan (for ARP, FA):</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself only; does not apply to TWU-Represented employees. <p>Voluntary Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Increase/Decrease your coverage (for increase, you must provide proof of good health) <p>Spouse Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Child Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself <p>Spouse AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for eligible Spouse/Company-recognized DP • Increase/Decrease for eligible Spouse/Company-recognized DP <p>Child AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage • Increase/Decrease coverage <p>Flexible Spending Account Benefits:</p> <ul style="list-style-type: none"> • Start/ Stop Flexible Spending Accounts • Increase/Decrease Flexible Spending Account contributions • Cannot reduce to an amount less than what has already been deducted or paid • Company-recognized Domestic Partners

If You Experience the Following Life Event...	Then, You Can...
<p>Your covered dependent no longer meets the Plan's eligibility requirement, i.e.:</p> <p>If the dependent attains the age at which he/she is no longer eligible to be covered as your dependent</p> <p>If the dependent is employed and becomes eligible for his/her employer's group health plan</p> <p>If the dependent marries and is no longer eligible for Dental and Vision Benefits</p> <p>If the dependent marries and enrolls in his/her spouse's employer group health plan</p>	<p>and their dependents are not eligible to participate in FSAs.</p> <p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself, your Spouse/Company recognized Domestic Partner (DP), and/or your eligible dependent (dependent coverage may be subject to QMCSO). • You may change Medical Benefit Options; your deductible and out-of-pocket maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO. <p>Optional Short-Term Disability Benefit (for FA, TWU, ARP):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Short-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Long-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Long-Term Disability (for FA, ARP):</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself only. Does not apply to TWU-Represented employees. <p>Voluntary Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Increase/Decrease your existing coverage (for increase, you must provide proof of good health) <p>Spouse Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start or stop coverage. <p>Child Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start or stop coverage. <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself <p>Spouse AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for eligible

New

If You Experience the Following Life Event...	Then, You Can...
	<p>Spouse/Company-recognized DP</p> <p>Child AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Flexible Spending Account Benefits:</p> <ul style="list-style-type: none"> • Start/ Stop Flexible Spending Accounts • Increase/Decrease Flexible Spending Account contributions • Cannot reduce to an amount less than what has already been deducted or paid • Company-recognized Domestic Partners and their dependents are not eligible to participate in FSAs. <p>Additionally:</p> <ul style="list-style-type: none"> • Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible dependent's address.
<p>Your dependent child attains age 13 or he or she or no longer requires Dependent Day Care Flexible Spending Account</p> <p>OR</p> <p>Your elderly parent no longer requires Dependent Day Care Flexible Spending Account</p>	<p>Dependent Care Flexible Spending Account:</p> <ul style="list-style-type: none"> • Reduce/Stop Dependent Care Flexible Spending Account contributions. • Company-recognized Domestic Partners and their dependents are not eligible to participate in FSAs. • No other changes to benefits are allowed
<p>Your benefit coverages are significantly improved, lowered or lessened by the Company</p> <p>(Plan Administrator/Sponsor will determine whether or not a change is "significant")</p> <p>OR</p> <p>Your contribution amount is significantly increased or decreased by the Company</p> <p>(Plan Administrator/Sponsor will determine whether or not a change is "significant")</p> <p>Note: Long-Term Disability Plan, as noted here, does not apply to TWU-Represented employees, as their Long-Term disability</p>	<p>Make changes to the applicable benefit coverages:</p> <ul style="list-style-type: none"> • The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.

If You Experience the Following Life Event...	Then, You Can...
coverage is offered by their union.	
<p>You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMCSO) that requires you to provide health care coverage for a child</p>	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Start coverage for yourself • Start coverage for your dependent named in the QMCSO • You may change Medical Benefit Options; your deductible and out-of-pocket maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO • You can start dental/vision coverage for yourself and/or your dependent ONLY if the QMCSO specifically orders it. <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start/Increase as long as it is not within 60 days of the end of the plan year
<p>You, or your dependents enroll in Medicare or Medicaid</p>	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Stop coverage for the applicable eligible person <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start/Increase as long as it is not within 60 days of the end of the plan year • Stop/Decrease contributions
<p>You or your dependents lose Medicaid or CHIP coverage</p>	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Start coverage for yourself and your eligible dependents <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start/Increase as long as it is not within 60 days of the end of the plan year
<p>You or your dependents become eligible for a state premium assistance program</p>	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Start coverage for yourself • Start coverage for your eligible dependents • If you're adding a dependent, you can change your Medical Benefit Option. If you change, your deductible and out of pocket amounts will transfer to your newly elected Option. <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start or increase as long as it is not

New

New

If You Experience the Following Life Event...	Then, You Can...
<div data-bbox="40 241 146 310" data-label="Text">New</div> <p>You, your Spouse/Company-recognized DP, or your eligible dependent become eligible for and enrolled/disenrolled in government-sponsored Tricare coverage</p>	<p>within 60 days of the end of the plan year</p> <p>Medical:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Start/Stop coverage for your Spouse/Company-recognized DP • Start/Stop coverage for your eligible dependent
<p>You move to a new home address: Update both your permanent AND alternate addresses on the Update MY Information page of American Airlines Benefits Service Center Submit a revised Federal Form W-4 Form for payroll tax purposes. The form is available online through the Pay and Compensation page of American Airlines Benefits Service Center Contact other organizations such as the American Credit Union and C. R. Smith Museum directly to update your contact information. Provide your new address and current emergency contact numbers to your manager/supervisor, as well.</p> <p>If you move or relocate to a new location within the last two months of the year, contact American Airlines Benefits Service Center so they can ensure your elections are filed for this current year and for next year.</p>	<div data-bbox="1507 541 1612 611" data-label="Text">New</div> <p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • You may change medical options if your existing medical option is unavailable in your new location, or if your new location offers a new medical option not available in your old location. • No changes allowed for Dental and/or Vision <p>Optional Short-Term Disability Benefit (FA, TWU, ARP):</p> <ul style="list-style-type: none"> • Start coverage for yourself only if you had no access to this coverage in your prior state • Stop coverage for yourself if your new state prohibits OSTD coverage <p>Company-provided Short-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Long-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Long-Term Disability (for FA, ARP):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • No changes allowed <p>Spouse/Company-recognized DP Term Life:</p> <ul style="list-style-type: none"> • No changes allowed <p>Child Term Life:</p> <ul style="list-style-type: none"> • No changes allowed <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • No changes allowed <p>Spouse/Company-recognized DP AD&D/VPAL:</p>

If You Experience the Following Life Event...	Then, You Can...
	<ul style="list-style-type: none"> • No changes allowed <p>Child AD&D/VPAl:</p> <ul style="list-style-type: none"> • No changes allowed <p>Healthcare Spending Accounts:</p> <ul style="list-style-type: none"> • Changes are permitted only if changes were allowed in Medical coverage • Start/Stop HCFSA contributions • Increase/Decrease HCFSA contributions • DDFSA—no changes allowed
<p>You become disabled</p> <p>Note: Long-Term Disability, as noted here, does not apply to TWU-represented employees, as their Long-Term disability coverage is offered by their union</p>	<p>Notify: Your manager/supervisor and download a Disability Claim Form.</p> <p>Complete and submit: Your claim for disability benefits.</p>

If You Experience the Following Life Event...	Then, You Can...
<p>You start an unpaid leave of absence</p>	<p>Access the American Airlines Benefits Service Center to register your “Going on Leave of Absence” Life Event and your benefit elections in the American Airlines Benefits Service Center (you will receive instructions from the American Airlines Benefits Service Center). It will display for you a confirmation statement showing your choices, the monthly cost of benefits, etc.</p> <p>Your cost depends on: The type of leave you are taking</p> <p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Stop coverage • Stop Spouse/Company-recognized DP • Stop eligible dependent <p>Optional Short-Term Disability Benefit (FA, TWU, ARP):</p> <ul style="list-style-type: none"> • Stop coverage <p>Company-provided Short-Term Disability (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Long Term Disability (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Long-Term Disability (for FA, ARP):</p> <ul style="list-style-type: none"> • Stop coverage <p>Voluntary Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Stop coverage <p>Spouse/Company-recognized DP Term Life:</p> <ul style="list-style-type: none"> • Stop coverage <p>Child Term Life:</p> <ul style="list-style-type: none"> • Stop coverage <p>AD&D/VPAL Insurance Benefit:</p> <ul style="list-style-type: none"> • Stop coverage <p>Spouse/Company-recognized DP AD&D/VPAL:</p> <ul style="list-style-type: none"> • Stop coverage <p>Child AD&D/VPAL:</p> <ul style="list-style-type: none"> • Stop coverage <p>Healthcare Spending Accounts:</p> <ul style="list-style-type: none"> • Changes are permitted only if changes were allowed in Medical coverage

If You Experience the Following Life Event...	Then, You Can...
	<ul style="list-style-type: none"> • Stop/Decrease HCFSA contributions • Stop/Decrease DDFSA contributions • Cannot reduce any FSA to amount lower than what has been deducted or paid
<p>You return from an unpaid leave of absence</p> <p>Note: Long-Term Disability, as noted here, does not apply to TWU-Represented employees, as their Long-Term disability coverage is offered by their union</p>	<p>If you did not continue payment of your benefits during your leave and wish to reactivate your benefits upon your return to work, you may do so; however, you will be required to provide proof of good health for certain benefits (i.e., Voluntary Term Life Insurance, Short and Long Term Disability, etc.)</p> <p>Go to the American Airlines Benefits Service Center, register your “Return to Work” life event and make selections or changes to your benefits.</p> <p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Resume/Start coverage for yourself • Start coverage for your spouse/Company-recognized DP • Start coverage for your eligible dependents <p>Optional Short-Term Disability Benefit (FA, TWU, ARP):</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself; proof of good health is required <p>Company-provided Short-Term Disability Benefit (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Long-Term Disability Benefit (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Long-Term Disability (FA, ARP):</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself; proof of good health is required <p>Voluntary Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself; proof of good health is required • Increase/Decrease coverage for yourself; for increase, proof of good health is required <p>Spouse Term Life Insurance:</p>

If You Experience the Following Life Event...	Then, You Can...
	<ul style="list-style-type: none"> • Start/Resume coverage; proof of good health is required • Increase/Decrease coverage; for increase, proof of good health is required <p>Child Term Life Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself • Stop/Decrease coverage for yourself <p>Spouse AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage • Increase/Decrease coverage <p>Child AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start/Increase contributions • Stop/Decrease contributions • Company-recognized Domestic Partners and their dependents are not eligible to participate in FSAs.

If You Experience the Following Life Event...	Then, You Can...
<p>You change from part-time to full-time employment or full-time to part-time employment</p> <p>Note: Long-Term Disability Plan, as noted here, does not apply to TWU-Represented employees, as their Long-Term disability coverage is offered by their union, or to Pilots, as their disability coverage is provided under a separate plan</p>	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Start/Stop coverage for your Spouse/Company-recognized DP • Start/Stop coverage for your eligible dependent <p>Optional Short-Term Disability Insurance Benefit (FA, TWU, ARP):</p> <ul style="list-style-type: none"> • Start coverage for yourself; proof of good health is required • Minimum duration of enrollment is 2 years <p>Company-provided Short-Term Disability Benefit (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Long-Term Disability (OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Long-Term Disability (FA, ARP):</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself; proof of good health is required • Stop coverage for yourself <p>Voluntary Term Life Insurance Benefit :</p> <ul style="list-style-type: none"> • Start/Resume coverage for yourself; proof of good health is required • Stop coverage for yourself • Increase/Decrease coverage for yourself; for increase, proof of good health is required <p>Spouse Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start/Resume coverage; proof of good health is required • Stop coverage <p>Child Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start/Resume coverage • Stop coverage <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself

If You Experience the Following Life Event...	Then, You Can...
	<p>Spouse/Company-recognized DP AD&D/VP AI Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage • Increase/Decrease coverage <p>Child AD&D/VP AI Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Healthcare and Dependent Care Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start/Stop Flexible Spending Accounts • Increase/Decrease Flexible Spending Account contributions. • Company-recognized Domestic Partners and their dependents are not eligible to participate in FSAs.
<p>You die</p>	<p>Continuation of Coverage:</p> <p>Your eligible dependents should contact your manager/supervisor, who will coordinate with a Survivor Support representative at the American Airlines Benefits Service Center to assist with all benefits and privileges, including the election of Continuation of Coverage, if applicable.</p>
<p>Your spouse, common law spouse, or Company-recognized Domestic Partner dies or other dependent dies</p>	<p>Contact: American Airlines Benefits Service Center within 31 days of your eligible Spouse, common law spouse, same-sex spouse, Company-recognized Domestic Partner or other eligible dependent's death to update your records and make the appropriate changes, if applicable, to your benefits coverage.</p>
<p>You end your employment with the Company or you are eligible to retire</p>	<p>Review: "When Coverage Ends" in the <i>General Enrollment</i> section.</p> <p>Review: The information you receive regarding Continuation of Coverage through COBRA.</p> <p>Contact: American Airlines Benefits Service Center for information on retirement.</p>

If You Experience the Following Life Event...	Then, You Can...
<p>You transfer to another workgroup</p>	<p>Medical, Dental, and Vision:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself, your Spouse/Company recognized Domestic Partner (DP), and/or your eligible dependent (dependent coverage may be subject to QMCSO). • You may change Medical Benefit Options; your deductible and out-of-pocket maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO. <p>Optional Short-Term Disability Benefit (FA, TWU, ARP):</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself only. If you enroll for the first time, coverage is for a duration of 2 years. <p>Company-provided Short-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Company-provided Long-Term Disability (for OMSSS):</p> <ul style="list-style-type: none"> • No changes allowed <p>Voluntary Long-Term Disability (for FA, ARP):</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself only; does not apply to TWU-Represented employees <p>Voluntary Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Increase/Decrease your coverage with proof of good health <p>Spouse Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Child Term Life Insurance Benefit:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>AD&D/VPAL Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself <p>Spouse AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage for eligible Spouse/Company-recognized DP

New

If You Experience the Following Life Event...	Then, You Can...
	<ul style="list-style-type: none"> • Increase/Decrease for eligible Spouse/Company-recognized DP <p>Child AD&D Insurance:</p> <ul style="list-style-type: none"> • Start/Stop coverage <p>Flexible Spending Account Benefits:</p> <ul style="list-style-type: none"> • Start/ Stop Flexible Spending Accounts • Increase/Decrease Flexible Spending Account contributions • Cannot reduce to an amount less than what has already been deducted or paid • Company-recognized Domestic Partners and their dependents are not eligible to participate in FSAs.
<p>You and/or your eligible dependent(s) declined American's medical coverage because you or they had coverage elsewhere (external to American), and any of the following events occur:</p> <p>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)</p> <p>Employer contributions for the other coverage stopped</p> <p>Other coverage was COBRA and the maximum COBRA coverage period ended</p> <p>Exhaustion of the other coverage's lifetime maximum benefit</p> <p>Other employer-sponsored coverage is no longer offered</p> <p>Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your eligible dependents no longer reside, live, or work in its service area</p> <p>You have a new dependent via your marriage/common law marriage/declaration of a Company-recognized Domestic Partner, your child's birth/adoption/placement for adoption with you</p>	<p>Medical Coverage:</p> <ul style="list-style-type: none"> • Start coverage for yourself • Start coverage for your Spouse/Company-recognized DP • Start coverage for your eligible dependent • You may change Medical Benefit Options; your deductible and out-of-pocket maximum will carry over to your new Medical Benefit Option. <p>Health Care Flexible Spending Account:</p> <ul style="list-style-type: none"> • Start/Increase HCFSAs contributions

New

If Your Dependent(s) Lose Eligibility Under the Plan

If your dependent(s) lose eligibility under the Plan, you must file a Life Event or contact American Airlines Benefits Service Center to remove the ineligible dependent(s) from your coverage — even if you have missed the 31 day deadline.

If you contact American Airlines American Airlines Benefits Service Center after the 31 day deadline you will be able to remove your dependent(s) from coverage, but the effective date of the removal will be the date you notified American Airlines Benefits Service Center, and your resulting contribution rate changes, if any, will be effective as of the date you notified American Airlines Benefits Service Center.

You will not receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified American Airlines Benefits Service Center of their ineligibility.

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

New

If You Process Your Life Event after the Deadline

If you miss the 31 day deadline and the event occurred in the current year, you must wait until the next Annual Benefits Enrollment period to add your dependents.

If you are removing a dependent from coverage after the deadline, they will be removed effective the date that we receive your request and not retroactively.

If you miss the 31 day deadline and the event occurred in the previous year, you may add dependents to your file but you may not cover them under your benefits, make any changes to existing dependents or make any benefit plan changes. (Adding the dependent to your file lists the dependent as eligible to be enrolled at the next Annual Benefits Enrollment, but does not enroll him or her in benefits currently.)

New

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 Life Event within 31 days of the date it occurs.

Birth or adoption of a child: To add a natural child to your 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. These documents may take more than 31 days to arrive and prevent you from starting coverage effective on the baby's birth date.

To add an adopted child to your benefit coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective the date the child is placed with you for adoption and is not retroactive to the child's date of birth.

Relocation: If you are enrolled in the STANDARD, VALUE or CORE Medical Option and you move to a location where the STANDARD, VALUE or CORE Medical Option is available, you will stay enrolled in STANDARD, VALUE or CORE Medical Option. If you

were enrolled in an HMO that is not offered in your new location, you may elect a self-funded medical option or an HMO if it exists in your new location.

If a STANDARD, VALUE or CORE Medical Option network is not available, you must choose another medical Option (OUT-OF-AREA), or you may waive coverage if you have other coverage (such as your spouse's employer-sponsored plan).

Contact American Airlines Benefits Service Center and a representative will assist you with your election. If you are enrolled in an HMO or in the STANDARD, VALUE or CORE Medical Option and you do not process your relocation Life Event within 31 days of your move, you will stay in your selected plan. If your selected plan is not available, you will automatically be enrolled in the default Medical Benefit Option, which is CORE.

Change in Medical Benefit Option: If you change medical Options, your deductibles and out-of-pocket maximums may not transfer to the new Option. For a detailed explanation of how this works, see "[Mid-Year Medical Benefit Option Change: Impact on Deductibles and Out-of-Pocket Maximums](#)" in the *Medical Benefit Options Overview* section.

Special dependent: To cover a special dependent (foster child or child for whom you have become the legal guardian), you must complete a [Statement of Eligibility for Special Dependent Form](#) and return it to American Airlines Benefits Service Center, regardless of the 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 Criteria](#)" in the *General Eligibility* section.

Stepchild: A stepchild is eligible for coverage under the same terms as any natural or adopted child.

Benefit Coverages Affected by Life Events

Flexible Spending Accounts Benefit: If you change the amount of your pre-tax salary reduction election during the year, claims from your Health Care Flexible Spending Account for eligible health care expenses incurred before the change are payable up to the original amount you elected to contribute. Claims for expenses incurred after the change are payable up to your newly elected contribution amount. You forfeit part of your balance when the contributions before your change are greater than your claims before the change and you reduce the amount you elect to contribute. Your Dependent Care Flexible Spending Account reimburses based on the contributions in your account at the time of the claim. **If you are a Home-Based Representative or Level 84 Premium Services Representative, you may enroll in the Limited Purpose Flexible Spending Account, the Health Savings Account, and the Dependent Care Flexible Spending Account.**

When you process a Life Event change, the change to your Flexible Spending Accounts is only valid for the remainder of the calendar year. **If you process a Life Event change within the last two months of the year, you will not be able to change FSA elections, as there will not be time to process changes to your Flexible Spending Accounts for that year.**

Voluntary Term Life Insurance Benefit: You may only increase this coverage by one level per year with approved proof of good health.

Move/Relocation: If you want to process a Relocation or Move Life Event within the last two months of the year, you must contact American Airlines Benefits Service Center so they can help you ensure that you make appropriate changes for the remainder of this current year and for next year.

Additional Health Benefit Rules

This section includes:

- Qualified Medical Child Support Orders (QMCSO) Procedures
 - Use of Terms
 - Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice
 - Review of a Medical Child Support Order or Notice
 - Procedures upon Final Determination
 - Appeal Process
- Coordination of Benefits
 - Other Plans
- Coordination with Medicare
 - Benefits for Individuals Who Are Eligible for Medicare
 - Benefits for Disabled Individuals
- When Coverage Ends
- Continuation of Coverage – COBRA Continuation
 - Eligibility
 - Continuation of Coverage for You and Your Dependents Qualifying Events
 - Continuation of Coverage for Your Dependents Only (Qualifying Events)
 - How to Elect Continuation of Coverage
 - Continuation of Coverage for Employees in the Uniformed Services
 - Continuation of Coverage While on a Family and Medical Leave
 - Other Employee Obligations
 - Other Special Rules
 - Trade Adjustment Act
 - Impact of Failing to Elect Continuation of Coverage on Future Coverage
 - Additional Questions
 - American Recovery and Reinvestment Act of 2009 (ARRA)
- HIPAA Certificate of Creditable Coverage

Qualified Medical Child Support Orders (QMCSO) Procedures

The following procedures have been adopted and amended with respect to medical child support orders received by group health benefits and plans maintained for employees of participating American Airlines Group subsidiaries. These procedures shall be effective for medical child support orders issued on or after the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) relating to employer-provided group health plan benefits.

These procedures are for health coverage under the Group Life and Health Benefits Plan for Employees of Participating American Airlines Group Subsidiaries (“the Plan”), consisting of the following options:

- STANDARD Medical Option
- CORE Medical Option
- VALUE Medical Option
- Out of Area (OOA) Medical Option
- HMOs
- Dental Benefits
- Vision Insurance Benefits
- Health Care Flexible Spending Account

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 OBRA '93 with respect to a group health plan).
- The term “QMCSO” or “NMSN,” as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these Procedures, or a notice from a state agency ordering the coverage of an Alternate Recipient under health benefits with respect to a Participant under a plan and that meets the requirements to be an NMSN decreed to be a QMCSO.
- The term “Plan Administrator,” as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at 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 employee's dependent during the pendency of a QMCSO or NMSN review. A dependent's entitlement to benefits under the Plan prior to the approval of a QMCSO or an NMSN is determined by the dependent's eligibility and enrollment in the Plan in accordance with the terms of the Plan. Without a QMCSO or NMSN, the Company cannot be held liable if an employee's dependent is either (i) not enrolled in coverage in the Plan, or (ii) is eliminated from coverage in the Plan. In addition, neither American Airlines, Inc. nor the Plan has any obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) an employee's dependent except upon application by the

employee in accordance with the terms of the Plan, or in accordance with a QMCSO or NMSN. If the requesting party needs assistance in preparing or submitting a QMCSO or NMSN, he or she may contact the Plan Administrator or go to the [Department of Labor website](#) for more information on QMCSOs and NMSNs and for sample NMSN forms or to obtain a sample [National Medical Support Notice](#).

Review of a Medical Child Support Order or Notice

Not later than 20 business days after receipt by the Plan Administrator of a medical child support order, the Plan Administrator shall review the Order to determine if it meets the criteria to make it a QMCSO or NMSN. Under OBRA '93, a state-ordered medical child support order is not necessarily a Qualified Medical Child Support Order. Thus, before the Plan honors the Order, the Order must meet the requirements for a QMCSO or NMSN specified above.

Procedures upon Final Determination

The Participant, Alternate Recipient and any party specified in the medical child support order shall be notified of the acceptance of the medical child support order or national medical support notice as being qualified. Once the Order is determined to be a QMCSO or NMSN, the Plan Administrator will follow the terms of the Order and shall authorize enrollment of the Alternate Recipient as well as have any payments for such coverage deducted from the payroll of the Participant. In addition, a copy of the appropriate Guide describing applicable Medical benefit options and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipient, at the issuing agency's address. If the Participant is not enrolled, the Plan Administrator shall enroll the Participant, as well as the child in the coverage. Notification will occur within 40 business days of receipt of the Order or notice.

If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Participant, the Alternate Recipient, the state agency issuing the notice or any designated representative in writing of such fact within 40 business days of receipt of the Order or notice. The notification will state the reasons the Order or notice is not a QMCSO or NMSN and that the Plan Administrator shall treat the Participant's benefits as not being subject to the Order. Any subsequent determination that an Order is a QMCSO will be administered prospectively only.

Appeal Process

If the Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he or she must file an Application for Appeal within 60 days of receiving notification of denial of the medical child support order's or medical support notice's qualification. Appeals will be reviewed by the Employee Benefits Committee (EBC) or its authorized delegate in accordance with ERISA and the terms and provisions of the Plan and notify the Participant or Alternate Recipient within 60 days of receipt of the appeal of their decision. A copy of the Plan's appeal procedures, as set forth in the Employee Benefits Guide (the formal Plan Document and Summary Plan Description) shall be provided upon request.

Coordination of Benefits

This section explains how to coordinate coverage between the Company-sponsored Medical, Dental and Vision Insurance Benefits and any other benefits/plans that provide coverage for you or your eligible dependents.

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

For example, if your dependent is covered by another benefit/plan and the VALUE Medical Option is his or her secondary coverage, the VALUE Medical Option pays only up to the maximum benefit amount payable under the VALUE Medical 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 will pay benefits only for the portion of the hospital stay occurring after you became eligible for coverage under the benefit program.

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

Other Plans

The term “other group medical benefit/plan” or “other group dental benefit/plan” or “other group vision insurance benefit/plan” in this section includes any of the following:

- 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 or Medicaid
- Property or homeowner's insurance or no-fault motor vehicle coverage
- Other individual insurance policies

Which Plan Is Primary

This section explains how to coordinate coverage between the Company-sponsored Medical, Dental and Vision Insurance Benefits and any other benefits/plans that provide coverage for you or your eligible dependents.

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

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

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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 or, under this Plan, effective June 1, 2015, the Maximum Out-of-network Charge ("MOC")). If both the primary plan and this Plan do not have a network allowable expense, the eligible expense will be the greater of the two plans' reasonable and customary or usual and prevailing charges. The maximum combined payment you can receive from all plans may be less than 100% of the total eligible expense.

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 will pay benefits only for the portion of the hospital stay occurring after you became eligible for coverage under the benefit program.

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

The term "other group medical benefit/plan" or "other group dental benefit/plan" or "other group vision 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 or Medicaid
- Property or homeowner's insurance or no-fault motor vehicle coverage
- Other individual insurance policies

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

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.
- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under Medical, Dental and Vision Insurance Benefits and Medicare are paid according to federal regulations. In case of a conflict between Medical, Dental and Vision Insurance Benefits 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 “Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice” in the [Qualified Medical Child Support Order](#) section).

- For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents’ ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the other plan has a gender rule, that plan determines which plan is primary.

Coordination with Medicare

Benefits for Individuals Who Are Eligible for Medicare

If you (or one of your dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare Benefits for prescription drug benefits), the following rules apply:

- The American Airlines Group plan is the primary payer – in other words, your claims go to the American Airlines Group plan first – if you are currently working for a participating American Airlines Group subsidiary.
- If you become eligible for Medicare due to you (or your dependent) having end-stage renal disease, then American Airlines Group is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer.
- If you become eligible for Medicare due to becoming eligible for Social Security disability and your coverage under this plan is due to the current employment status of the employee, then the American Airlines Group plan pays primary. For this purpose, you will only be considered to have current employment status during first six months in which you receive Company paid disability benefits that are subject to FICA tax. Generally, Medicare does not begin to pay benefits until after this period ends.
- American Airlines, Inc. plan pays secondary and Medicare is the primary payer if you (or your dependent) are covered by Medicare, do not have end-stage renal disease and you are not currently working for the American Airlines, Inc. or deemed to have coverage because of current employment status.
- If you (or your dependent) are over age 65 and the American Airlines Group plan would otherwise be the primary payer because you are still working, you or your dependent may elect Medicare as the primary payer of benefits. If you do, benefits under the American Airlines Group plan will terminate.

Benefits for Disabled Individuals

If you stop working for a participating American Airlines Group subsidiary because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you must apply for Medicare Parts A, B and D, or Parts C and D, whichever is applicable. Medicare Part A provides inpatient hospitalization benefits, Medicare Part B provides outpatient medical benefits, such as doctor’s office visits and Medicare Part D provides prescription drug benefits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the American Airlines Group plan, the American Airlines Group plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the American Airlines Group plan considers eligible, the American Airlines Group plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any.

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

When Coverage Ends

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

- The date a Plan or benefit Option terminates
- The last day for which your contribution has been paid
- 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 a Plan

Your spouse's coverage will automatically terminate on the earliest of:

- The date a Plan or benefit Option terminates
- The last day for which your spouse's contribution has been paid
- The date he or she is no longer your spouse
- The date you are no longer eligible for a 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, coverage terminates 90 days after your death.

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

Continuation of Coverage – COBRA

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your health benefits are cancelled, along with your other benefits. You may elect to continue your health benefits as part of your continuation of coverage options available through Aon Hewitt, Inc., the COBRA administrator. Aon Hewitt, Inc. will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not

continue your medical coverage through COBRA, claims incurred after the date of your termination are not payable.

The STANDARD Medical Option, VALUE Medical Option, CORE Medical Option, OUT-OF-AREA Medical Option, Dental Benefits, Vision Insurance Benefits, HMOs and the Health Care Flexible Spending Account provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain Qualifying Events. If you and/or your dependents have coverage at the time of the Qualifying Event, you may be eligible to elect continuation of coverage under the following:

- Medical Benefits
- Dental Benefits
- Vision Insurance Benefits
- Health Care Flexible Spending Account Benefit, for the remainder of the calendar year in which you became eligible for continuation of coverage. (Although you would not be able to make contributions on a pre-tax basis, by electing continuation of coverage for this account, you would still have the opportunity to file claims for reimbursement based on your account balance for the year.)

The coverage under COBRA is identical to coverage provided under the benefits or plans for similarly situated employees or their dependents, including future changes. Although your Company-recognized Domestic Partner and his or her children do not have rights to COBRA coverage under existing federal law, the Company currently offers them the opportunity to continue health coverages that would be lost when certain events occur. This is subject to change.

Eligibility

Eligibility for continuation of coverage depends on the circumstances that result in the loss of existing coverage for you and your eligible dependents. The sections below explain who is eligible to elect continuation of coverage and the circumstances that result in eligibility for this coverage continuation.

Continuation of Coverage for You and Your Dependents Qualifying Events

- You may elect continuation of coverage for yourself and your eligible dependents, including a Company-recognized Domestic Partner and his or her children, for a maximum period of 18 months if your coverage would otherwise end because of layoff or termination of your employment for any reason (except in the event of termination for gross misconduct).
- If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you (or any eligible dependent) are disabled at any time during the first 60 days of continuation of coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself and your dependents, including a Company-recognized Domestic Partner and his or her children. To qualify for this additional coverage, the Qualified Beneficiary must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (Aon Hewitt, Inc.) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.

Continuation of Coverage for Your Dependents Only (Qualifying Events)

Your covered dependents may continue coverage for a maximum period of 36 months if coverage would otherwise end because of:

- Your divorce or legal separation
- Your Company-recognized Domestic Partner relationship ends
- You become eligible for (enrolled in) Medicare benefits
- Loss of eligibility because the dependent, including children 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). The dependent loses coverage on the last day of the month in which they attain age 26.
- Your death
- Your Company-recognized Domestic Partner's death

If you experience more than one of these Qualifying Events, your maximum continuation of coverage is the number of months allowed by the Qualifying Event that provides the longest period of continuation.

How to Elect Continuation of Coverage

Solicitation of Coverage

Solicitation following layoff or termination: In the event that your employment ends through layoff or termination, you will automatically receive information from Aon Hewitt, Inc., the COBRA administrator, about electing continuation of coverage through COBRA.

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

If you want your over-age dependent to be solicited for COBRA continuation of coverage, you must complete the Life Event within 60 days of the date of the event's occurrence, and you must request that your dependent who is losing coverage be solicited for COBRA. If you do not complete the Life Event within this 60-day period and request that your dependent be solicited for COBRA, your dependent will lose his or her opportunity to continue coverage under COBRA.

If you fail to notify the Company of a dependent's loss of eligibility within 60 days after the Qualifying 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 "[Life Events](#)" in the *Life Events* section, Benefits Service Center will advise Aon Hewitt, 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 Aon Hewitt can send solicitation information.

You (or your dependents) must provide written notification of your desire to elect to purchase continuation of coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage, or else you lose your right to elect to continue coverage. See "[Contact Information](#)" in the *Reference Information* section for Aon Hewitt, Inc.'s address.

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

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

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 American Airlines Benefit Service Center.

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 Life Event. To add your dependents, contact American Airlines Service Center within 31 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 of coverage. You should notify American Airlines Benefits Service Center of the newborn child or child newly placed for adoption within 31 days of the child's birth or placement for adoption.

All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to continuation of coverage.

Paying for 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 Aon Hewitt, 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.

Refund of Premium Payments

If you elect continuation of coverage and later discover that you do not meet the eligibility requirements for coverage, for example, if you enroll in Medicare benefits, you must contact

Aon Hewitt, Inc. 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, American Airlines Group currently offers them the opportunity to continue health coverages that would be lost when certain events occur.

This time limit for refunds also applies if the Company discovers that continuation of coverage has been provided to you or your dependent in error.

When continuation of coverage begins: If you or your dependents elect continuation of coverage within 60 days of receiving your election forms, the coverage becomes effective on the date your other coverage would otherwise end. Thus, the first premium for continuation of coverage includes payment for this retroactive coverage period.

When continuation of coverage ends: Continuation of coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29 or 36 months) expires. (See “Processing Life Events After Continuation of Coverage Is in Effect” in this section.)
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds (“NSF” or “bounced”) are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the participant is eligible for continuation of coverage up to the maximum time period.
- The Plan participant continuing coverage becomes enrolled in Medicare
- The Company no longer provides the coverage for any of its employees or their dependents

See “[Dependent Eligibility Criteria](#)” in the *General Eligibility* section.

Continuation of Coverage for Employees in the Uniformed Services

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

New

While you are on military leave, your benefit coverage or the cost of that coverage will not change.

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

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

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

The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Employee Policy Guide.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time.

If you are eligible, you can take up to 12 weeks of unpaid leave for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care, if the leave is concluded within 12 months of the birth or placement for adoption or foster care;
- For the care of a spouse, child, or parent who has a serious health condition;
- For your own serious health condition that makes you unable to perform the functions of your job;
- For a “qualifying exigency” arising because an employee’s spouse, child, or parent, is on covered active duty in a foreign country (or has been notified of an impending call or order to covered active duty in a foreign country) in the Armed Forces; or
- For the care of a “covered servicemember” with a serious injury or illness if the employee is the spouse, child, parent or next of kin of the covered servicemember.

Depending on your state of residence, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Other Employee Obligations

In order to protect you and your family’s rights, you should keep both Aon Hewitt, Inc. and the Company informed of any changes in the addresses of your family members.

Impact of Failing to Elect Continuation of Coverage on Future Coverage

In considering whether to elect continuation of coverage, you should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by certain group health plans if you have more than a 63-day gap in health coverage, and election of continuation of coverage may help you not have such a gap. 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 may also have the right to enroll in coverage through a state-based or federally-facilitated healthcare exchange under the Patient Protection and Affordable Care Act. You will also have the same special enrollment rights at the end of continuation of coverage if you get continuation of coverage for the maximum time available to you.

Additional Questions

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

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Plan Information

American Airlines, Inc. is the plan sponsor, as that term is defined under ERISA Section 3(16)(B) , of the plans listed below

Plan Name	Plan Number
American Airlines, Inc. Group Life and Health Benefits Plan This plan includes: Medical Benefits <ul style="list-style-type: none">• STANDARD Medical Option with Health Reimbursement Account• CORE Medical Option with Health Savings Account• VALUE Medical Option with Health Incentive Account• OUT-OF-AREA Medical Option with Health Reimbursement	501

Plan Name	Plan Number
<p>Account</p> <ul style="list-style-type: none"> Health Maintenance Organizations <p>Optum EAP Benefit (American Airlines EAP is not part of the Plan)</p> <p>Dental Benefit Option</p> <p>Vision Insurance Benefit</p> <p>Employee Term Life Insurance Benefits</p> <p>Spouse Term Life Insurance Benefits</p> <p>Child Term Life Insurance Benefits</p> <p>Accidental Death & Dismemberment Insurance Benefits (Employee, Spouse, Child)</p> <p>Special Purpose Accident Insurance Benefit</p> <p>Special Risk and Accident Insurance</p> <p>Optional Short-Term Disability Insurance</p> <p>Management Personal Accident Insurance (For Management, Specialist and Officer employees)</p> <p>Health Care Flexible Spending Account Benefit</p> <p>Dependent Care Flexible Spending Account Benefit</p> <p>Limited Purpose Flexible Spending Account Benefit</p> <p>For Home-Based Representatives or Level 84 Premium Services Representatives:</p> <p>Medical Benefit</p> <ul style="list-style-type: none"> CORE Medical Option with Health Savings Account <p>Optum EAP Benefit (American Airlines EAP is not part of the Plan)</p> <p>Dental Benefit Option</p> <p>Vision Insurance Benefit</p> <p>Voluntary Employee Term Life Insurance Benefits</p> <p>Spouse Term Life Insurance Benefits</p> <p>Child Term Life Insurance Benefits</p> <p>Accidental Death & Dismemberment Insurance Benefits (Employee, Spouse, Child)</p> <p>Special Purpose Accident Insurance Benefit</p> <p>Special Risk and Accident Insurance</p> <p>Optional Short-Term Disability Insurance</p> <p>Dependent Care Flexible Spending Account Benefit</p> <p>Limited Purpose Flexible Spending Account Benefit</p>	
<p>American Airlines, Inc. Long-Term Disability Plan</p> <p>For Flight Attendants, Agents, Representatives, Planners, Officers, Management, Specialists, Support Staff and Home-Based Representatives or Level 84 Premium Services Representatives. TWU-Represented employees have Long-Term Disability available through their labor union.</p>	509

Plan Name	Plan Number
American Airlines, Inc. Long-term Care Insurance Plan	510

Administrative Information

Plan Sponsor and Administrator

American Airlines, Inc., or its authorized delegate

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

The Plan Administrator for Urgent and Second Level Claim Appeals

Employee Benefits Committee (EBC)

American Airlines

Mail Drop 5134-HDQ1

P.O. Box 619616

DFW Airport, TX 75261-9616

Agent for Service of the Legal Process

Managing Director, Health and Wellness

American Airlines, Inc.

Mailing address:

Mail Drop 5126-HDQ1

P.O. Box 619616

DFW Airport, TX 75261-9616

Express Delivery address:

4333 Amon Carter Blvd.

Fort Worth, TX 76155

Network/Claim Administrator

The Network/Claim Administrator for each benefit or plan vary and are listed in *Contact Information*.

Trustee

State Street Bank & Trust

200 Newport Avenue

North Quincy, Massachusetts 02171

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Plan Amendments

The Company or its authorized delegate has the sole authority to adopt new employee benefit plans, amend existing plans, and terminate plans. The Company may at any time amend the Plan by written instrument executed by an officer of the Company. Further, the Company reserves the right to terminate the Plan at any time. On or after the effective date of a termination, no further benefits shall be payable to or on behalf of any participant to whom such terminate applies.

Plan Administrator

- To control and manage the operation and administration of the Plan;
- To interpret and construe the provisions of the Plan in its sole discretion, its interpretation in good faith to be final and conclusive on all persons claiming benefits under the Plan. The Company shall be the “administrator” for purposes of ERISA, and shall be responsible for the administration of the Plan. In addition to the power and authorities expressly conferred upon in in this Plan, the Administrator shall have all such powers and authorities as may be necessary to carry out provisions of the Plan, including but not limited to the power and authority:
- To make benefit determinations in its sole discretion
- To determine all questions related to eligibility for benefits in its sole discretion
- To resolve any disputes arising under the Plan.

The Company may employ such attorneys, agents, accountants, and consultants as it may deem necessary or advisable to assist in carrying out its duties. The Company shall be the “named fiduciary” as that term is defined in Section 402(a)(2) of ERISA. The Company may, in writing, designate a person or persons or committee to carry out any of the powers, authority, or responsibilities for the operation and administration of the Plan which are retained by it or granted to it, including, without limitation, the administration of claims, authority to authorize payment of benefits, the review of denied or modified claims, and the discretion to decide matters of fact and interpret Plan provisions. Any act authorized, permitted or required to be taken under the Plan by the company and which has not been delegated, may be taken by the appropriate officer the Human Resources Department of the Company.

The Employee Benefits Committee (EBC) the sole authority to interpret, construe, and determine claims under the Plans. The EBC, in consultation with actuaries, consultants, Employee Relations, Human Resources and the Legal Department, has the discretion to adopt such rules, forms, and procedures 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.

Plan Funding

This section describes the funding arrangements for the plans, Options and benefits in the Guide.

The coverage for the following benefits is self-funded through both Company and employee contributions:

- STANDARD Medical Option
- CORE Medical Option
- VALUE Medical Option
- OUT-OF-AREA Medical Option
- Dental Benefits
- Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group Subsidiaries

The network and/or claim administrators are independent companies that provide claim payment services. They do not insure these benefits.

Health Maintenance Organizations (HMOs) Vision Insurance Benefits and are fully insured and are funded through both Company and employee contributions.

Coverage for the following benefits is fully insured and premiums are paid by the Company:

- Employee Basic Term Life Insurance Benefit
- Special Purpose Accident Insurance Benefit
- Special Risk Accident Insurance Benefit
- Basic AD&D Insurance Benefit (Management and Support Staff only)
- Short-Term Disability (Management and Support Staff only)

The following benefits are self-insured and paid by the Company:

- Long-Term Disability (Management and Support Staff only)

The following benefits are fully insured and paid entirely by employee contributions:

- Optional Short-Term Disability Insurance – (TWU and Agents, Representatives, Planners only)
- Voluntary Accidental Death & Dismemberment Insurance Benefit
- Voluntary Life Insurance Benefit
- Spouse Term Life Insurance Benefit
- Child Term Life Insurance Benefit
- Long-Term Care Insurance Plan

The following benefits are self-funded and paid entirely by employee contributions through a VEBA Trust:

- American Airlines Inc. Voluntary Long-Term Disability Plan – (TWU and Agents, Representatives, Planners only)

Collective Bargaining Agreement

Certain benefits (medical and dental benefits, life insurance benefits) described in this Guide are maintained subject to a collective bargaining agreement. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator. This agreement is also available for review during normal

business hours at the corporate offices of American Airlines, Inc. (see “[Contact Information](#)” in the *Reference Information* section).

No Liability for Benefits

Notwithstanding any other provision of the Plan, neither the Company nor the Plan shall have any liability to provide any benefit that is to be provided through any insurance contract or health maintenance organization contract in the event that such benefit is not paid or otherwise provided by the issuer of such contract.

No Commitment to Employment

Nothing in the Plan shall be construed as a commitment or agreement upon the part of any person to continue his employment with the Company or a Participating Employer, and nothing contained in the Plan shall be construed as a commitment on the part of the Company or a Participating Employer to any rate of compensation of any person for any period, and all employees of the Company and Participating Employers shall remain subject to discharge to the same extent as if that Plan had never been put into place.

No Precedent

Except as otherwise specifically provided, no action taken in accordance with the provisions of the Plan by the Plan Administrator or the Company shall be construed or relied upon as precedent for similar action under similar circumstances.

Severability

If a provision of the Plan is held illegal or invalid, the illegality or invalidity does not affect the remaining parts of the Plan and the Plan must be construed and enforced as if the illegal or invalid provision had not been included in the Plan.

Assignment of Benefits

You may request that the network/claim administrator pay your service provider directly by assigning your benefits.

You may assign medical, dental and vision benefits for eligible expenses incurred for hospital care, surgery, dental care 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 whether you can assign Life Insurance Benefits, see “Assignment of Benefits” under “[Special Provisions](#)” in the *Life Insurance* section.

Confidentiality of Claims

The Company and its agents (including the network/claim 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 [“Notice of Privacy Rights — Health Care Records”](#).

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 receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the network/claim administrator may pay all or part of the benefit to:

- Your guardian
- Your estate
- Any institution or person (as payment for expenses in connection with the claim)
- Any one or more persons among the following relatives: your eligible Domestic Partner, parents, children, brothers or sisters.

Payment of a claim to anyone described above releases the Plan Administrator from all further liability for that claim.

Claims are processed in order of receipt. Payment of a claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the 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

The Plan and the network/claim administrator shall have the right to recover from any participant or former participant the amount of any benefits paid by the Plan (i) for expenses incurred on behalf of a participant which were not paid by the participant and were not legally required to be paid by the participant, (ii) which exceeded the amount of benefits payable under the Plan, or (iii) for expenses which were recovered from or paid by a source other than this Plan, as describe below in “Subrogation.” If the participant or former participant, or any other person or organization, does not repay to the Plan the amount owed in a lump sum within 30 days of receiving notice, then notwithstanding any provision in this Guide to the contrary and without limiting any other remedies available to the Plan, the Plan may reduce the amount of any benefits that become payable to the participant or the participant’s service providers to recover the amount owed to the Plan.

The network/claim administrator may also seek recovery from one or more of the following:

- Any plan participant to or for whom benefits were paid
- Any other self-funded plans or insurers
- Any institution, physician, or other service provider
- Any other organization

New Subrogation

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that the

Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. The Plan has the right to subrogate 100% of the benefits paid or to be paid on your behalf.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.

Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.

The Plan Sponsor.

Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.

Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.

Providing any relevant information requested by the Plan.

Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.

Responding to requests for information about any accident or injuries.

Making court appearances.

Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.

Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with us. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.

You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. The Plan has the right to 100% reimbursement in a lump sum and has the right to recover interest on the amount paid by the Plan because of the actions of a third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and the Plan is not responsible for your attorney's fees, expenses and costs. The Plan is not subject to any state laws or equitable doctrines, including but not limited to the so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine," which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs.

Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable doctrine or state law shall limit or defeat the Plan's subrogation and reimbursement rights.

If this Section applies, the Plan will not cover either the reasonable value of the services to treat such an injury, sickness or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded.

Benefits paid by the Plan may also be considered to be benefits advanced.

If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

The Plan's rights to recovery will not be reduced due to your own negligence.

Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

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

Claim Processing Requirements and Appeals

Medical Benefit Claims

The Patient Protection and Affordable Care Act (PPACA) 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). 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.

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 network/claim administrator or benefit administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- As soon as possible after receipt of a claim initiated for urgent care, but no later than 72 hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification)
- Fifteen days after receipt of a pre-service claim

For post-service claims (claims that are submitted for payment after you receive medical care), the network/claim administrator 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 network/claim administrator or benefit administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the network/claim administrator 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 network/claim administrator's or benefit administrator's receipt of the requested information
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time

For pre- and post-service claims, a 15-day extension may be allowed to make a determination, provided that the network/claim administrator or benefit administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the network/claim 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/claim 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
- 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

- 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 Benefit Plan Claim

The network/claim administrator or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- Date of service, the health care provider, the claim amount (if applicable)
- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for internal appeal or external review, and will not trigger the start of an internal appeal or external review)
- A description of 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/claim administrator is required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale

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

If the Network/Claim Administrator or benefit administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review, you may pursue a civil action under ERISA §502(a), or you may pursue civil action under state law if the adverse benefit determination involved a fully-insured benefit. However, keep in mind that the claim and appeal process won't be deemed exhausted based on *de minimis* violations of law (as long as the Plan Administrator or Network/Claim Administrator that the violation was for good cause, was committed in a good faith exchange of information between you, or was due to matters beyond the Plan Administrator's or Network/Claim Administrator's control).

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

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

If your claim is filed under one of the Plan's fully-insured benefits (an HMO, for example), contact the insurer for information on the State process for immediate review.

Disability Claims (Applies to Short-Term Disability Pay, Optional Short-Term Disability Insurance Benefit and American Airlines, Inc. Long-Term Disability Plan)

All Disability Benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the network/claim administrator. After the network/claim administrator has reviewed the claim for Disability Benefits and obtained any other information that it deems necessary or relevant, the network/claim administrator shall notify you within a reasonable period of time not to exceed 45 days after receipt of the

acceptance or denial of the claim. The 45-day period during which a claim for Disability Benefits is reviewed may be extended by the network/claim administrator for up to 30 days, provided the network/claim administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 45-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 30-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 30-day period provided the network/claim administrator notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for Disability Benefits is denied, in whole or in part, the network/claim administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial
- Specific references to the Plan provisions on which the denial is based
- A description of any information or material necessary to perfect the claim
- An explanation of why this material is necessary
- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review
- 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 claim administrator determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for Disability Benefits as of the date you fail or refuse to comply and you shall not be entitled to any further Disability Benefits. However, your claim shall be reinstated upon your compliance with the network/claim administrator's request for information or upon a demonstration to the satisfaction of the network/claim administrator that under the circumstances the network/claim administrator's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due to you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the network/claim administrator, taking into consideration the cause or reason for your failure or refusal, the length of the period and other facts or circumstances the network/claim administrator deems relevant.

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 network and/or claim administrator. After the network and/or claim administrator has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the network and/or claim

administrator shall notify you within a reasonable period of time not to exceed 90 days after receipt of the acceptance or denial of the claim. The 90-day period during which a claim for benefits is reviewed may be extended by the case manager or network and/or claim administrator for up to 90 days, provided the network and/or claim administrator both determine that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 90-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 90-day period provided the network and/or claim administrator notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for Disability Benefits is denied, in whole or in part, the network and/or claim administrator shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial,
- Specific references to the Plan provisions on which the denial is based,
- A description of any information or material necessary to perfect the claim,
- An explanation of why this material is necessary,
- An explanation of the Plan's appeal and review procedure, including a statement of the Participant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review, 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 network and/or claim administrator determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the network and/or claim administrator's request for information or upon a demonstration to the satisfaction of the network and/or claim administrator that under the circumstances the network and/or claim administrator's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the network and/or claim administrator, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the network and/or claim administrator deems relevant.

Appealing a Denial — For Non-Grandfathered Medical Options (STANDARD, CORE, VALUE, OUT-OF-AREA) and HMO Medical Options

This contains appeal information and requirements specific to the Non-Grandfathered Medical Options.

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 continues to review. Those rules may carry a later compliance date. 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 and/or claim 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 and/or claim administrators. Your network health care providers may appeal directly to the network and/or claim 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 and/or claim 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 and/or claim 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 network and/or claim administrator or benefit administrator that rendered the adverse benefit determination. Second Level Appeals are conducted by the Employee Benefits Committee (EBC) or its delegate at American Airlines, Inc. (Appeals may be filed on adverse benefit determinations such as claim denial or reduction in benefits, eligibility/enrollment denial, partial payment or partial denial of benefits, rescission of coverage, application of a benefit penalty, or other such adverse benefit determinations.)

This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document. The one exception to this mandatory two-tiered process is an appeal for an urgent care claim – for urgent care claim appeals, only Second Level Appeals are required – no First Level Appeals are necessary. Employees must use both levels of appeal (or the Second Level Appeal for urgent care claims) and must exhaust all administrative remedies to resolve any claim issues.

With respect to adverse benefit determinations made on fully insured benefits, as follows:

- Employee Term Life Insurance Benefit
- Accidental Death & Dismemberment Insurance Benefits (employee, spouse/Domestic Partner, child, VPAI and all Company-provided Accident Insurance Benefits)
- Vision Insurance Benefit
- HMOs
- Long-Term Care Insurance Plan

The appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The EBC cannot render a decision involving fully insured benefits (except for administrative, eligibility and enrollment issues, as stated previously). The insurers and HMOs make the final appeal determinations for their respective insured coverages/benefits. Each insurer or HMO has its own appeal process, and you should contact the respective insurer or HMO for information on how to file an appeal (see “[HMO Contact Information](#)” in the *Health Maintenance Organizations (HMOs)* section.)

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the network and/or claim administrator or benefit administrator. You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the network and/or claim administrator or benefit administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination. For urgent care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

To file a First Level Appeal with the network and/or claim administrator or benefit administrator, please complete an Application for First Level Appeal, and include with the Application all comments, documents, 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 network and/or claim administrator 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 disability claims, within 45 days of receipt of your First Level Appeal. If the network/claim administrator or benefit administrator requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (the network and/or claim administrator or benefit administrator will notify you if this additional time period is needed to complete a full and fair review of your case). For disability claims, this process may also be referred to as a “Second Level Review.”
- For all other claims for all benefits other than Medical or Disability, within 60 days of receipt of your First Level Appeal, if the network and/or claim administrator or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your First Level Appeal (the network and/or claim administrator 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 EBC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the EBC 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 EBC) 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 EBC, 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 EBC 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 network

and/or claim administrator or benefit administrator and the EBC to review and complete the appeals must be no more than 60 days. If the First Level Appeal review is completed by the network and/or claim administrator or benefit administrator in 15 days, then the EBC has the remaining 45 days (for a total of 60 days) to complete its review and render its decision.

If the EBC requires additional time to obtain information to evaluate your Second Level Appeal for Disability, it may have an additional 45 days to complete your Second Level Appeal. The EBC will notify you if this additional time period is needed to complete a full and fair review of your claim.

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 EBC. Appointed officers of American Airlines, Inc. are on the EBC. In some cases, the EBC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the network and/or claim administrator or benefit administrator, if appropriate, will be reviewed by the EBC or its designee(s).

In the filing of appeals under Company-sponsored health and welfare benefit plans, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as “relevant” to your claim if it:
 - Was relied upon in making the benefit determination
 - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
 - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
 - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony.
- Receive from the Plan Administrator or Network/Claim Administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond to the new rationale
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person’s subordinate
- A review in which the Plan Administrator or network/claim processor has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the

medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)

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

The External Review Process

After you have exhausted (or have been deemed to have exhausted) your internal appeal rights under the benefit plan(s), you have the right to request an external review of your adverse benefit determination. This external review process is defined by federal law—and American Airlines, Inc.-sponsored, non-grandfathered Medical Benefit Options will comply with the requirements of this external review process.

The external review process is applicable to adverse benefit determinations made under group health plans, in which the adverse benefit determination involved a medical judgment—such as:

- adverse determinations based on lack of medical necessity
- adverse determinations based on the assertion that the service or supply at issue was determined to be experimental, investigational, or unproven in nature
- adverse determinations based on the assertion that the service or supply was cosmetic in nature
- adverse determinations based on appropriateness or type of care, appropriateness of place of care, manner of care, level of care, or whether provider network status could have affected availability or efficacy of treatment
- adverse determinations based on the determination of whether care constituted “emergency care”, “urgent care”
- adverse determination based on a plan exclusion or limitation of coverage for a particular treatment in the presence of certain medical conditions
- adverse determination based on the determination of whether care was “preventive” in nature and the care was not referenced by the US Preventive Care Task Force, the Advisory Committee on Immunization Practices, or the Centers for Disease Control
- adverse determination that brings into question if the benefit plan is complying with the non-quantitative treatment limitations in the Mental Health Parity and Addiction Equity Act (such as methods and limitations on medical management)

American Airlines, Inc. retains three Independent Review Organizations (IROs), as required by federal law, to conduct external reviews, and these IROs meet federal requirements as to

levels of expertise, type and manner of reviews. They will conduct external reviews in compliance with the requirements of federal law. The three contracted IROs are:

- Network Medical Review (an ExamWorks company)
- Medical Review Institute of America
- American Medical Review, Inc.

An external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

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.

Notice of Privacy Rights — Health Care Records

This notice applies to all Plan participants of participating American Airlines Group subsidiaries. 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 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 American Airlines Group subsidiaries (particularly, the STANDARD Medical Option, the CORE Medical Option, the VALUE Medical Option, the OUT-OF-AREA Medical Option, the HMOs, Dental Benefits, Vision Insurance Benefits, Health Care Flexible Spending Accounts Benefit, Limited Purpose Flexible Spending Account, Health Savings Account), the Supplemental Medical Plan for Employees of Participating American Airlines Group subsidiaries, the Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group subsidiaries, TransWorld Airlines, Inc. 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 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 employee assistance programs.

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 American Airlines Group subsidiaries for any of the purposes described above. ARRA requires disclosures for purposes of payment to meet its minimally necessary standard.

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.

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 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.

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, employee benefit plans or employment-related activities.

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).

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 Protected Health Information 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 Protected Health Information 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 Health and Wellness, at American Airlines, Mail Drop 5126-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 Health and Wellness, at American Airlines, Mail Drop 5126-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 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/Company-recognized Domestic Partner 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 EBC 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 EBC 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 American Airlines Group subsidiaries May Use Your Health Information

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 Plans include the health plan components of:

- The Group Life and Health Benefits Plan for Employees of Participating American Airlines Group Subsidiaries (Plan 501)
- The Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group Subsidiaries (Plan 515)
- Trans World Airlines, Inc. Retiree Health and Life Benefits Plan (Plan 511)
- Any other Group Health Plan for which American serves as Plan Administrator

This Section 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, dental, prescription drug, mental health, and health care flexible spending account benefits, are subject to the limitations described in this section. The EAP is included only to the extent that it may be 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:

- Disability plans (Short-Term, Optional Short-Term and Long-Term Disability),
- Life Insurance plans, including Accidental Death & Dismemberment (AD&D) Insurance,
- Workers' Compensation plans, which provide benefits for employment-related accidents and injuries, and
- Property and casualty insurance.

In addition, the Company and Participating Employers may have personal medical information about you that is used for routine employment activities. Medical information held or used by the Company and Participating Employers 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 Employee Assistance Program (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 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, the Company and Participating Employers have agreed to:

- Not use or further disclose the information other than as permitted or required by this Employee Benefits Guide, as it may be amended by the Company 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 employee 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.
- Ensure that there is an adequate separation between the Plans and the employer Plan Sponsor as will be set forth below.

Separation of American Airlines Group Subsidiaries and the Group Health Plans

The following employees or classes of employees or other persons under the control of the Company or Participating Employers shall be given access to PHI for the purposes related to the Plan:

- Benefits 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.

- The EBC, its delegated authority, due to their role in governing health plan matters, including rendering appeal decisions and other health plan administrative matters.
- Benefits Compliance and the EBC Appeals group personnel involved in receiving, researching and responding to health plan member appeals filed with the EBC.
- American Airlines Benefits Service Center 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 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 American Airlines Benefits Service Center personnel, and thus have access to the call center systems.
- The Records Room personnel responsible for managing benefit plan record storage.
- Certain Employee Relations Operation 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 possible involvement in mental health and substance abuse benefits under the Plans, but only to the extent of their involvement with the Group Health Plans.
- Legal department employees, including Employment and Labor Attorneys, ERISA counsel, Litigation Attorneys and any other attorneys involved in health plan legal matters, and including paralegals and administrative assistants, and Legal Records Room personnel who manage record storage.
- American Airlines Benefits Service Center 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 the People Department and Benefits, including administrative staff, key vendor managers and certain management personnel responsible for disaster recovery procedures.
- 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.
- 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 the Company or Participating Employers, including payment and health care operations.

The Company and Participating Employers 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.

Noncompliance 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 non-compliance, 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 PHI 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 the Company and other American Airlines Group Subsidiaries.

The Group Life and Health Benefits Plan for Employees of Participating American Airlines Group Subsidiaries with respect to the benefits and benefit Options providing medical benefits, dental benefits, vision benefits, health care flexible spending accounts and the HMOs offered hereunder, the Supplemental Medical Plan for Employees of Participating American Airlines Group subsidiaries, the Trans World Airlines, Inc. Retiree Health and Life Benefits Plan, the Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group subsidiaries 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](#)".

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 employee 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, preauthorization, 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)

- 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.

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

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

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

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

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

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

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

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

Your Rights Under ERISA

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

Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of

Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue group health coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We 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:

American Airlines Benefits Service Center
PO Box 564103
Charlotte, NC 28256-4103
1-888-860-6178

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.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your

employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2014. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	MONTANA – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	NEBRASKA – Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
IOWA – Medicaid	NEVADA – Medicaid
Website: www.dhs.state.ia.us/hipp Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.yourtexasbenefits.com Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, contact either:

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

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

AA SCHIP Model Notice, 2014

Reference Information

This section includes:

- Contact Information
- Glossary
- Archive

Contact Information

The following table lists the names, addresses, phone numbers and websites (when available) for these important contacts.

For Information About:	Contact:	At:
Health and Welfare Benefits General questions, dependent eligibility, information updates,	American Airlines, Inc Benefits Service Center P.O. Box 564103 Charlotte, NC 28256-4103	Phone: 1-888-860-6178
Online Help from a Benefits Service Center Representative	American Airlines, Inc Benefits Service Center Chat	my.aa.com or www.jetnet.aa.com click on Pay and Benefits, click Benefits Service Center, click on "chat" on the upper right portion of the screen
Forms, Guides and Contact Information	my.aa.com (Benefits page)	
Qualified Medical Child Support Orders (QMCSO)	American Airlines QMCSO P.O. Box 1542 Lincolnshire, IL 60069-1542	Phone: 1-888-860-6178 Fax: 1-847-442-0899 (Include a cover sheet with the employer name and employee name)
Medical and Mental Health/Chemical Dependency Coverage		
<ul style="list-style-type: none"> o Standard Medical Option o Core Medical Option o Value Medical Option 	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp Provider directory: http://www.bcbstx.com/americanairlines
<ul style="list-style-type: none"> o Out-of-Area Medical Option o Network/Claims Administrator 	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp Provider directory: http://www.myuhc.com/groups/americanairlines
Health Maintenance Organizations (HMOs)	See the Health Maintenance Organizations (HMOs) section	Call the number on your HMO ID card.

For Information About:	Contact:	At:
<ul style="list-style-type: none"> • Coverage for Incapacitated Child • Standard Medical Option • Core Medical Option • Value Medical Option • Out-of-Area Medical Option • (HMOs – contact your elected HMO) 	Blue Cross and Blue Shield of Texas P.O. Box 833940 Richardson, TX 75083	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
CheckFirst (Predetermination of Benefits) (Except HMOs)		
<ul style="list-style-type: none"> • Standard Medical Option • Core Medical Option • Value Medical Option • Out-of-Area Medical Option 	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
QuickReview (Pre-authorization for Hospitalization)		
<ul style="list-style-type: none"> • Standard Medical Option • Core Medical Option • Value Medical Option • Out-of-Area Medical Option 	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
Medical Case Management and Wellness		
<ul style="list-style-type: none"> • Nurseline • Informed Care Management • Health Advocate • Lifestyle Coaching • Health Assessment 	ActiveHealth Management	1-888-227-6558 Website: http://my.aa.com/healthmatters

For Information About:	Contact:	At:
<ul style="list-style-type: none"> • Short-Term Case Management • Standard Medical Option • Core Medical Option • Value Medical Option • Out-of-Area Medical Option 	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	1-877-235-9258 Website: https://www.jetnet.aa.com/jetnet/go/ssobcbs.asp
	UnitedHealthcare AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	1-800-955-8095 Website: https://www.jetnet.aa.com/jetnet/go/ssouhc.asp
Prescription Drugs (Except HMOs)		
Mail Service Drug Option (Mail Order Pharmacy Service)	Express Scripts P.O. Box 3938 Spokane, WA 99220-3938	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions-Prior Authorization	Express Scripts 8111 Royal Ridge Parkway, Suite 101 Irving, TX 75063	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Prescriptions-Retail	Express Scripts Member Services - Phone Inquiries	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Filing Retail Prescription Claims	Express Scripts P.O. Box 2160 Lee's Summit, MO 64063-2160	1-800-988-4125 Website: https://www.jetnet.aa.com/jetnet/go/ssomedco.asp
Employee Assistance Program		
Employee Assistance Program	EAP at American Airlines	1-800-555-8810
Dental Coverage		
Dental Benefits Network/Claims Administrator	MetLife AMR Dental Claim Unit P.O. Box 981282 El Paso, TX 79998-1282	1-866-838-1072 Website: https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Provider Listing Participating Dentists	Preferred Dentist Program	1-800-474-7371 Website: https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Vision Insurance		
Vision Insurance Benefit	Spectera Vision 2811 Lord Baltimore Drive Baltimore, MD 21244	1-800-217-0094 Website: http://www.spectera.com
Life Insurance		
Life Insurance Benefits	MetLife American Airlines Customer Unit P.O. Box 3016 Utica, NY 13504-3016	1-800-638-6420

For Information About:	Contact:	At:
Accident Insurance		
Accidental Death & Dismemberment (AD&D) Insurance Benefit Other Accident Insurance Benefits	Contact American Airlines, Inc. Benefits Service Center P.O. Box 564103 Charlotte, NC 28256-4103	Phone: 1-847-554-1884
Disability Coverage for Agents, Representatives, Planners, Officers, Management/Specialists and Support Staff		
Optional Short Term Disability (OSTD) Insurance	MetLife Disability American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590	1-888-533-6287 FAX: 1-800-230-9531 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Long Term Disability (LTD) Plan	MetLife Disability American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590	1-888-533-6287 FAX: 1-800-230-9531 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Disability for TWU-Represented Employees		
Optional Short Term Disability (OSTD) Insurance	MetLife Disability American Airlines Claim Unit P.O. Box 14590 Lexington, KY 40511-4590	1-888-533-6287 FAX: 1-800-230-9531 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Long Term Disability Coverage	Your Local TWU Office	Your LTD coverage is offered through the TWU and is not an American Airlines, Inc.-sponsored benefit
Flexible Spending Accounts (FSAs), Health Savings Accounts (HSA), Health Reimbursement Accounts (HRA), Health Incentive Account (HIA)		
HSA (applies to Core Option Only) HRA (applies to Standard and Out-of-Area Options Only) HIA (applies to Value Option Only) Health Care FSA (for Standard, Value, and Out-of-Area Options Only) Limited Purpose Health Care FSA (applies to Core Option Only) Dependent Day Care FSA	AonHewitt : Your Spending Account Services P.O. Box 785040 Orlando, FL 32878-5040	Fax: 1-888-211-9900

For Information About:	Contact:	At:
Long-Term Care Insurance Plan		
Long-Term Care Insurance Plan	MetLife Long-Term Care 57 Greens Farms Road Westport, CT 06880	1-888-526-8495 Website (claims tracking and coverage information): https://www.jetnet.aa.com/jetnet/go/ssometlife.asp
Direct Billing Services		
Direct Billing while on LOA	American Airlines, Inc. P.O. Box 1346 Carol Stream, IL 60132-1346	Phone: 1-888-860-6178 Fax: 1-847-554-1884
Continuation of Coverage (COBRA)		
Continuation of Coverage (COBRA Administrator)	American Airlines, Inc. P.O. Box 1345 Carol Stream, IL 60132-1345	Phone: 1-800-860-6178 Fax: 1-847-554-1884
Other Information		
Employee Benefits Committee (Information about appeals)	EBC American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616	ICS or 1-817-967-1412
Other Options (Not Company-Sponsored)		
The following program options are offered to eligible employees (and eligible dependents). American Airlines, Inc. does not sponsor these programs. For information about these options, contact the sponsor(s) directly:		
Group Prepaid Legal Services	Hyatt Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2507	1-800-821-6400
Group Homeowners' and/or Automobile Insurance	Metropolitan Property & Casualty Insurance Company 477 Martinsville Road, 4 th Floor Liberty Corner, NJ 07938	1-800-438-6388

Glossary

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 Administrators will accept assignments for out-of-network providers.

Assignment of benefits (Applies to active employees/dependents and to retired employees who retired on or prior to October 31, 2012)

You may make an irrevocable assignment (a permanent, unchangeable transfer) of the value of your life insurance benefit. This action permanently transfers all rights and interest, both present and future, in the benefits under this life insurance. Anyone considering assignment of life insurance should consult a legal or tax advisor before taking such action.

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

American Airlines, Inc. and any successor thereto.

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.

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.

Educational services

A service is considered to be an educational service, if:

It is a service for learning and educational disorders (which include, but are not limited to, services for reading disorders, alexia, developmental dyslexia, dyscalculia, spelling disorders and other learning difficulties).

It is an early intensive behavioral interventions for autism and pervasive developmental disorders (which include, but are not limited to, development delay services and Applied Behavior Analysis (ABA)).

It involves testing or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded).

Eligible 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 fee limits, when ordered by a licensed physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage. See MOC definition below for more information.

Emergency

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.

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.

Hospital-based services

This includes: hospital facility charges, freestanding surgical facilities, physician charges, room and board, diagnostic testing, X-ray and lab fees, anesthesia, dialysis, chemotherapy and MRIs.

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.

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 allow 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 Out-of-Network Charge (MOC)

The MOC is the amount that your claims administrator will use in determining how much the plan will pay toward out of network services. The MOC is a percentage of the rate that the federal Medicare program would pay for the service. The MOC for out-of-network providers and facilities will be limited to 140% of the amount the federal Medicare program would have paid for the same service. Your claims administrator will determine the MOC based on this formula.

Medical Benefit or Medical Benefit Option

The medical coverage offered by the Company to eligible employees to provide benefits for eligible employees and covered dependents in the event of an illness or injury.

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 Administrators 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.

Participating Employer

US Airways, Inc. and any other entity that the Company designates as a Participating Employer for purposes of this Plan through Corporate Resolution.

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

Plan Administrator

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

Plan Document

A written document or documents that establish the terms of employer sponsored group coverage. This Guide serves as the Plan Document for each of the plans listed under "Plan Information" in the "Plan Administration" section, along with any other Guide published by the Company that sets forth the terms and conditions of these plans, and any and all insurance policies and certificates of insurance and other documents that set forth the terms and conditions of insured benefits under these plans.

Plan Sponsor

American Airlines, Inc. is the Plan Sponsor. A Plan Sponsor is the legal entity that has adopted the Plan and has authority regarding its operation, amendment and termination.

Pre-existing condition or pre-existing condition limitation (applies to Optional Short-Term Disability Insurance and American Airlines, Inc. Long-Term Disability Plan for active employees only). A pre-existing condition includes any physical or mental condition that was diagnosed or treated before the participant's original coverage effective date (the date first enrolled in coverage) in a plan and that will not be covered under that plan for a specified period after enrollment.

Preferred Provider Organization (PPO) (applies to the Medical 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.

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 and general vitamins as prescribed to treat a medical condition.

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, the American Airlines, Inc. Long-Term Disability Plan (this plan is not for TWU-Represented employees) or increase levels of Life Insurance for you or your spouse/DOMESTIC PARTNER (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 Health Benefit Rules section of your Employee Benefits Guide or 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

A document provided to participants outlining terms of employer sponsored group coverage. This Guide serves as the Summary Plan Description for each of the plans listed under “Plan Information” in the “Plan Administration” section, along with any other Guide published by the Company that contains a description of these plans. .. In our efforts to provide you with multimedia access to benefits information, American Airlines, Inc. has created online versions of the Summary Plan Descriptions for our benefit plans. If there is any discrepancy between the online version and the official hard copy of this 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. Note that for the STANDARD, VALUE and CORE Medical Benefit Options, this methodology shall not apply for medical services rendered on or after June 1, 2015 (instead, “Maximum Out-of-Network Charge,” above will apply). 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.

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 non-participating 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 Employee Benefits Guide are available at <http://www.aacareers.com/ebg/Archive/default.asp>.

Management and Support Staff Short-Term Disability Plan Insurance Certificate

American Airlines, Inc.

**Non-Contract Employees: Management Support Staff
And Director Level and above**

Disability Income Insurance: Short Term Benefits

Certificate Date: January 1, 2015

American Airlines, Inc.
4333 Amon Carter Blvd Md 5138
Ft. Worth, TX 76155

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

American Airlines, Inc.



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

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder: American Airlines, Inc.

Group Policy Number: 29920-G

Type of Insurance: Disability Income Insurance: Short Term Benefits

MetLife Toll Free Number(s):
For Claim Information FOR DISABILITY INCOME CLAIMS: 1-800-638-2242

THIS CERTIFICATE ONLY DESCRIBES DISABILITY INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at

1-800-638-2242

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should You have a dispute concerning Your premium or about a claim, You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE:

This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener información o para someter una queja:

Usted puede llamar al numero de teléfono gratis de MetLife para información o para someter una queja al

1-800-638-2242

Puede comunicarse con el Departamento de Seguros de Texas para obtener información acerca de compañías, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

Web: <http://www.tdi.state.tx.us>

Email: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO:

Este aviso es solo para propósito de información y no se convierte en parte o condición del documento adjunto.

NOTICE FOR RESIDENTS OF ALL STATES

WORKERS' COMPENSATION

This certificate does not replace or affect any requirement for coverage by workers' compensation insurance.

MANDATORY DISABILITY INCOME BENEFIT LAWS

For Residents of California, Hawaii, New Jersey, New York, Rhode Island and Puerto Rico

This certificate does not affect any requirement for any government mandated temporary disability income benefits law.

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.

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

**DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1 (800) 927-4357**

NOTICE FOR RESIDENTS OF CONNECTICUT

MANDATORY REHABILITATION

This certificate contains a mandatory rehabilitation provision, which may require you to participate in vocational training or physical therapy when appropriate.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Policyholder. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Idaho Department of Insurance

Consumer Affairs

700 West State Street, 3rd Floor

PO Box 83720

Boise, Idaho 83720-0043

1-800-721-3272 (for calls placed within Idaho) or 208-334-4250 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

**Metropolitan Life Insurance Company
1-800-638-5433**

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at www.in.gov/idoi

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF DISABILITY INCOME INSURANCE

1. If Your Disability Income Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your Disability Income Insurance ends because:
 - You cease to be in an Eligible Class; or
 - Your employment terminates;

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

Continuation of Your Disability Income Insurance under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

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

NOTICE FOR RESIDENTS OF UTAH

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

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

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

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

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

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-877-310-6560 - toll-free
1-804-371-9944 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, New York 10166
1-800-638-5433

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

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

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Disability Income Insurance For You: Short Term Benefits

For All Employees:

Weekly Benefit.....	66.67% of Your Predisability Earnings, subject to the INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section. If this amount is not an even multiple of \$1.00, it will be rounded to the next higher \$1.00.
Maximum Weekly Benefit.....	\$4,695
Minimum Weekly Benefit.....	\$15, subject to the Overpayments and Rehabilitation Incentive subsections of this certificate
Elimination Period.....	For Injury <ul style="list-style-type: none">• 7 days of Disability For Sickness <ul style="list-style-type: none">• 7 days of Disability
Maximum Benefit Period.....	180 days
Rehabilitation Incentives.....	Yes

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are working for the Employer on the Employer's regular work schedule, in the usual course of the Employer's business, for earnings that are paid regularly, and that You are performing the Essential Functions of Your Own Occupation. This must be done at:

- the Employer's usual place of business;
- an alternate work site at the direction of the Employer other than Your home unless clear specific expectations and duties are documented; or
- a location to which Your job requires You to travel.

You will be deemed to be Actively at Work during weekends or Employer approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off. Temporary and seasonal workers are excluded from coverage. Individuals whose employment status is being continued under a severance or termination agreement will not be considered Actively at Work.

Beneficiary means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section.

Disabled or Disability means that You are:

- unable to perform the Essential Functions of Your Own Occupation due to Your Sickness or Injury;
- under the Regular Care of a Doctor; and

You are unable to earn:

- more than 80% of Your Pre-disability Base Weekly Income due to the same Sickness or Injury.

For purposes of determining whether a Disability is the direct result of an accidental injury, the Disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If Your occupation requires a license, the fact that You lose Your license for any reason will not, in itself, constitute Disability.

Domestic Partner means each of two people, one of whom is an employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 1. 18 years of age or older;
 2. unmarried;
 3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
 4. sharing a primary residence with the other person and have been so sharing for the immediately preceding 6 months; and
 5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

DEFINITIONS (continued)

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the employee.

For Texas residents **Domestic Partner** means the following:

Domestic Partner means each of two people, one of whom is an employee of the Policyholder, who:

- have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:
 1. 18 years of age or older;
 2. unmarried;
 3. the sole domestic partner of the other person and have been so for the immediately preceding 6 months;
 4. sharing a primary residence with the other person and have been so for the immediately preceding 6 months; and
 5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the employee.

Elimination Period means the period of Your Disability during which We do not pay benefits. The Elimination Period begins on the day You become Disabled and continues for the period shown in the SCHEDULE OF BENEFITS.

Noncontributory Insurance means insurance for which the Policyholder does not require You to pay any part of the premium.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
 - parents;
 - children (natural, step or adopted);
 - siblings;
 - grandparents; or
 - grandchildren.

DEFINITIONS (continued)

Policyholder's Retirement Plan means a plan which:

- provides retirement benefits to employees; and
- is funded in whole or in part by Policyholder contributions.

The term does not include:

- profit sharing plans;
- thrift or savings plans;
- non-qualified plans of deferred compensation;
- plans under IRC Section 401(k) or 457;
- individual retirement accounts (IRA);
- tax sheltered annuities (TSA) under IRC Section 403(b);
- stock ownership plans; or
- Keogh (HR-10) plans.

Predisability Earnings means Your gross weekly income from Your Employer in effect just prior to Your date of Disability. It does not include income received from the grant, award, sale, conversion and/or exercise of shares of stock or stock options, commissions, bonuses, overtime pay, any other extra compensation, or income received from sources other than Your Employer.

If You become Disabled while You are on a covered layoff or leave of absence, We will use the Pre-disability base weekly income from Your employer in effect just prior to the date of disability will be used Your absence begins.

Pre-existing Condition means a sickness or accidental injury for which You:

- You received medical treatment, consultation, care or services, or
- Took prescription medication or had medications prescribed;

In the 3 months before Your insurance under this certificate takes effect. However, Pre-existing Condition does not include any condition for which You had tests if the condition was found not to exist.

We will not pay benefits for a Disability that results from a Pre-existing Condition; if You have been Actively at Work for less than 12 consecutive months after the date Your Disability insurance takes effect under this certificate.

The Pre-existing provision will apply to all Legacy American Airlines employees hired on or after January 1, 2015 and waived for all Legacy American Airlines employees hired prior to January 1, 2015.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

DEFINITIONS (continued)

Regular Care means that You:

- personally visit a Doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat Your disabling condition(s); and
- are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for Your Disability by a Doctor whose specialty or experience is the most appropriate for Your disabling condition(s), according to generally accepted medical standards.

Regular Care will not mean invasive surgery for which other treatment alternatives are available.

Rehabilitation Program means a program designed to assist You to return to work.

As Your file is reviewed, medical and vocation information will be analyzed to determine if rehabilitation services might help You to return to work.

Once the initial review is completed by Our Rehabilitation Program specialists working along with Your Doctor and other appropriate specialists, We may elect to offer You and pay for a Rehabilitation Program. If the Rehabilitation Program is not developed by Our Rehabilitation Program specialists, You must receive written approval from Us for the program before it begins.

- The Rehabilitation Program may include, but is not limited to, the following services:
- coordination with Your Employer to assist You to return to work;
- adaptive equipment to allow You to work;
- worksite modification to allow You to work;
- vocational evaluation to determine how Your Disability may impact Your employment options;
- job placement services;
- resume preparation;
- job seeking skills training;
- retraining for a new occupation; or
- assistance with relocation that may be part of an approved Rehabilitation Program.

If at any time, You decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that We feel is appropriate for Your Disability and that has been approved by Your Doctor, Your benefit payment will end as set forth in the Date Benefit Payment Ends provision.

Sickness means illness, disease or pregnancy, including complications of pregnancy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

We, Us and Our mean MetLife.

Written or Writing means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and Your mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All employees who are classified by the Contract Holder as Non-Contract Employees including Legacy US Airways and Legacy American Airlines. Temporary or seasonal employees are not included in the covered classes. Non-Contract includes Management, Support Staff and Director Level and above.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS.

If You are in an eligible class on January 1, 2015, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after January 1, 2015, You will be eligible for the insurance described in this certificate on the date You enter that class.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing an enrollment form.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Noncontributory Insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Increase in Insurance

An increase in insurance, if You are Actively at Work, will take effect on the date of the increase in Your earnings.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

Decrease in Insurance

A decrease in insurance due to a change in class of employee or a decrease in Your earnings will take effect on the date of change.

If You make a Written request to decrease Your insurance, that decrease will take effect as of the date of Your Written request.

Changes in Your Disability Income Insurance will only apply to Disabilities commencing on or after the date of the change.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. the date You cease to be in an eligible class. You will cease to be in an eligible class on the date You cease Active Work in an eligible class, if You are not disabled on that date; or
5. the last day You are in active date employment, except as provided under the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section of this certificate; or
6. the last day You are in Active Work due to a Disability that is not covered under this certificate.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

Reinstatement of Disability Income Insurance

If Your insurance ends, You may become insured again as follows:

1. If Your insurance ends because:

- You cease to be in an eligible class; or
- Your employment ends; and

You become a member of an eligible class again within 31 days of the date Your insurance ended, the limitation for Pre-existing Conditions will be applied as if Your insurance had remained in effect with no interruption.

2. If Your insurance ends because you cease making the required premium while on an approved Family and Medical Leave Act (FMLA) or other legally mandated leave of absence, and you become a member of an eligible class within 31 days of the earlier of:
 - The end of the period of leave You and the Policyholder agreed upon; or
 - The end of the eligible leave period required under the FMLA or other similar legally mandated leave of absence law,

You will not have to complete a new Waiting Period or provide evidence of Your insurability.

3. In all other cases where Your insurance ends because the required premium for Your insurance has ceased to be paid, You will be required to provide evidence of Your insurability.

If You become insured again as described in either item 1 or 2 above, the limitation for Pre-existing Conditions will be applied as if Your insurance had remained in effect with no interruption.

SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE

To prevent a loss of insurance because of a change in insurance carriers, the following rules will apply if this Disability Income Insurance replaces a plan of group disability income insurance provided to You by the Policyholder:

Prior Plan means the plan of group disability income insurance provided to You by the Policyholder through another carrier on the day before the Replacement Date.

Replacement Date means the effective date of the Disability Income Insurance under the Group Policy.

Rules for When Insurance Takes Effect if You were Insured Under the Prior Plan on the Day Before the Replacement Date:

- **If You are Actively at Work on the day before the Replacement Date**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.
- **If You are not Actively at Work on such date because you are Disabled**, You will become insured for Disability Income Insurance under this certificate on the Replacement Date.

We will credit any time You accumulated toward the Elimination Period under the Prior Plan to the satisfaction of the Elimination Period required to be met under this certificate.

Any benefits paid for such Disability will be equal to those that would have been payable to You under the Prior Plan less any amount for which the prior carrier is liable.

Benefit payments for such Disability will end on the earliest of:

- the date that payments end under the subsection DATE BENEFIT PAYMENTS END in this certificate; or
- the date that payments would have ended under the provisions of the Prior Plan of Insurance.
- **If You are not Actively at Work on such date for any other reason**, You will become insured for Disability Income Insurance under this certificate on the date you return to Active Work.

Rules for When Insurance Takes Effect if You were Not Insured Under the Prior Plan on the Day Before the Replacement Date:

- You will be eligible for Disability Income Insurance under this certificate when you meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU; and
- We will credit any time You accumulated under the Prior Plan toward the eligibility waiting period under the Prior Plan to the satisfaction of the eligibility waiting period required to be met under this certificate.

Rules for Pre-existing Conditions

In determining whether a Disability is due to a Pre-existing Condition, We will credit You for any time You were insured under the Prior Plan. If Your Disability is due to a Pre-existing Condition as described in this certificate, but would not have been due to a pre-existing condition under the Prior Plan, We will pay a benefit equal to the lesser of:

- the benefit amount under this certificate; or
- the disability income insurance benefit that would have been payable to You under the Prior Plan.

If Your Disability would have been due to a pre-existing condition under the Prior Plan, it will be treated as having been caused by a Pre-existing Condition under this certificate.

Rules for Temporary Recovery from a Disability under the Prior Plan

We will waive the Elimination Period that would otherwise apply to a Disability under this certificate if You:

- received benefits for a disability that began under the Prior Plan ("Prior Plan's disability");
- returned to work as an active full-time employee prior to the Replacement Date;

SPECIAL RULES FOR GROUPS PREVIOUSLY INSURED UNDER A PLAN OF DISABILITY INCOME INSURANCE (continued)

- become Disabled, as defined in this certificate, after the Replacement Date and within 90 days of Your return to work due to a sickness or accidental injury that is the same as or related to the Prior Plan's disability;
- are no longer entitled to benefit payments for the Prior Plan's disability since You are no longer insured under such Plan; and
- would have been entitled to benefit payments with no further elimination period under the Prior Plan, had it remained in force.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR FAMILY AND MEDICAL LEAVE

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

AT THE POLICYHOLDER'S OPTION

The Policyholder has elected to continue insurance by paying premiums for employees who are not Disabled and cease Active Work in an eligible class for any of the reasons specified below.

Disability Income Insurance will continue for the following periods:

1. if You cease Active Work due to injury or sickness, for a period in accordance with the Policyholder's general practice for an Employee in Your job class;
2. if You cease Active Work due to layoff, for a period in accordance with the Policyholder's general practice for an Employee in Your job class; or
3. if You cease Active Work due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an Employee in Your job class.

The Policyholder's general practice for employees in a job class determines which employees with the above types of absences are to be considered as still insured and for how long among persons in like situations.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

EVIDENCE OF INSURABILITY

No evidence of insurability is required for the insurance described in this certificate.

DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS

If You become Disabled while insured, Proof of Disability must be sent to Us. When We receive such Proof, We will review the claim. If We approve the claim, We will pay the Weekly Benefit up to the Maximum Benefit Period shown in the SCHEDULE OF BENEFITS, subject to the Date Benefit Payments End section.

To verify that You continue to be Disabled without interruption after Our initial approval of the Disability claim, We may periodically request that You send Us Proof that You continue to be Disabled. Such Proof may include physical exams, exams by independent medical examiners, in-home interviews, or functional capacity exams, as needed.

While You are Disabled, the Weekly Benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

BENEFIT PAYMENT

If We approve Your claim, benefits will begin to accrue on the day after the day You complete Your Elimination Period. We will pay the first Weekly Benefit one week after the date benefits begin to accrue. We will make subsequent payments weekly thereafter so long as You remain Disabled. Payment will be based on the number of days You are Disabled during each week. For any partial week of Disability, payment will be made at the daily rate of 1/7th of the Weekly Benefit payable.

We will pay Weekly Benefits to You. If You die, We will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who We Will Pay.

RECOVERY FROM A DISABILITY

For purposes of this subsection, the term Active Work only includes those days You actually work.

The provisions of this subsection will not apply if Your insurance has ended and You are eligible for coverage under another group short term disability plan.

If You Return to Active Work Before Completing Your Elimination Period

If You return to Active Work before completing Your Elimination Period and then become Disabled, You will have to complete a new Elimination Period.

If You Return to Active Work After Completing Your Elimination Period

If Your current Disability is related or due to the same cause(s) as Your prior Disability for which We have made a payment:

We will treat Your current Disability as part of Your prior claim and You will not have to complete another Elimination Period if You return to Active Work for the Employer on a full-time basis for 90 consecutive days or less. Your Disability will be subject to the same terms, provisions and conditions that were used for the original Disability.

If Your current Disability is unrelated to Your prior Disability for which We have made a payment:

We will treat Your current Disability as a new claim and You will have to complete another Elimination Period. Your Disability will be subject to all of the plan provisions.

If You become covered under any other group disability plan, You will not be eligible for payments under this certificate.

DISABILITY INCOME INSURANCE: SHORT TERM BENEFITS (continued)

REHABILITATION INCENTIVES

Rehabilitation Program Incentive

If You participate in a Rehabilitation Program, We will increase Your Weekly Benefit by an amount equal to 10% of the Weekly Benefit. We will do so before We reduce Your Weekly Benefit by any Other Income.

Work Incentive

If You work while You are Disabled and receiving Weekly Benefits, including self-employment, and Your weekly Work Earnings are 80% or less of Your Pre-disability Base Weekly Income, Your Weekly Benefit will be adjusted as follows:

1. Add Your weekly Work Earnings to Your Gross Weekly Benefit payment.
2. Compare the answer in item 1 to your Pre-disability Base Weekly Income

If the answer from item 1 is less than or equal to 100% of your Pre-disability Base Weekly Income, We will not further reduce Your Net Weekly Benefit payment. If the answer from item 1 is more than 100% of Your Pre-disability Base Weekly Income, We will subtract the amount over 100% from Your Net Weekly Benefit payment. We may require You to send Proof of Your weekly Work Earnings.

We will not pay a Weekly Benefit for any week in which Your Work Earnings exceed 80% of Your Pre-disability Base Weekly Earnings.

In addition, the Minimum Weekly Benefit will not apply.

If Your Work Earnings are expected to fluctuate widely from week to week, We may average Your Work Earnings over the most recent 3 weeks to determine if Your claim should continue, subject to all other terms and conditions in this certificate. If We average your Work Earnings, We will terminate Your claim if the average of Your work earnings from the last 3 weeks exceeds 80% of Your Pre-disability Base Weekly Income.

Moving Expense Incentive

If You participate in a Rehabilitation Program while You are Disabled, We may reimburse You for expenses You incur in order to move to a new residence recommended as part of such Rehabilitation Program. Such expenses must be approved by Us in advance.

You must send Proof that You have incurred such expenses for moving.

We will not reimburse You for such expenses if they were incurred for services provided by a member of Your immediate family or someone who is living in Your residence.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT

We will reduce Your Disability benefit by the amount of all Other Income. Other Income includes the following:

1. any disability or retirement benefits which You, Your Spouse or child(ren) receive because of Your disability or retirement under:
 - any state or public employee retirement or disability plan; or
 - a no-fault auto law for loss of income, excluding supplemental disability benefits;
 - any income received for disability under a group insurance policy to which the Policyholder has made a contribution, but only with respect to benefits for loss of time from work due to disability; or
 - plan or arrangement, whether insured or not, as a result of employment by or association with the Employer; or as a result of membership in or association with any groups, associations, union or other organization, including benefits required by state law or under an Employer sponsored short term disability program individually underwritten;
 - any state or government retirement system.
2. The gross amount that You, Your Spouse and children receive or are eligible to receive because of Your disability under:
 - the Railroad Retirement Act;
 - the Canada Pension Plan;
 - the Quebec Pension plan; or
 - any similar plan or act.

Amounts paid to Your former Spouse or to Your children living with such Spouse will not be included.

3. The gross amount that You receive because of Your disability from the Veteran's Administration, or any other foreign or domestic governmental agency. If Your Disability begins and You were already receiving payments from the Veteran's Administration, We will only subtract the amount of any increase in benefit that is attributed to such Disability.
4. The gross amount that You receive as retirement payments or the gross amount Your Spouse and children receive as retirement payments because You are receiving payments under:
 - the Railroad Retirement Act;
 - the Canada Pension Plan;
 - the Quebec Pension plan; or
 - any similar plan or act.

Benefits paid to Your former Spouse or to Your children living with such Spouse will not be included.

5. The amount that You:
 - receive as Disability payments under the Policyholder's Retirement Plan;
 - voluntarily elect to receive as retirement or early retirement payments under the Policyholder's Retirement Plan;
 - receive as retirement payments when You reach normal retirement age, as defined in the Policyholder's Retirement Plan;

Retirement payments will be those benefits which are paid based on Your Employer's contribution to the Policyholder's Retirement Plan. Disability benefits which reduce the retirement benefits under the plan will also be considered as a retirement benefit.

Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. We will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code or by the Canada Customs and Revenue Agency including any future amendments which affect the definition.

6. The amount You receive under Laws providing maritime maintenance and cure.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT (continued)

7. The amount of loss of time benefits that You receive under any Salary Continuation or Accumulated Sick Leave.
8. The amount that You receive under any unemployment income act or law due to the end of employment with Your Employer.

With the exception of retirement payments, We will only subtract deductible sources of other income which are payable as a result of the same Disability.

We will not reduce Your payment by Your Social Security or Canada or Quebec Pension Plan retirement payments if Your Disability begins after age 65 and You were already receiving Social Security or Canada or Quebec Pension Plan retirement payments.

SINGLE SUM PAYMENT

If You receive Other Income in the form of a single sum payment, You must, within 10 days after receipt of such payment, give Written Proof satisfactory to Us of:

- the amount of the single sum payment;
- the amount to be attributed to income replacement; and
- the time period for which the payment applies.

When We receive such Proof, We will adjust the amount of Your Disability benefit.

If We do not receive the Written Proof described above, and We know the amount of the single sum payment, We may reduce Your Disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If We adjust the amount of Your Disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an Overpayment.

If You receive Other Income in the form of a single sum payment and We do not receive the Written Proof described above within 10 days after You receive the single sum payment, We will adjust the amount of Your Disability Benefit by the amount of such payment.

DISABILITY INCOME INSURANCE: INCOME WHICH WILL NOT REDUCE YOUR DISABILITY BENEFIT (SHORT TERM OR LONG TERM)

We will not reduce Your Disability benefit to less than the Minimum Benefit shown in the SCHEDULE OF BENEFITS, or by the following sources:

- 401 (k) plans;
- profit sharing plans;
- thrift plans;
- tax sheltered annuities;
- stock ownership plans;
- non-qualified plans of deferred compensation;
- pension plans for partners;
- credit disability insurance;
- franchise disability income plans;
- a retirement plan from another employer;
- individual retirement accounts (IRA);
- vacation payouts;
- disability or retirement benefits which You began receiving prior to Your Disability;
- individual disability income plans other than those plans for which Your Employer, directly or indirectly, has paid all or part of the cost or made payroll deductions.

Once We have subtracted any Other Income from Your Gross Weekly Benefit, We will not further reduce Your Short Term benefit payment due to a cost of living increase from that source.

DISABILITY INCOME INSURANCE: DATE BENEFIT PAYMENTS END

Your Disability benefit payments will end on the earliest of:

- the end of the Maximum Benefit Period for Short Term Benefits shown in the Schedule of Benefits;
- if the Insurance Company determines the Employee is able to work under a modified work arrangement and he or she chooses not to do so;
- When You are able to work in Your Own Occupation by using adaptive equipment or a worksite modification that We consider appropriate for your situation and that is approved by an independent Doctor, but You choose not to;
- the date You are no longer Disabled;
- the date You die;
- the date You choose not to participate in a Rehabilitation Program that We consider appropriate for Your situation and is approved by an independent Doctor;
- the date You fail to have a medical exam requested by Us as described in the Physical Exams subsection of the GENERAL PROVISIONS section;
- the date Your Work Earnings exceed the amount allowable under the terms of this certificate.
- the date You fail to provide required Proof of continuing Disability.

While You are Disabled, the benefits described in this certificate will not be affected if:

- Your insurance ends; or
- the Group Policy is amended to change the plan of benefits for Your class.

DISABILITY INCOME INSURANCE: PRE-EXISTING CONDITIONS

Pre-existing Condition means a Sickness or accidental injury for which You:

- received medical treatment, consultation, care, or services; or
- took prescription medication or had medications prescribed;

in the 3 months before Your insurance under this certificate takes effect.

We will not pay benefits for a Disability that results from a Pre-existing Condition, if You have been Actively at Work for less than 12 consecutive months after the date Your Disability insurance takes effect under this certificate.

DISABILITY INCOME INSURANCE: LIMITED DISABILITY BENEFITS

For Occupational Disabilities

We will not pay benefits for any Disability:

- which happens in the course of any work performed by You for wage or profit; or
- for which You are eligible to receive under workers' compensation or a similar law.

DISABILITY INCOME INSURANCE: EXCLUSIONS

We will not pay for any Disability caused or contributed to by:

1. war, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;
2. Your active participation in a riot;
3. intentionally self-inflicted injury;
4. of or attempt to commit or taking part in a felony;
5. Occupational Sickness or Injury; or
6. A Pre-existing Condition. See pre-existing condition definition for full exclusion explanation.

We will not pay Short Term Benefits for any Disability caused or contributed to by elective treatment or procedures, excluding organ donations, such as:

1. cosmetic surgery or treatment primarily to change appearance;
2. reversal of sterilization;
3. liposuction;
4. visual correction surgery; and
5. in vitro fertilization; embryo transfer procedure; or artificial insemination (excluding Disability resulting from pregnancy as a result of in vitro fertilization); and
6. laser vision corrective surgery.

However, pregnancies and complications from any of these procedures will be treated as a Sickness.

FILING A DISABILITY INCOME INSURANCE CLAIM: SHORT TERM BENEFITS

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder.

If You are unable to report for Active Work due to a Sickness or accidental injury, and You think that You may be Disabled, You should contact MetLife or Your benefits representative to initiate a claim. We recommend that You do so no later than 14 days after the first day You are unable to report for Active Work so that Your claim can be processed in a timely manner.

When a claimant files an initial claim for Disability Income Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days after the end of the Elimination Period.

Notice of claim and Proof for Disability Income Insurance may also be given to Us by following the steps set forth below:

Step 1

A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2

We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

Step 3

When the claimant receives the claim form the claimant should fill it out as instructed and return it with the required Proof described in the claim form. If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4

The claimant must give Us Proof not later than 90 days after the end of the Elimination Period.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given within 90 days after the end of the Elimination Period or if it is not reasonably possible to give notice of claim or Proof within such period, they are given as soon as is reasonably possible thereafter.

Items to be Submitted for a Disability Income Insurance Claim

When submitting Proof on an initial or continuing claim for Disability Income insurance, the following items may be required:

- documentation which must include, but is not limited to, the following information:
 - the date Your Disability started;
 - the cause of Your Disability;
 - the prognosis of Your Disability;
 - the continuity of Your Disability; and
- Your application for:
 - Other Benefit Sources;
 - Federal Social Security disability benefits; and
 - Workers compensation benefits or benefits under a similar law.
- Written authorization for Us to obtain and release medical, employment and financial information and any other items We may reasonably require to document Your Disability or to determine Your receipt of or eligibility for Other Benefit Sources;
- any and all medical information, including but not limited to:
 - x-ray films; and
 - photocopies of medical records, including:

FILING A DISABILITY INCOME INSURANCE CLAIM: SHORT TERM BENEFITS (continued)

- histories,
 - physical, mental or diagnostic examinations; and
 - treatment notes; and
- the names and addresses of all:
 - physicians and medical practitioners who have provided You with diagnosis, treatment or consultation;
 - hospitals or other medical facilities which have provided You with diagnosis, treatment or consultation;
 - pharmacies which have filled Your prescriptions within the past three years; and
- additional proof elements as required and described within the additional plan provisions for which you are filing a claim for benefits.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Disability Income Benefit Payments: Who We Will Pay

We will make any benefit payments during Your lifetime to You or Your legal representative as Beneficiary. Any payment made in good faith will discharge Us from liability to the extent of such payment.

Upon Your death, We will pay any amount that is or becomes due to Your designated Beneficiary. If there is no Beneficiary designated or no surviving designated Beneficiary at Your death, We may determine the Beneficiary for any amount that is or becomes due, according to the following order:

1. Your Spouse or Domestic Partner, if alive;
2. Your child(ren), if there is no surviving Spouse or Domestic Partner;
3. Your parent(s), if there is no surviving child(ren);
4. Your sibling(s), if there is no surviving parent(s);
5. Your estate, if there is no such surviving sibling(s).

If more than one person is eligible to receive payment, We will divide the benefit amount in equal shares.

Payment to a minor or incompetent will be made to such person's guardian. The term "children" or "child" includes natural and adopted children.

Any periodic payments owed to Your estate may be paid in a single sum.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid Insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

GENERAL PROVISIONS (continued)

Physical Exams

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

Overpayments for Disability Income Insurance

Recovery of Overpayments

We have the right to recover any amount that We determine to be an overpayment.

An overpayment occurs if We determine that:

- the total amount paid by Us on Your claim is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us. Our rights and Your obligations in this regard are described in the reimbursement agreement that You are required to sign when You submit a claim for benefits under this certificate. This agreement:

- confirms that You will reimburse Us for all overpayments; and
- authorizes Us to obtain any information relating to sources of Other Income.

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future Disability benefits, including the Minimum Benefit, payable to You or any other payee under the Disability sections of this certificate;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

GENERAL PROVISIONS (continued)

Lien and Repayment

If You become Disabled and You receive Disability benefits under this certificate and You receive payment from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate (for example, a judgment, settlement, payment from Federal Social Security or payment pursuant to Workers' Compensation laws), You shall reimburse Us from the proceeds of such payment up to an amount equal to the benefits paid to You under this certificate for such Disability. Our right to receive reimbursement from any such proceeds shall be a claim or lien against such proceeds and Our right shall provide Us with a first priority claim or lien over any such proceeds up to the full amount of the benefits paid to You under this certificate for such Disability. You agree to take all action necessary to enable Us to exercise Our rights under this provision, including, without limitation:

- notifying Us as soon as possible of any payment You receive or are entitled to receive from a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate;
- furnishing of documents and other information as requested by Us or any person working on Our behalf; and
- holding in escrow, or causing Your legal representative to hold in escrow, any proceeds paid to You or any party by a third party for loss of income with respect to the same loss of income for which You received benefits under this certificate, up to an amount equal to the benefits paid to You under this certificate for such Disability, to be paid immediately to Us upon Your receipt of said proceeds.

You shall cooperate and You shall cause Your legal representative to cooperate with Us in any recovery efforts and You shall not interfere with Our rights under this provision. Our rights under this provision apply whether or not You have been or will be fully compensated by a third party for any Disability for which You received or are entitled to receive benefits under this certificate.

**THIS IS THE END OF THE CERTIFICATE.
THE FOLLOWING IS ADDITIONAL INFORMATION.**

SPECIAL SERVICES

Social Security Assistance Program

If your claim for Disability benefits under this plan is approved, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply For Social Security Disability Benefits

Both you and your employer contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security's program of disability protection. Since your tax dollars help fund this program, it is in your best interest to apply for any benefits to which you may be entitled. Your spouse and children may also be eligible to receive Social Security disability benefits due to your Disability.

There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

1. Avoids Reduced Retirement Benefits

Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivors benefit.

2. Medicare Protection

Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

3. Trial Work Period

Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

4. Cost-of-Living Increases Awarded by Social Security Will Not Reduce Your Disability Benefits

MetLife will not decrease your Disability benefit by the periodic cost-of-living increases awarded by Social Security. This is also true for any cost-of-living increases awarded by Social Security to your spouse and children.

This is called a Social Security "freeze." It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your Disability benefit; with the following exceptions:

- a) an error by Social Security in computing the initial amount;
- b) a change in dependent status; or
- c) your Employer submitting updated earnings records to Social Security for earnings received prior to your Disability.

Over a period of years, the net effect of these cost-of-living increases can be substantial.

How MetLife Assists You in the Social Security Approval Process

As soon as you are approved for Disability benefits, MetLife begins assisting you with the Social Security approval process.

SPECIAL SERVICES

1. Assistance Throughout the Application Process

MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, are also located within our Claim Department. They provide expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

2. Guidance Through Appeal Process by Social Security Specialists

Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provides expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:

- a) Reconsideration by the Social Security Administration
- b) Hearing before an Administrative Law Judge
- c) Review by an Appeals Council established within the Social Security Administration in Washington, D.C.
- d) A civil suit in Federal Court.

3. Social Security Attorneys

Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security approved attorney's fee is credited to the Long Term Disability overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum Social Security Disability benefits award and will not be used to further reduce your Long Term Disability benefit.

Return To Work Program

Goal of Rehabilitation

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

Incentives For Returning To Work

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

Return-to-Work Services

As a covered employee you are automatically eligible to participate in our Return-to-Work Program. The program aims to identify the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities. There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. Vocational Analyses

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

2. Labor Market Surveys

SPECIAL SERVICES

Studies to find jobs available in your locale that would utilize your abilities and skills. Also identify one's earning potential for a specific occupation.

3. Retraining Programs

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

4. Job Modifications/Accommodations

Analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities.

This also includes changes in your job or accommodations to help you perform the previous job or a similar vocation, as required of your employer under the Americans With Disabilities Act (ADA).

5. Job Seeking Skills and Job Placement Assistance

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

Return-to-Work Program Staff

The Case Manager handling your claim will coordinate return-to-work services. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist, or Vocational Rehabilitation Consultant, who has advanced training and education to help people with disabilities return to work. One of our clinical specialists will work with you directly, as well as with local support services and resources. They have returned hundreds of individuals to meaningful, gainful employment.

Rehabilitation Vendor Specialists

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

1. attending physician's evaluation and recommendations;
2. your individual vocational needs; and
3. vendor's credentials, specialty, reputation and experience.

When working with vendors, we continue to collaborate with you and your doctor to develop an appropriate return-to-work plan.

ERISA INFORMATION

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE AMERICAN AIRLINES, INC. DISABILITY INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

NAME AND ADDRESS OF EMPLOYER

American Airlines, Inc.
4333 Amon Carter Blvd Md 5138
Ft. Worth, TX 76155
817-967-2887

PLAN ADMINISTRATOR NAME, BUSINESS ADDRESS AND PHONE NUMBER

American Airlines, Inc.
Mail Drop 5134-HGC, P.O. Box 619616
DFW Airport, Texas 75261-9616

EMPLOYER IDENTIFICATION NUMBER: 13-1502798

PLAN NUMBER	COVERAGE	PLAN NAME
516	Disability Income Insurance: Short Term Benefits	The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries, ("Plan").

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which MetLife is liable for Disability Income Insurance: Short Term Benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes seeking payment of benefits, service of legal process may be made upon MetLife by serving MetLife's designated agent to accept service of process.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 12th and ending on the following December 12th.

QUALIFIED DOMESTIC RELATIONS ORDERS/QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Disability Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

For claims for disability benefits, the claimant must report the claim to MetLife and, if requested, complete the appropriate claim form. The claimant must also submit the required proof as described in the "Filing A Claim" section of the certificate.

Claim forms requested by MetLife must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents, including insurance contracts 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 copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 which 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 or a medical child support order, you may file suit in a 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but American Airlines, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of American Airlines, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

***Agents, Reps, Planners, Home-Based &
Premium Service Reps, Flight Attendants, and
TWU-Represented employees Optional Short-
Term Disability Plan Certificate***

American Airlines, Inc.

Optional Short Term Disability Benefits

Certificate Date: January 1, 2006

INTRODUCTION

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

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

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

Your comprehensive disability program includes:

Financial Incentives for returning to work.

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

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

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



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

CERTIFICATE OF INSURANCE
For the Employees of

American Airlines, Inc.
(called the Employer)

This is your Certificate of Insurance for Short Term Disability Insurance as long as you are insured under This Plan. The Group Policy and this Certificate may be changed or canceled according to the terms, conditions and provisions of the Group Policy. This Certificate describes the benefits under the Plan in effect as of January 1, 2006. Any prior Certificate relating to the coverage set forth herein is void.

MetLife in its discretion has authority to interpret the terms, conditions, and provisions of the entire contract. This includes the Group Policy, Certificate and any Amendments.

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

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

A handwritten signature in black ink, appearing to read "C. Robert Henrikson".

C. Robert Henrikson
President and Chief Operating Officer

Group Policy No.: 29920-G

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

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

Form G.24303-Cert.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O

RECLAMOS: Si tiene una disputa concierne a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

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

1-800-638-5433

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

**ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904**

California residents please be advised of the following:

IMPORTANT NOTICE

**TO OBTAIN ADDITIONAL INFORMATION, OR
TO MAKE A COMPLAINT, CONTACT METLIFE
AT:**

**METROPOLITAN LIFE INSURANCE
COMPANY
200 PARK AVENUE
NEW YORK, NY 10166
ATTN: CORPORATE CONSUMER RELATIONS
DEPARTMENT
1-800-638-5433**

**IF, AFTER CONTACTING METLIFE
REGARDING A COMPLAINT, YOU FEEL THAT
A SATISFACTORY RESOLUTION HAS NOT
BEEN REACHED, YOU MAY FILE A
COMPLAINT WITH THE CALIFORNIA
INSURANCE DEPARTMENT AT:**

**CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)**

Georgia residents please be advised of the following:

IMPORTANT NOTICE

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

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.

- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or \$500,000 — whichever is lower. Other caps also apply:

- \$100,000 in net cash surrender values.
- \$500,000 in life insurance death benefits (including cash surrender values).
- \$500,000 in health insurance benefits.
- \$200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- \$5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

· COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.

· COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.

· THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.

· INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.

· THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166
Attn: Corporate Customer Relations Department

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

1-800-638-5433

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

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-371-9691 - Out-of-state

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

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

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PLAN HIGHLIGHTS

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

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

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

EMPLOYEE ELIGIBILITY

Eligible Employee: All Management /Specialist Employees, Agents, Support Staff, Skycaps, or Employees represented by the Transport Workers Union (TWU) Employees who are employed and paid for services by the Employer.

Optional Short Term Disability Eligibility Waiting Period:

Active Management /Specialist Employees: None

Active Agents, Support Staff, Skycaps, or Employees represented by the Transport Workers Union (TWU): 6 months of continuous employment with the Employer

Eligibility Date: January 1, 2006 or the date you complete the Eligibility Waiting Period, whichever is later.

SHORT TERM DISABILITY BENEFITS

Optional Short Term Disability Benefits

Amount Of Benefits

Weekly Benefit..... 50% of your Predisability Earnings, derived from Adjusted Monthly Salary, less any benefits from all other sources.

Maximum Benefit Duration:

TWU Employees..... 26 weeks

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

Waiting Period 8 days or the exhaustion of company sponsored accrued sick pay, whichever is later.

Maximum Covered Salary \$200,000 annually

Work Incentive:

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

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

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

LIMITATIONS

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

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

CONTRIBUTIONS

Your Short Term Disability Benefits are paid for by you.

BENEFITS CHECKLIST

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

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

Form G.24303-A

EMPLOYEE ELIGIBILITY

Active Employee

You are an Active Employee if you:

1. are an Eligible Employee working for the Employer doing all the material duties of your occupation at (i) your usual place of business; or (ii) some other location that your Employer's business requires you to be;
2. are a citizen or legal resident of the United States or Canada; and
3. are not a temporary or seasonal employee.

You will be deemed an Active Employee if:

1. you meet the above conditions; and
2. you are absent from work solely due to vacation days, holidays, scheduled days off, or approved leaves of absence not due to Disability.

Effective Date of Coverage

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

1. your Eligibility Date;
2. the date you meet the Active Employee requirements; or
3. the date of your written application.

If you enroll in this plan, your participation is required for two calendar years. If you fail to enroll for coverage at the initial offering, you will be required to wait until the next annual enrollment period and your enrollment will be treated as a Waiver of Coverage.

Waiver of Coverage

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

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

Changes in Amount of Weekly Benefit

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

1. will take effect on the date of the change; and
2. will apply only to Disabilities commencing thereafter.

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

Form G.24303-B

SHORT TERM DISABILITY BENEFITS

A. Weekly Benefit

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

1. you are Disabled; and
2. you became Disabled while covered under This Plan.

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

Contributions are required for the time that Weekly Benefits are payable.

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

1. termination of This Plan;
2. termination of your coverage; or
3. any plan change that is effective after the date you became Disabled.

When Benefits End

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

1. the end of the Maximum Benefit Duration;
2. the date you are no longer Disabled;
3. the date you fail to provide us with any of the information listed in Plan Highlights under Benefits Checklist;

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

Waiting Period

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

Definition of Disability

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

1. are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and
2. are unable to earn more than 80% of your Predisability Earnings at your Own Occupation for any employer in your Local Economy.

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

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

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

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

2. it is necessary to meet your basic health needs and is of demonstrable medical value;
3. it is consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;
4. it is consistent with the diagnosis of your condition; and
5. its purpose is maximizing your medical improvement.

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

1. if applicable state law requires that such practitioners be recognized for the purposes of certification of disability; and
2. the care and treatment provided by the practitioner is within the scope of his or her license.

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

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

Work Incentive

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

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

1. your Weekly Benefit (including your Rehabilitation Incentive when applicable);
2. the amount of your earnings for working while Disabled; and
3. the amount of Family Care Expenses for which you are eligible.

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

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

"Rehabilitation Program" means:

1. a return to active employment by you on either a part-time or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified taking into account your training, education, experience and past earnings; or
2. participating in vocational training or physical therapy. This must be deemed by one of our rehabilitation coordinators to be appropriate.

Rehabilitation Incentive

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

Family Care Expenses

After the 4th week of Disability, when you work or participate in a Rehabilitation Program approved by us, you will be reimbursed for

Eligible Family Care Expenses incurred with respect to each Eligible Family Member.

"Eligible Family Member" means a person who is:

1. living with you as part of your household; and
2. chiefly dependent on you for support.

"Eligible Family Care Expenses" mean the weekly expenses incurred by you in order for you to participate in a Rehabilitation Program, up to \$60 for each Eligible Family Member. These are expenses incurred:

1. to provide child care with respect to an Eligible Family Member under age 13. Child care must be provided by a licensed child care facility or other qualified child care provider. The child care provider may not be a member of your immediate family or living in your residence.
2. to provide care to an Eligible Family Member who as a result of mental or physical impairment, is incapable of caring for himself or herself. Family Care Expenses for services provided by a member of your immediate family or any one living in your residence will not be reimbursed.

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

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

Predisability Earnings

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

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

B. Reduction of Benefits - Other Income Benefits

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

1. will not be less than the amount shown in Plan Highlights under Minimum Weekly Benefit (except in the case of an Overpayment or while receiving work earnings);
2. will not be further reduced due to cost-of-living increases payable under Other Income Benefits after the correct reductions has been determined;
3. will not be reduced by any reasonable attorney fees included in any award or settlement; and
4. will not be reduced by any sources other than those shown below.

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

List of Sources of Other Income Benefits

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

2. No-fault Auto Laws

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

3. Third Party Recovery

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

4. Other Programs or Plans including:

- a. a compulsory benefit program of any government which provides payment for loss of time from your job because of your disability will be counted;
- b. any other group disability income plan, fund, or other arrangement, no matter what called, if the Employer contributes toward it or makes payroll deductions for it, will be counted; and
- c. any sick pay or other salary continuation, other than vacation pay, paid to you by the Employer will be counted.

Exceptions to Other Income Benefits

Other Income Benefits will not include:

- 1. group credit or mortgage disability insurance benefits; or
- 2. early retirement benefits not taken into constructive receipt; or
- 3. individual Insurance policies.

C. Temporary Recovery

Once benefits become payable under This Plan, you may Temporarily Recover from your Disability. If you become Disabled again due to the

same or related condition, you may not have to begin a new Waiting Period.

Once you have satisfied your Waiting Period, a period of Temporary Recovery is your return to work for less than 3 months for each period of Temporary Recovery.

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

1. the rate of earnings used to determine your Predisability Earnings; or
2. the terms, provisions, or conditions shown in your Certificate of Insurance.

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

D. Concurrent Disability

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

1. the Maximum Benefit Duration; and
2. Limitations and Exclusions that apply to the new cause of Disability.

E. Limitations

Limitation for Occupational Benefits

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

Limitation for Pre-existing Conditions

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

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

1. received medical treatment, consultation, care, or services;
2. took prescription medications or had medications prescribed;
or
3. had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care, or treatment.

F. Exclusions

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

1. war, insurrection, or rebellion;
2. active participation in a riot;
3. intentionally self-inflicted injuries or attempted suicide;
4. committing a felony.
5. elective treatment or procedures such as, but not limited to:
 - a. cosmetic surgery or treatment primarily to change appearance
 - b. in vitro fertilization
 - c. embryo transfer procedure
 - d. artificial insemination
 - e. sex-change surgery
 - f. reversal of sterilization
 - g. liposuction
 - h. radial keratotomy

Form G.24303-2

TERMINATION OF COVERAGE

This provision applies to you if you are not Disabled.

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

1. the date This Plan terminates;
2. the date you cease to be an Eligible Employee;
3. the date you stop making any required contributions;
4. the date you go on strike or are locked out; or
5. the date you are laid-off.

Approved Leave of Absence

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

1. the date the Employer stops paying the required premium;
2. the date the leave ends;
or
3. the last day of the month in which your leave of absence begins.

In the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period may be extended for a period agreed to by you and your Employer. It may not exceed 12 weeks following the date the leave begins. Your Employer must continue to pay the required premium.

Reinstatement of Coverage

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

1. If your coverage ends because you cease to be an Eligible Employee, and if you become an Eligible Employee again within 3 months, the Eligibility Waiting Period will be waived. You will not have to provide Evidence of Good Health.
2. If your coverage ends because you cease making the required contribution while on an approved Family Medical Leave Act (FMLA) leave of absence, and you become an Eligible Employee again within 31 days of the earlier of:
 - a. the end of the period of leave you and your Employer agreed upon; or
 - b. the end of the 12 week period following the date your leave began;the Eligibility Waiting Period will be waived and you will not have to provide Evidence of Good Health.
3. In all other cases, if your coverage ends because you fail to make the required contribution, you must provide Evidence of Good Health to become covered again.
4. If you become covered again as described in 1. and 2. above, the Pre-existing Condition Limitation will be applied as if there had been no gap in coverage.

Form G.24303-D

EXTENSION OF BENEFITS

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

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

1. This Plan terminates; or
2. you cease to be an Eligible Employee but required payments are made to us.

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

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

1. your Waiting Period; and
2. payment of any required contributions; and
3. all other applicable provisions of This Plan.

Form G.24303-C

CLAIMS

Notice of Disability

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

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

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

Proof of Disability

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

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

1. it was not reasonably possible to give written proof of Disability during the 6 month period; and
2. proof of Disability satisfactory to us was given to us as soon as was reasonably possible.

Documentation

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

1. the date your Disability started;
2. the cause of your Disability; and
3. the prognosis of your Disability.

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

These will include but are not limited to:

1. proof of continuing Disability;
2. proof you have applied, or are not eligible, for Other Income Benefits. If you do not provide proof you have applied for Other Income Benefits, we may reduce your Weekly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit;
3. proof that you applied for Social Security disability benefits until denied at the Administrative Law Judge level; and
4. proof you have applied for Workers' Compensation benefits or benefits under a similar law. If you do not provide proof that you have applied for these benefits, we may reduce your Weekly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit.

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

Method of Payment

When we determine you are Disabled:

1. Weekly Benefits are paid one week after you qualify for them and on a weekly basis thereafter.
2. Benefits will be paid to you. However, benefits unpaid at your death will be paid to:
 - a. your spouse, if living; otherwise
 - b. your children, if living, divided equally;
 - c. your estate. If benefits are payable to your estate, we may pay up to \$1,500 to someone related to you by

blood or by marriage whom we deem entitled to this amount. We will be discharged to the extent of any payment made in good faith.

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

Right To Recover Overpayments

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

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

1. retroactive awards received from sources shown in the List of Other Income Benefits;
2. fraud; or
3. any error we make in processing your claim.

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

You have the right to appeal any Overpayment recovery.

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

1. any other insurance company;

2. any other organization; or
3. any person to or for whom payment was made.

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

1. reducing or offsetting against any future benefits payable to you or your survivors;
2. stopping future benefit payments (including Minimum Benefits) which would otherwise be due under This Plan. Payments may continue when the Overpayment has been recovered; or
3. demanding an immediate refund of the Overpayment from you.

Legal Actions

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

1. within the 60 days after proof of Disability has been given; or
2. more than three years after proof of Disability must be filed. This will not apply if the law in the area where you live allows a longer period of time to file proof of Disability.

Medical Examinations

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

Incontestability of Coverage

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

No statement of health used by any person to get coverage can be used to declare coverage invalid if the person has been covered under This Plan for 2 years. In order to use a statement of health to deny

coverage before the end of 2 years, it must have been signed by the person. A copy of the signed statement must be given to the person or the person's beneficiary.

Assignment

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

Workers' Compensation

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

Form G.24303-E

**THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS
ADDITIONAL INFORMATION.**

SPECIAL SERVICES

RETURN TO WORK PROGRAM

Goal of Rehabilitation

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

Incentives For Returning To Work

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

Vocational Rehabilitation Services

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

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

1. Vocational Analyses

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

2. Labor Market Surveys

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

3. Retraining Programs

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

4. On-Site Job Analyses

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

5. Job Modifications/Accommodations

Changes in your job or accommodations to help you perform the previous job or a similar vocation, as required of your Employer under the Americans With Disabilities Act (ADA).

6. Training in Job Seeking Skills

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

Rehabilitation Staff

The Case Management Specialist handling your claim will begin the rehabilitation process. You may be referred to our professional Rehabilitation staff that includes Registered Nurses and vocational rehabilitation coordinators. Registered Nurses might address how

your medical condition impacts your ability to return to work. Vocational rehabilitation coordinators will focus on identifying how your abilities can be best applied to either your previous job or a new job.

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

Rehabilitation Vendor Specialists

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

1. Attending physician's evaluation and recommendations;
2. Your individual vocational needs; and
3. Vendor's credentials, specialty, reputation, and experience.

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

THE FOLLOWING IS ADDITIONAL INFORMATION.

ERISA INFORMATION

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE AMERICAN AIRLINES, INC. DISABILITY INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

NAME AND ADDRESS OF EMPLOYER

American Airlines, Inc.
5255 Amon Carter Blvd MD 4412
Ft. Worth, TX 76155

PLAN ADMINISTRATOR NAME, BUSINESS ADDRESS AND PHONE NUMBER

American Airlines, Inc.
Mail Drop 5134-HGC, P.O. Box 619616
DFW Airport, Texas 75261-9616

EMPLOYER IDENTIFICATION NUMBER: 13-1502798

PLAN NUMBER	COVERAGE	PLAN NAME
516	Short Term Disability Benefits	American Airlines, Inc. Employee Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which MetLife is liable for Short Term Disability Benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes seeking payment of benefits, service of legal process may be made upon MetLife by serving MetLife's designated agent to accept service of process.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan. In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

QUALIFIED DOMESTIC RELATIONS ORDERS/QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified

Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Disability Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

For claims for disability benefits, the claimant must report the claim to MetLife and, if requested, complete the appropriate claim form. The claimant must also submit the required proof as described in the "Filing A Claim" section of the certificate.

Claim forms requested by MetLife must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information

from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who

made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria and indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents, including insurance contracts 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 copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare 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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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 which 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 or a medical child support order, you may file suit in a 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but American Airlines, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of American Airlines, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.