AmericanAirlines®

EMPLOYEE BENEFIT COMMITTEE (EBC)
APPLICATION FOR SECOND LEVEL APPEAL: EXCLUDED OR INELIGIBLE EXPENSE

THIS APPLICATION FOR SECOND LEVEL APPEAL SHOULD BE USED TO APPEAL ADVERSE BENEFIT DETERMINATIONS INVOLVING EXCLUDED OR INELIGIBLE EXPENSES UNDER THE PLAN (e.g., EXPERIMENTAL OR INVESTIGATIONAL TREATMENT, SURGICAL CORRECTION OF VISION, COSMETIC TREATMENT OR SURGERY, WELLNESS ITEMS, ALTERNATIVE/COMPLEMENTARY MEDICAL TREATMENT, DENIAL OF FSA CLAIMS, ETC.)

IMPORTANT NOTICE:

YOU MUST COMPLETE THIS FORM AND PROVIDE ALL REQUESTED INFORMATION; OTHERWISE, YOUR APPEAL CANNOT BE ACCEPTED FOR REVIEW BY THE EBC.

In order for the EBC to carefully review the facts and give every consideration to your issue, you must include all of the information requested below. Failure to provide all pertinent documentation may affect the outcome of this review. It is essential that you keep copies of all documentation you submit in support of your Second Level Appeal. The information you submit is provided at your own expense. The records submitted will be retained by the EBC. You must file this Second Level Appeal within 180 days of the date you receive notice of the First Level Appeal determination from the Network/Claim Administrator or Claim Processor; otherwise, your right to further appeal is waived.

Your appeal must include the following:

- Complete, date, and sign this APPLICATION FOR SECOND LEVEL APPEAL (both employee and patient, other than a minor, must sign this Application)
- Attach a copy of the First Level Appeal determination letter you received from the Network/Claim Administrator or Claim Processor
- Explain, in detail, why you believe your issue in question should be approved by the EBC, and why your particular case should not be subject to the Plan's exclusion(s)
- Include all information and documents that you believe support your appeal
- Attach all Explanation of Benefit Statements (EOBs) and all correspondence relating to this issue
- For the service of supply at issue, include a copy of the applicable clinical records—physician's visits, operative report(s), related pathology reports, and if applicable, pre/post-operative photos, visual fields, jaw measurements, etc., depending upon the type of condition(s) or treatment at issue
- Include any published literature and/or documentation, if applicable, related to the service(s) or supply(ies) at issue
- If your appeal involves a Flexible Spending Account (Health Care FSA, Dependent Day Care FSA, Limited Purpose FSA) claims for reimbursement, include copies of all Explanation of Benefits Statements (EOBs) and correspondence from the Claim Processor
- If you experienced any extenuating circumstances that you believe have a bearing on your appeal, include complete and specific details of such circumstances, and provide documentation to support the existence of such circumstances, and how they affected your case
- Other_____

Your failure to provide all pertinent documents may affect the outcome of your appeal review.

THIS WILL BE YOUR ***FINAL*** ADMINISTRATIVE REVIEW; THEREFORE, INCLUDE ALL FACTS AND CIRCUMSTANCES THAT YOU WANT THE EBC TO CONSIDER WHEN IT REVIEWS YOUR SECOND LEVEL APPEAL. AFTER THE EBC RENDERS A DECISION ON YOUR APPEAL, ADDITIONAL OR NEW INFORMATION WILL ***NOT*** BE CONSIDERED. THEREFORE, IT IS IMPERATIVE THAT YOU INCLUDE ANY AND ALL PERTINENT INFORMATION WHEN YOUR SECOND LEVEL APPEAL IS SUBMITTED.

EMPLOYEE'S SECOND LEVEL APPEAL:

The benefit(s) to which I believe I am entitled is/are as follows (describe the type of benefit and the circumstances involving your case, being as specific as you can). Please refer to the specific Plan provision from your **Employee Benefits Guide**, which you believe entitles you to the benefit(s) you are claiming (attach additional pages if needed):

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TOTAL AMOUNT OF APPEAL (IF KNOWN) $_____

By signing this form, I attest to the validity of all information I have provided, and authorize the release of all clinical records and/or information pertinent to the evaluation of my appeal to the Network/Claim Administrator, Claim Processor, and the EBC at American Airlines, Inc., and its agents, including any health care professional selected by the EBC to assist with the appeal review. American Airlines, Inc. is the sponsor and administrator for the group health and welfare benefit plans.

PLEASE PRINT, SIGN, AND DATE THE FOLLOWING:

EE Name:	**Benefit ID#:**
EE#:	**EE Signature:**
SS#:	**Patient Signature:**
Address:	**Date:**
Address:	**Home Phone:**
City:	**Work Phone:**
State:	**Cell Phone:**
Zip:	**Email:**

MAIL (or use express delivery) COMPLETED FORM AND SUPPORTING MATERIALS TO:

FOR USPS REGULAR MAIL DELIVERY	FOR EXPRESS DELIVERY
Employee Benefit Committee	**Employee Benefit Committee**
American Airlines, Inc.	**American Airlines, Inc.**
PO BOX 619616 MD #5134-HDQ1	**4333 Amon Carter Blvd. MD #5134-HDQ1**
DFW Airport, TX 75261-9616	**Fort Worth, TX 76155**
817-967-1412	**817-967-1412**