American Airlines, Inc. Plus Plan for Active Employees
Summary Plan Description Effective January 1, 2022

Table of Contents

Introduction

American Airlines, Inc. (the "Company") is pleased to provide you with this Summary Plan Description ("SPD") which describes the health benefits available to you and your covered family members under the American Airlines, Inc. Plus Plan for Active Employees (the "Plan") effective January 1, 2022.

This SPD provides a comprehensive overview of the medical and prescription drug benefits available under the Plan as well as the limitations, exclusions, Deductible and Co-Insurance requirements that apply to medical and prescription drug benefits. This SPD also describes the Health Reimbursement Arrangement ("HRA"), which is a component of the Plan. Please refer to the American Airlines, Inc. Retiree HRA Plan for details about the Retiree HRA that you may be eligible for due to your enrollment in this Plan.

The terms and conditions of the Plan are set forth in this Summary Plan Description, the formal Plan Document, and all benefits booklets or other formal documents that the Network/Claim Administrator of the Plan creates or relies upon in administering the benefits under the Plan. Together, these documents are incorporated by reference into the formal Plan Document and constitute the written instruments under which the Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Plan.

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

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

The Company, or its authorized delegate, reserves the right to modify, amend or terminate any of the Plans, any program described in this SPD, or any part thereof, at its sole discretion. You will be notified of any changes that affect your benefits, as required by federal law.

There is a "Glossary" at the end of this SPD that defines capitalized terms and how they apply to the benefits described in this SPD.

Eligibility and Enrollment

Eligible Employees

Generally, all active, full-time or part-time employees on U.S. Payroll of American Airlines, Inc. are eligible for the Plan, except for any individual or employee specifically listed as ineligible in the "Ineligible Employees" section below.

Ineligible Employees

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

- **A leased employee, as defined in section 414(n) of the Internal Revenue Code.** This includes any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service ("IRS"), or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker. This term includes any of the following former classifications:
    - **Temporary employee.** If a temporary worker becomes a Regular Employee, and meets all of the other requirements to participate in the Plan without a break in service, the time worked as a full-time temporary worker will be credited solely toward the eligibility requirement for the Plan. Under no circumstances will time worked as a temporary worker entitle the individual to retroactive coverage under the Plan.
    - **Provisional employee.**
    - **Associate employee.**
- An independent contractor.
- Any person:
    - Who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion);
    - Who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate; or
    - Who tells the Company he/she is an independent contractor, or is employed by another company while providing services to the Company, even if the worker is, or may be reclassified at a later date as, an employee of the Company by the courts, the IRS or the DOL.

Eligibility in the Plan for Active Employees After Age 65

As long as you are working as an active employee for American Airlines, Inc., you are eligible for health and welfare benefit plan coverage irrespective of your age—even if you're age 65 or older. When you reach age 65 (or your Spouse reaches age 65), you (or your Spouse) must process a Life Event if you want Medicare to be your only coverage. Please see the "Life Event" section for information about how to process a

Life Event. If you elect Medicare as your only coverage, your Company-sponsored active medical coverage will terminate, including coverage for your Eligible Dependents. If your Spouse elects Medicare as his or her only coverage, only your Spouse's Company-sponsored active medical coverage will terminate. Please see the Retiree Benefit Guide for information about retiree medical benefit coverage under the American Airlines, Inc. Group Life and Health Plan for Retirees and the American Airlines, Inc. Supplemental Medical Plan. Please see the American Airlines, Inc. Retiree HRA Plan for information about the Retiree HRA you may be eligible for due to your enrollment in this Plan.

Dependent Eligibility

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

- Spouse or Common Law Spouse.
- Child until the end of the month he/she turns 26 (as defined below in the Determining a Child's Eligibility section).
- Disabled Dependent Child age 26 or over, as defined below under "Coverage for a Disabled Dependent Child."
- Child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Coverage for a Disabled Dependent Child

Below you will find the critical steps that you, as the employee, are required to take to request disability status for your dependent Child.

A "Disabled Dependent Child" age 26 or older is eligible for continuation of coverage if all of the following criteria are met:

- The Child is mentally or physically incapable of self-support and was deemed mentally or physically incapable of self-support prior to turning age 26.
- You complete and return the "Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability" to the American Airlines Benefits Service Center prior to the date coverage would otherwise end, or if the child is not in coverage within 60 days of your qualifying Life Event (such as marriage or loss of coverage).
- The American Airlines Benefits Service Center will review your request for administrative eligibility, then forward your request to your Network/Claim Administrator for medical review of the application for

approval.

- The Child continues to meet the criteria for dependent coverage under this Plan.
- You provide additional medical proof of disability as may be required from time- to-time when requested. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your Network/Claim Administrator determines the Child is no longer disabled. If you elect to drop coverage for your Child, you may later reinstate it if requested within 60 days of your qualifying life event (such as loss of coverage).
- Either the Child maintains legal residence with you and is wholly dependent on you for maintenance and support, or you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Determining a Child's Eligibility

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

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Spouse or Common Law Spouse as defined by the Plan
- Stepchild
- Special Dependent, if you meet all of the following requirements:
    - You or your Spouse must have legal custody or legal guardianship of the child. (It is not necessary for your Spouse to be covered under the Plan in order for a child for whom your Spouse has legal custody or legal guardianship to be eligible).
    - The child must maintain legal residence with you and be wholly dependent on you for maintenance and support.
    - You must submit a Statement of Dependent Eligibility for Special Dependent Form to the 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 60 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by American Airlines Benefits Service Center. If you submit the request after the 60-day time frame, the child will not be added to your coverage.

- QMCSO Dependent: A child for whom you are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency.

Parents or Grandchildren

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

Dependents of Deceased Employees

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

Your covered dependents are also eligible to continue coverage for up to 36 months under COBRA Continuation Coverage at the full COBRA rate, if they had these benefits at the time of your death. If your covered dependents elect COBRA Continuation Coverage, the 90 days of coverage provided at no contribution cost immediately after your death are part of the 36 months of COBRA coverage. See the "COBRA" section for further information.

If you are over age 55 but not yet 65, or a Pilot and over age 50 but not yet 65 and working as an active employee with 10 or more years of seniority, your surviving Spouse may be eligible for retiree medical benefits if you would have been eligible for retiree medical benefits if you had been retired on your date of death. See the Retiree Benefit Guide for further information.

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

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

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

- **Spouse (SP)**: Your Spouse means an individual who is lawfully married to the employee and not legally separated. An individual

shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.

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

Proof of Dependent Eligibility

If you:

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

you must submit proof of the dependents' eligibility to American Airlines Benefits Service Center within 31 days of the date the documentation is requested by the American Airlines Benefits Service Center. Examples of proof demonstrating your dependents' eligibility for coverage include: official government-issued birth certificates, adoption papers, marriage licenses, etc.

Requests for proof of your dependents' eligibility will be provided via email, phone calls and/or paper correspondence mailed to your address on file. Failure to respond to these requests within 31 days will result in your request to add coverage for your dependents being denied. **Important:** It is your responsibility to respond to the emails, phone calls, and/or paper correspondence you will receive within the 31-day timeframe. Coverage will not be in place until you have timely requested their enrollment and provided satisfactory proof of eligibility. If such proof is timely provided, enrollment and coverage will be retroactive to the date of the event (i.e. Marriage, Birth, or Hire Date).

American Airlines, Inc. reserves the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions

may result in termination of Plan coverage and efforts to recover any overpaid benefits will be made.

Married Employees and Dependent Children Whose Parents are Employees

When two employees are married to each other they are referred to as "Married Employees" for this section. Employees cannot be covered as employees under more than one medical benefit sponsored by American Airlines, Inc. Therefore, Married Employees have the option of being covered either: (1) as an employee and a dependent Spouse under the Plan; or (2) separately as individual employees each without a dependent Spouse under their own Plan benefits.

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

During Annual Enrollment:

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

The Health Reimbursement Arrangements will be maintained independently.

Change in employment: If Married Employees choose to maintain separate benefits and one of them ends his or her employment with the Company, the individual who terminates his or her employment is eligible for coverage as a dependent Spouse.

Active employees married to retiree dependents: Retiree dependents married to active employees are only eligible for coverage as dependents of active employees if they are *not* enrolled in retiree medical benefits sponsored by the Company. The benefits available and benefit limits, if any, are defined by the active employee's coverage.

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

If the Married Employee on leave elects to be covered as the Dependent of his or her actively working Married Employee, then the actively working Married Employee's health coverage determines the health benefit coverage for all dependents, including the Married Employee on leave. Because the termination of the Spouse's coverage is a Life Event (see the Life Events section), the actively working Married Employee may make changes to his or her other coverages.

The actively working Married Employee may elect to:

- Add the Spouse on leave as a dependent
- Cover only Eligible Dependent Children
- Cover both the Spouse and Children
- Enroll himself or herself, and the Spouse and Children as dependents.

If the Spouse on leave is covered as a dependent during the leave of absence, the following conditions apply:

- Provided the Spouse on leave makes Timely Payments for benefits, Company- provided coverage (where the Company pays its share of the cost and the Spouse on leave pays his/her share) will continue for the timeframe allowed based upon Company policy or Joint Collective Bargaining Agreement during a leave of absence for family, sick, injury-on-duty or maternity leaves.

Eligible Dependent Children:

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

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

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

When Coverage Begins

New Employees

New Employee Enrollment

As a new employee, you will receive information shortly after you begin working regarding enrollment in the Plan. You have **60 days** from your Hire Date to enroll in the Plan and you may elect coverage for yourself and your Eligible Dependents (see the Dependent Eligibility section).

When Coverage Begins as a Newly Hired Employee

If you enroll by the enrollment deadline, your selected coverage is retroactive to your Hire Date and your paycheck is adjusted as necessary.

Coverage under the Plan will not begin until: (i) you have reported to your first day of work, and (ii) except as otherwise noted, you are "actively-at-work." "Actively-at-work" means you are at work and performing all of the regular duties of your job.

The "actively-at-work" requirement does not apply if the reason you are not actively-at-work is due to a health condition; in that event, your coverage is effective on your Hire date as long as you have reported to your first day of work.

Current Employees

Annual Enrollment

Each year, eligible employees have the opportunity to select benefits for the upcoming Plan Year — January 1 through December 31. During Annual Enrollment you can:

- Enroll for coverage,
- Add or remove a dependent from coverage - you have 31 days to submit required documentation to verify your dependents to the American Airlines Benefits Service Center after such information is requested,
- Make changes to your prior elections, or
- Continue your previous elections at the applicable new rates (if available).

When Coverage Begins as a Current Employee

When you enroll during the Annual Enrollment Period, your selected coverage (or default coverage) begins on January 1 and continues through December 31 (the Plan Year) as long as you continue to be eligible for the Plan as described in the "Employee Eligibility" section and satisfy other Plan requirements, such as Timely Pay premiums

How to Enroll

All employees enroll using the online enrollment tool — the American Airlines Benefits Service Center. Visit my.aa.com for information on enrolling.

The American Airlines Benefits Service Center
The American Airlines Benefits Service Center (the online enrollment tool) on my.aa.com reflects the current benefits coverages available to you and the rates for those coverages. The American Airlines Benefits Service Center is updated during Annual Enrollment with your benefit options and the new rates for the upcoming Plan Year – January 1 through December 31.

Benefits continuation if you go on a leave of absence

Eligibility During Leaves of Absence and Disability

You may be eligible to continue coverage under the Plan for yourself and your Eligible Dependents for a period of time during a leave, subject to the specific rules on Jetnet. The type of leave you take determines the cost of your benefits (i.e., whether you and the Company share the cost of the benefits or you pay the full cost of benefits). In order to continue your benefits during a leave of absence, you must Timely Pay the required contributions for your benefits during your leave. The due date will be noted on your billing statement. You may also be able to elect COBRA continuation coverage, as described later in this document.

Your leave of absence begins on the effective date indicated on your HR record, which is submitted to reflect that you are on a leave of absence.

An unpaid leave of absence is considered a Life Event (see the Life Events section), and you may make changes to your coverage. Once you record your Life Event and benefit elections on the American Airlines Benefits Service Center, it will display a confirmation statement showing your choices, the monthly cost of benefits, covered dependents, etc.

If you elect not to continue your benefits during your leave of absence or if you fail to Timely Pay for your benefits, your benefits will terminate for the duration of your leave of absence. When you return to active employee status, you may reactivate your benefits.

Continuation of Coverage for Employees in the Uniformed Services

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

While you are on military leave, your benefit coverage or the cost of that coverage will not change, unless there is an increase applicable to your workgroup.

If you choose not to continue your medical coverage while on military leave, you are eligible for reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days

The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Domestic U.S. Policies, which is available via Jetnet.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to twelve weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time, at the same contribution level that applied prior to the leave. Other applicable laws (*e.g.*, state laws) may also require the Company to allow employees to continue their elected medical coverage during leave for certain family and medical situations.

In order to continue your benefits during a leave of absence, you must Timely Pay the required contributions for your benefits during your leave.

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

Generally, your contributions for benefits elected under the Plan are taken from your paycheck on a pre-tax basis automatically, without any required action from you. However, in certain circumstances, such as if you reduce your hours, your paycheck may not be sufficient to pay the required contributions. In order to continue your benefits when your paycheck is not sufficient to pay required contributions, you must Timely Pay the required contributions for your benefits through another method (e.g., a personal check). You will receive a billing statement if this occurs, and the due date will be noted on your billing statement.

If at any time you fail to Timely Pay for your benefits, your benefits may terminate and you may not resume participation in the Plan until the earliest of: (i) a HIPAA Special Enrollment Event (including Special Enrollment for Medicaid and CHIP) that allows you to enroll, or (ii) the next Plan year.

Making Changes During the Year

When the new benefit year begins on January 1, you may only change your elections if you experience one of the following events described below: HIPAA Special Enrollment Events (including Special Enrollment for Medicaid and CHIP) and Life Events.

HIPAA Special Enrollment Events

If you declined coverage for you or your dependents because you or they have medical coverage elsewhere and one of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your dependents in the Plan, in which case coverage will be effective the date of the event:

- You and/or your dependents lose eligibility for other medical coverage for reasons that include legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
- The employer contributions to the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.
- You and/or one of your dependents exhaust a lifetime maximum in another employer's health plan or other health insurance coverage, where permitted by law.
- You and/or one of your dependents' employers cease to offer benefits to the class of employees through which you (or one of your dependents) had coverage
- You and/or one of your dependents were enrolled under an HMO or other group or individual plan or arrangement that will no longer cover you (and/or one of your dependents) because you and/or one or your dependents no longer reside, live or work in its service area

In addition, you may enroll yourself and/or your dependents in the Plan if one of the following events occurs:

- You have a new dependent as a result of your marriage or common law marriage, your child's birth, adoption or placement for adoption with you. In the case of these events, coverage is retroactive to the date of the event.

As an employee, you may enroll yourself and request enrollment for your new Spouse or Common Law Spouse and any new Dependents within 60 days of your marriage or declaration. You may request enrollment for a new Child within 60 days of his or her birth, adoption or placement for adoption. If you miss the 60 day deadline, you are not able to enroll and you will have to wait until the next Annual Enrollment period to enroll yourself and/or your Dependent. In addition, you must submit proof of the dependents' eligibility to American Airlines Benefits Service Center within 31 days of the date the documentation is requested by the American Airlines Benefits Service Center.

You must already be enrolled or enroll yourself in benefits in order to elect coverage for your Dependents. If your Spouse or Common Law Spouse is not enrolled in the Plan on the date of birth, adoption, or placement for adoption of a Dependent, you may enroll yourself and request enrollment for your Spouse or Common Law Spouse in the Plan when you enroll a Child due to birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact American Airlines Benefits Service Center (see Contact Information).

Special Enrollment for Medicaid and CHIP

An employee and/or Eligible Dependent may enroll in the Plan if he or she is no longer eligible for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act, if the employee and/or Eligible Dependent requests coverage under the Plan within 60 days after the date of termination from this Medicaid/CHIP coverage. Such coverage shall be effective on the date of the event.

In addition, an employee and/or Eligible Dependent may enroll in the Plan if he or she becomes eligible for assistance under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act, where such assistance will be provided through the Plan, if the employee and/or Eligible Dependent requests coverage under the Program within 60 days of the date that he or she is determined to be eligible for assistance. Such coverage shall be effective on the date of the event. If you and/or your Dependent(s) are currently enrolled in the Plan, you have the option of terminating the enrollment of you and/or your child(ren) in the Plan and enroll in Medicaid or a state child health plan. Please note that, once you terminate your enrollment in the Plan, your children's enrollment will also be terminated.
Failure to notify the Company of your loss or gain of eligibility for coverage under Medicaid or a state children's health plan within 60 days will prevent you from enrolling in the Plan and/or making any changes to your coverage elections until the next annual enrollment period or Life Event.

Life Events

You also may change certain elections mid-year if you experience a Life Event and your change is consistent with that event. Allowable changes vary by the type of Life Event you experience.

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

When you experience a Life Event, remember these guidelines:

- Most Life Events are processed online through the American Airlines Benefits Service Center. Visit Life Events on Jetnet for a complete list of all Life Events and the correct procedures for processing your changes.
- If you register your Life Event within 60 days of the event (as applicable), your changes are retroactive to the date the Life Event occurred.
- The Company reserves the right to request documented proof of dependent eligibility criteria for benefits at any time. If you do not provide proof of eligibility when requested, or if any of the information you provide is not true and correct, your actions may result in termination of benefits coverage.
- Any change in your cost for coverage applies on the date the change is effective. Retroactive contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.

If You Experience the Following Life Event…	Then, You May be Able to…
You become eligible for Company-provided benefits for the first time	Enroll online through the American Airlines Benefits Service Center.
Your Spouse or Eligible Dependent Child dies	• You lose a Spouse or Eligible Dependent Child: Stop coverage for your lost Spouse/Eligible Dependent Child (dependent coverage may be subject to QMCSO). Start coverage for yourself or your Eligible Dependent Child if the loss of your Spouse results in loss of eligibility under your Spouse's plan • You gain a Spouse/Eligible Dependent Child: Start coverage for yourself, your Spouse and/or your Eligible Dependent Child. Stop coverage for yourself and/or your Eligible Dependent Child if you gain coverage under new Spouse's plan. • Change in your, your Spouse's or your Eligible Dependent Child's employment: If you/your Spouse or your Eligible Dependent Child gain eligibility under the other employer's plan, you can drop yourself, your Spouse, and/or your Eligible Dependent Child. If you/your Spouse or your Eligible Dependent Child lose eligibility or employer contribution under the other employer's plan, you can add yourself, your Spouse, and/or your Eligible Dependent Child.
You or your Spouse gives birth to or adopts a Child or has a Child placed with you for adoption or you gain an Eligible Dependent(s) • To add a natural child to your coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth if your name is listed as a parent. You should not wait to receive the baby's Social Security number or official birth certificate. These documents may take more than 60 days to arrive and prevent you from starting coverage effective on the baby's birth date. • To add an adopted child to your benefit coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective the date the child is placed with you for adoption and is not retroactive to the child's date of birth.	
You get legally married (including common law marriage), divorced, legally separated, or have your married annulled	
You change your employment with an employer other than the Company OR Change in Spouse's Eligible Dependent Child's employment or other health coverage OR Your Spouse's Eligible Dependent Child's employer no longer contributes toward health coverage OR Your Spouse's/Eligible Dependent Child's employer no longer covers employees in your Spouse's/Eligible Dependent Child's position	

If You Experience the Following Life Event…	Then, You May be Able to…
Your covered Eligible Dependent Child no longer meets the Plan's eligibility requirement, i.e.: • If the dependent attains the age at which he/she is no longer eligible to be covered as your Eligible Dependent • If the dependent marries and enrolls in his/her Spouse's employer group health plan	• Stop coverage for your Spouse/Eligible Dependent Child (dependent coverage may be subject to QMCSO). **Additionally:** • Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible Dependent's address.
Your benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant") OR Your contribution amount is significantly increased or decreased by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")	• The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMCSO) that requires you to provide health care coverage for a Child	• Start coverage for yourself • Start coverage for your Eligible Dependent Child named in the QMCSO
You, or your Eligible Dependents enroll in Medicare or Medicaid or CHIP coverage	• Stop coverage for you or the affected Eligible Dependent.
You, or your Eligible Dependents lose Medicare, Medicaid or CHIP coverage	• Start coverage for yourself and the affected Eligible Dependent.
You, or your Eligible Dependents become eligible for Medicaid or CHIP coverage	• Start coverage for yourself and the affected Spouse or Eligible Dependent Child.

If You Experience the Following Life Event…	Then, You May be Able to…
You, your Spouse or your Eligible Dependent Child become eligible for/lose eligibility for and become enrolled/dis-enrolled in government-sponsored Tricare coverage	• Start coverage for yourself if you lose eligibility • Stop coverage for yourself if you gain eligibility • Start coverage for your Spouse if he/she loses eligibility • Stop coverage for your Spouse if he/she gains eligibility • Start coverage for your Eligible Dependent Child if he/she loses eligibility • Start coverage for your Eligible Dependent Child if he/she gains eligibility
You start an unpaid leave of absence	Access the American Airlines Benefits Service Center to register your "Going on Leave of Absence" Life Event and update your benefit elections. A confirmation statement showing your choices, the monthly cost of benefits, etc. will display. **Your cost depends on:** The type of leave you are taking • Stop coverage • Stop Spouse coverage • Stop Eligible Dependent Child coverage
You return from an unpaid leave of absence	If you did not continue payment of your benefits during your leave and wish to reactivate your benefits upon your return to work, you may do so. Access the American Airlines Benefits Service Center, register your "Return to Work" Life Event and make selections or changes to your benefits. If you return within 30 days, you will be placed back in the elections you were in prior to your leave unless you experience another change in status event. • Start/Resume coverage for yourself • Start coverage for your Spouse • Start coverage for your Eligible Dependent Child

If You Experience the Following Life Event…	Then, You May be Able to…
You or your Eligible Dependent are newly eligible for COBRA	• Change Plan benefits
You die	**Continuation of Coverage:** Your Eligible Dependents can either contact your manager/supervisor or a survivor support representative at the American Airlines Benefits Service Center to assist with all benefits and privileges, including the election of continuation of coverage, if applicable.
You end your employment with the Company or you are eligible to retire	**Review: "**When Coverage Ends" in the *Eligibility and Enrollment* section. **Review:** The information you receive regarding continuation of coverage through COBRA. **Contact:** American Airlines Benefits Service Center for information on retirement.
You transfer to another workgroup	• Changes are allowed only to the extent that the change in workgroup affects benefit eligibility • Start/Stop coverage for yourself, your Spouse and/or your Eligible Dependent Child (dependent coverage may be subject to QMCSO).
You, your Spouse, and/or your Eligible Dependent Child declined the Company's medical coverage because you or they had coverage elsewhere (external to the Company), and any of the following events occur: • Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause) • Employer contributions for the other coverage stopped • Other coverage was COBRA and the maximum COBRA coverage period ended • Exhaustion of the other coverage's lifetime maximum benefit • Other employer-sponsored coverage is no longer offered • Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your Eligible Dependents no longer reside, live, or work in its service area	• Start coverage for yourself ○ Note that you must enroll in the coverage in order to elect coverage for your Eligible Dependent Child • Start coverage for your affected Spouse • Start coverage for your affected Eligible Dependent Child

If You Experience the Following Life Event…	Then, You May be Able to…
You, your Spouse, or your Eligible Dependent Child enroll in other employer-sponsored coverage.	You may make the following changes if they are on account of, and correspond with, the change made under the other employer-sponsored coverage: • Stop coverage for yourself, Spouse, and Eligible Dependent Child
You, your Spouse, or your Eligible Dependent Child stop coverage under other employer- sponsored coverage.	You may make the following changes if they are on account of, and correspond with, the change made under the other employer-sponsored coverage: • Start coverage for yourself, Spouse, and Eligible Dependent Child

If Your Dependent(s) Lose Eligibility Under the Plan But You Process Your Life Event after the Deadline

If your dependent(s) lose eligibility under the Plan (e.g. divorce), you must register a Life Event or contact American Airlines Benefits Service Center to remove the ineligible Dependent(s) from your coverage — even if you have missed the 60-day deadline.

If you contact American Airlines Benefits Service Center after the 60-day deadline, you will be able to remove your dependent(s) from coverage, but the effective date is the loss of eligibility date (e.g. legal effective date of the divorce).

You will 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. In addition, the coverage for your dependent(s) will be retroactively terminated and any claims paid under the Plan will be reversed.

Important: If you do not register 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.

COBRA coverage or, for those enrolled in this Plan or another Company-sponsored medical plan, premiums for medical care insurance purchased on the healthcare exchange or the individual market (if you are not enrolled in a Company-sponsored medical plan you may not receive reimbursement for medical care insurance);

If you are enrolled in Medicare, Medicare Part A expenses and premiums for Medicare Part B, Medicare Part D and supplemental plans as well as out-of-pocket medical expenses not covered by Medicare;

If Your Dependents Gain Eligibility Under the Plan But You Process Your Life Event after the Deadline

If you miss the 60 day deadline and the event occurred in the current year, you must wait until the next Annual Enrollment Period to add your dependents or experience another Life Event.

If you miss the 60 day deadline and the event occurred in the previous year, you may add dependents to your file but you may not cover them under your benefits or make any changes to existing dependents. (Adding the dependent to your file lists the dependent as eligible to be enrolled at the next Annual Enrollment, but does not enroll him or her in benefits currently.)

When Coverage Ends

Coverage for you and your dependents will automatically terminate on the earliest of:

- The day that your employment ends;
- The date the Plan terminates;
- The last day for which required contributions were paid;
- The date you or a dependent is no longer eligible for this coverage;
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan.

Your surviving Spouse will be ineligible for coverage on the date he or she remarries.

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 Plan coverage for up to 36 months under COBRA Continuation Coverage at the full COBRA rate, if they had these benefits at the time of your death. The 90 days of coverage are part of the 36 months of COBRA coverage. See the "COBRA" section for further information.

Expenses incurred after the date your coverage (or your dependents' coverage) terminates are not eligible for reimbursement under the Plan.

Medical Benefits

Medical Benefits Overview

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

You may choose from the following coverage levels:

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

If you waive coverage, your dependents cannot be enrolled in coverage. See the Eligibility section for additional rules.

Network/Claim Administrator

A Network/Claim Administrator is the administrator for the Plan that processes health care claims, determines Medical Necessity, and manages a Network of health care Providers and care facilities.

Network/Claim Administrator Responsibilities

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.

Please note that groups of providers (such an association of physicians or clinics) may have some providers that are In-Network Providers and other providers that are Out-of-Network Providers. Just because some providers in the group are In-Network does not mean all providers in the group are In-Network.

Who is my Network/Claim Administrator

The medical portion of the Plan is administered by two Network/Claims administrators:

- Blue Cross and Blue Shield of Texas (BCBS)
- UMR

How the Plan Works

The Plan offers a Network of preferred Physicians, hospitals and other medical service Providers that have agreed to charge negotiated rates for covered medical services. However, you may use any qualified licensed Physician.

If you use an In-Network Provider, the Plan will pay your covered medical expenses at a higher level of benefit. When you use an In-Network Provider, you pay only a (i) Co-Pay or (ii) Deductible and Co-Insurance for most services.

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.

If you choose to use an Out-of-Network Provider, the payment will be calculated based on the Maximum Out-of-Network Charge (MOC), and the Plan will pay your covered medical expenses at a lower level of benefit compared to the In-Network rate. After you meet the annual Out-of-Network Deductible, the Plan pay 60 percent of Out-of-Network eligible expenses, up to the MOC, for most Medically Necessary services. The MOC is the amount that your Network/Claims Administrator will use in determining how much the Plan will pay toward out of Network services.

- **MOC for Out-of-Network Providers:** Except as provided under ERISA section 716 (which applies to certain emergency services and certain charges from nonparticipating providers practicing in provider facilities), the MOC for individual Out-of-Network Providers is either a rate negotiated by the Network/Claims Administrator, or, if no negotiated rate exists, 140 percent of the rate that the federal Medicare program would pay for the service.
- **MOC for Out-of-Network Facilities:** except as provided under ERISA section 716 (which applies to certain emergency services and certain charges from nonparticipating providers practicing in provider facilities), the MOC for Out-of-Network facilities will be limited to 140 percent of the amount the federal Medicare program would have paid

for the same service, or an amount based on 60 percent of the reasonable and customary charge as determined by your Claims Administrator using its internal claims databases.

Your Network/Claims Administrator will determine the MOC based on this formula. In addition to the percentage of Co-Insurance 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 the MOC.

In the following rare instances, the payment is determined according to the following rules, 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 Plan will treat 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 Plan will treat the Out-of- Network Provider's full billed charge as an eligible expense.
- If the claim is for care in a "clinical gap", the Plan will treat the Out-of-Network Provider's full billed charge as an eligible expense, as long as In- Network Providers in the area with the same credentials cannot provide the specific treatment that a patient needs.
- If the Network/Claim Administrator is unable to determine the MOC based on Medicare reimbursements, the Plan will treat 75 percent of the Network/Claim Administrator's contracted In-Network rate (i.e. the average for the region/market) as an Eligible Expense for an Out-of-Network Provider.

The following rule applies to services rendered by an anesthesiologist, radiologist, or pathologist:

- If you receive care from an Out-of-Network anesthesiologist, radiologist, or pathologist at an In-Network facility, and you have no control over choosing the anesthesiologist, radiologist, or pathologist, then the Plan will reimburse the Out- of-Network anesthesiologist, radiologist, or pathologist using the In-Network benefit level.

Go online for more information and to access a list of In-Network Providers.

Cost-Sharing

Note: All of the medical services and supplies described in the Schedule of Medical Benefits chart below must be Medically Necessary in order to be covered by the Plan.

See the Glossary for the definition of Medically Necessary.

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

Important Facts For You To Know About The Plan Chart...	
Co-Insurance	This is the percentage of covered expenses that you're required to pay. When you see a percentage referenced in the Plan 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 Plan chart, it is the Co-Pay that is your financial responsibility. This amount is applied to your Out-of-Pocket Maximum, but not to your Deductible.
Deductible	For most covered expenses, you must meet the Plan'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. This includes preventive services and Co-Pays, except Co-Pays for the emergency room. The Plan 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. Co-Pays for covered expenses do NOT count toward your satisfaction of the Deductible for the calendar year. **Facts about the family annual Deductible:** The family Deductible limits apply if more than one person is covered in the Plan. The family Deductible is satisfied when you have paid all your, and your covered dependents', covered expenses equal to the individual Deductible for each covered person. If there are two (2) people covered then, each person must reach the individual Deductible amount before the family Deductible is satisfied and then the Plan will begin to pay its percentage of the covered expenses. If there are three (3) or more people covered under your family coverage,

	three (3) members of your family have to reach the individual Deductible amount before the family Deductible is satisfied and then the Plan will begin to pay its percentage of the covered expenses. You do not have to meet the family Deductible amounts under the Plan in order for the Plan to begin paying its percentage for a family member that has met his/her individual Deductible.
Medical Necessity	ALL of the medical services and supplies described in the Plan chart must be Medically Necessary in order to be determined to be covered expenses. If those services and supplies are not Medically Necessary, they cannot be covered by the Plan. See the Glossary for the definition of Medical Necessity.
Out-of-Pocket/Out-of-Pocket Maximum	This is the portion of covered expenses that you have to pay each Plan Year before expenses are payable at 100 percent. Out-of-Pocket Maximum never includes expenses that are excluded from coverage, or expenses that exceed the Maximum Out-of-Network Charge limits for Out-of-Network services. **Facts about the individual Out-of-Pocket Maximum:** • Only each covered individual's portion of covered expenses can be used to meet his/her individual annual Out-of-Pocket Maximum. **Facts about the family Out-of-Pocket Maximum:** • In families consisting of two (2) members, each person must reach the individual Out-of-Pocket Maximum before his or her expenses are payable at 100 percent. • In families consisting of three (3) or more members, if the family Out-of-Pocket Maximum is met cumulatively, expenses are payable at 100 percent for all members of the family even if the individual Out-of-Pocket Maximums have not been met by each member.

Schedule of Medical Benefits		
Annual (Calendar Year) Deductibles and Out-of-Pocket Limits		
	In-Network	**Out-of-Network**
Individual Coverage Annual Deductible	$1,500	$3,000
Family Coverage Annual Deductible	$4,500	$9,000
Individual Coverage Annual Out-of-Pocket Maximum	$4,500	$9,000
Family Coverage Annual Out-of-Pocket Maximum	$9,000	$18,000
Individual medical maximum benefit	Unlimited	
Preventive Care		
ACA preventive care	No cost to you	40% Co-Insurance
COVID-19 preventive services[1] See "Covered Expense" section for details and limitations.	No cost to you	No cost to you
Medical Care		

[1] This information is current during the public health emergency declared by the Secretary of Health and Human Services as a result of COVID-19.

Physician's office visit (including X-ray, lab work, injections and in office surgery)	$25 per visit	40% Co-Insurance
Telehealth office visit Provided by Doctor on Demand or the Network Administrator	$20 per visit	Not applicable
Specialist's office visit (including X-ray, lab work, injections, and in office surgery)	$45 per visit	40% Co-Insurance
Retail/ Convenience Clinic visit (i.e., clinics inside of retail pharmacies.) Including lab, x-ray and other charges	20% Co-Insurance	40% Co-Insurance
Urgent Care Clinic, lab, x-ray, and other charges made by the Urgent Care clinic An Urgent Care Clinic does not include an independent freestanding emergency department, as that term is used in ERISA section 716.	20% Co-Insurance	40% Co-Insurance
Chemotherapy/Radiation/Infusions	20% Co-Insurance	40% Co-Insurance

Speech, physical, occupational, restorative and rehabilitative therapy Educational Services are not covered	20% Co-Insurance	40% Co-Insurance
COVID-19 Tests and Related Services[2] See "Covered Expense section for details and limitations.	No cost to you	No cost to you
Outpatient Services (not in a Physician office setting or a hospital)		
Diagnostic X-ray and lab (for non-urgent, non-immediate and non-emergent care)	No cost to you if performed at Physician's office or non-hospital imaging center/lab 20% if at hospital	40% Co-Insurance
Outpatient surgery	20% Co-Insurance	40% Co-Insurance
Hospital Services		
Inpatient room and board	20% Co-Insurance	40% Co-Insurance

[2] This information is current during the public health emergency declared by the Secretary of Health and Human Services as a result of COVID-19.

Surgery	20% Co-Insurance	40% Co-Insurance
Emergency Ambulance	20% Co-Insurance 40% Co-Insurance Non-Emergencies	20% Co-Insurance; 40% Co-Insurance Non-Emergencies
Emergency Room If you're admitted to the Hospital as an Inpatient directly from the Emergency Room, the Emergency Room Co-Pay is waived.	$200 Co-Pay + 20% Co-insurance	$200 Co-Pay + 20% Co-insurance
Out-of-Hospital Care		
Convalescent and Skilled Nursing Facilities following hospitalization Within 15 days of hospitalization. Maximum of 60 days per episode, as long as the individual is enrolled in an American Airlines Medical Plan.	20% Co-Insurance	40% Co-Insurance
Home Health Care Maximum of 40 services	20% Co-Insurance	40% Co-Insurance
Hospice Care	20% Co-Insurance	40% Co-Insurance
Other Services		

Supplies, equipment and Durable Medical Equipment (DME) Your cost is the Co-Insurance shown, regardless of where the device is purchased, and is *in addition to* any Physician's visit costs you're required to pay.	20% Co-Insurance	40% Co-Insurance
		Mental Health and Chemical Dependency Benefits
Inpatient mental and chemical dependency health care	20% Co-Insurance	40% Co-Insurance
Alternative Mental Health Care Center – intensive Outpatient and partial hospitalization	20% Co-Insurance	40% Co-Insurance
Outpatient mental health care	No cost to you	40% Co-Insurance
Marriage/ Couple/ Family Therapy	No cost to you	40% Co-Insurance

Covered Expenses

The Plan pays benefits for covered expenses, which are charges for procedures, services, equipment and supplies that are defined under the Plan as:

- Medically Necessary (as defined in the Glossary)
- Not excluded under the Plan – see "Excluded Expenses" later in this chapter, and
- Not in excess of Plan limits.

Some covered expenses may also require prior authorization. See "Prior Authorization" later in this chapter for more details. Some services are also subject to specific restrictions and limitations in addition to Co-Pay/Co-Insurance requirements, as described below. Please note that the services listed below are not an exhaustive list of covered services. Covered services include, but are not limited to, the services listed below. If you have a question on the coverage of a particular service, please contact the Network/Claim Administrator. The limitations and restrictions described below are in addition to other Plan rules, including Co-Pay/Co-Insurance and exclusions.

- **Applied Behavior Analysis (ABA) Therapy**: ABA Therapy is an Educational Service under the Plan. The Plan covers ABA Therapy for autism spectrum disorder. Even though these are educational in nature, these services must be Medically Necessary. In the case of ABA Therapy, the Plan will cover services that are provided by a licensed ABA provider, that are habilitative in nature and that are backed by credible research demonstrating that the services have a measurable and beneficial effect on the patient's health outcomes. You are required to obtain a Prior Authorization for ABA Therapy.
- **Acupuncture**: Treatment for illness or injury (performed by a certified acupuncturist) for diagnosed illness or injury, only when acupuncture treatment has been proven to be both safe and effective treatment for such diagnosed illness or injury. (Coverage does not include acupuncture treatment for conditions in which the treatment has not been proven safe and effective such as: glaucoma, hypertension, acute low back pain, infectious disease and allergies.)
- **Allergy care:** Charges for Physician's office visits, allergy testing, shots and serum are covered.
- **Ambulance:** Professional ambulance services and air ambulance 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 your Network/Claim Administrator authorizes the transfer

Note: 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:** To determine whether an assistant surgeon is considered Medically Necessary, use the CheckFirst Pre-determination procedure.
- **Bariatric Surgery:** The Plan covers Bariatric Surgery. Prior Authorization is required. If you do not pre-authorize you might be subject to a $250 penalty, and you may be responsible for the full amount of the charges for the procedure or service if you do not meet the requirements for the surgery. This is a limited, one- time benefit for the entire time the patient is covered under an American Airlines Medical Plan. Bariatric Surgery includes Gastric Bypass (Roux-en-Y), Lap band, Gastric Sleeve and Duodenal Switch. To be eligible for Bariatric Surgery, the patient must be 18 years of age or older.
- **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 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.
- **Clinical Trials.** Routine patient costs otherwise covered by the Plan that are associated with participation in phases I-IV of Approved Clinical Trials (as further defined in the Glossary) (i.e., clinical trials that are federally funded and certain drug trials) to treat cancer, ALS or other Life-Threatening Conditions, as determined by the Third Party Administrator and as required by law. These costs will be subject to the Plan's otherwise applicable Deductibles and limitations and do not include items that are provided for data collection or services that are clearly inconsistent with widely accepted and established standards of care or otherwise payable or reimbursable by another party.

- **Colonoscopies (non-preventive – not within the U.S. Preventive Task Force A or B recommendations/diagnostic – required as part of a work-up for symptoms or a medical conditions)**: Non-preventive/diagnostic colonoscopies are covered, regardless of age, under the Plan both In-Network and Out-of-Network.
- **Colonoscopies (preventive)**: In-Network, routine screening colonoscopies are covered under the Plan at 100 percent, as described in the U.S. Preventive Services Task Force A or B recommendations. Note that the guidelines may be specific to gender, age, or your personal risk factors for a disease or condition. Please click here to view those recommendations: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b- recommendations/
- **Complications from Non-Covered Services**: Medical treatments and/or procedures to treat medical complications (i.e. diseases and/or illnesses) arising from non-covered services under the Plan are an Eligible Expense if they are otherwise an Eligible Expense under the Plan
- **Convalescent or Skilled Nursing Facilities**: 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, defined as 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, is not covered under the American Airlines Medical Plan.
- **Cosmetic surgery**: 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. See Excluded Expenses.
- **COVID-19 Preventive Services:*** Any “qualifying coronavirus preventive service” (within the meaning of 29 CFR § 2590.715–2713) with no cost-sharing. A qualifying coronavirus preventive services

means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and has a rating of A or B in the recommendation of the USPSTF or is recommended by the Advisory Committee on Immunization Practices of the CDC. The Plan will cover any qualifying coronavirus preventive service within 15 business days after the date of the recommendation.

- **COVID-19 Tests and Related Items and Services:***

  (1) **COVID-19 Tests:** An in vitro diagnostic test defined in section 809.3(a) of title 21, Code of Federal Regulations (or its successor regulations) for the detection of SARS-CoV-2 or the diagnosis of COVID-19, and the administration of such a test, that:
  - Is approved, cleared, or authorized under section 510(k), 513, 515, or 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 360(k), 360c, 360e, 360bbb–3);
  - The developer has requested, or intends to request, emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 360bbb–3), unless and until the emergency use authorization request under such section 564 has been denied or the developer of such test does not submit a request under such section within a reasonable timeframe;
  - Is developed in and authorized by a State that has notified the Secretary of HHS of its intention to review tests intended to diagnose COVID–19; or
  - Other tests that the Secretary of HHS determines appropriate in guidance

  (2) **Related Items and Services:** Items and services furnished to an individual during visits that result in an order for, or administration of, a COVID-19 diagnostic test, but only to the extent that the items or services relate to the furnishing or administration of the test or to the evaluation of such individual for purposes of determining the need of the individual for the product, as determined by the individual's attending healthcare provider. An attending provider for this purpose is an individual who is licensed (or otherwise authorized) under applicable law, who is acting within the scope of the provider's license (or authorization), and who is responsible for providing care to the patient.

*This information is current during the public health emergency declared by the Secretary of Health and Human Services as a result of COVID-19.

- **Dental expenses for Dental examination, diagnosis, care and treatment of one or more teeth, the tissue around them, the alveolar process or the gums, only when care is rendered for:**
  - 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, unless the member is under the age of 18 at the time of the injury.
- If the Accidental Injury requires that you have Dental implants, the maximum benefit is $15,000 for the entire time the person is covered under an American Airlines Medical Plan.
- 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)
- Dental procedures that are necessitated by either severe disease (including but not limited to cancer) or traumatic event, as long as the dental service is medically necessary and the service is incidental to and an integral part of service covered under the medical benefits of the Plan. Examples of services include, but are not limited to, the extraction of teeth prior to or following chemotherapy or radiation therapy of the head and neck. Treatment of oral tissues related to chemotherapy must be supported by documentation of a direct link between the destroyed bone or gums and the chemotherapy.
- If the severe disease requires that you have Dental implants, there must be no other treatments, such as dentures or a bridge, available.

- **Dental anesthesia**: Dental anesthesia or sedation in conjunction with a dental procedure is covered if patient meets the following criteria:
  - Is under the age of five; or
  - Has a physical, developmental, intellectual, cognitive, or medically compromising condition or disability for which dental treatment under local anesthesia cannot be expected to provide a successful and safe result
  - Preauthorization is required. See QuickReview for Preauthorization procedures.

- **Detoxification**: Detoxification is covered as a chemical dependency condition.

Contact your Network/Claim Administrator for details.

- **Dietician services:** In-Network Dieticians services (i.e., consultations and training) are covered.

- **Durable Medical Equipment (DME):** Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, in its discretion, approve the purchase of such items instead of rental. Replacement of DME is covered only for mobility-related DME (i.e. wheelchairs) if the device was stolen, destroyed in a fire and/or natural disaster, is rendered non-repairable or non-functional, or prescription or condition has changed (improved or deterioration) or due to the natural growth of a Child. Replacement of DME and/or components (such as batteries or software) resulting from normal wear and tear is not covered. Examples of DME are items such as CPAP or BiPAP machines, wheelchairs, hospital beds, nebulizers, oxygen concentrators, TENS units, passive range of motion devices, joint cooling devices, bone stimulators, custom orthotics, etc.
- **Emergency Medical Condition**: A medical condition involving acute symptoms (including severe pain) that are severe enough so a prudent layperson, with average knowledge of health and medicine, could reasonably expect that lack of immediate medical attention will result in:
    - Placing the person's health (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
    - Serious impairment to bodily functions; or
    - Serious dysfunction of any body organ or part.

  Treatment for an Emergency Medical Condition shall include coverage for emergency services as defined in ERISA section 716 and underlying regulations, including items and services required for medical screening examinations, stabilization, and additional services, as medically necessary as required under ERISA.
- **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.
- **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.
- **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.
- **Family/Marriage/Couples Therapy**:
    - The Plan will cover counseling visits for you and your family (family therapy) or you and your Spouse (marriage therapy).

Family therapy is a type of psychological counseling that can help family members improve communication and resolve conflicts. Marriage therapy is a type of psychological counseling that helps couples recognize and resolve conflicts and improve their relationships.

- Only the employee needs to be a Plan participant in order for the service to be covered.

- **Gender Reassignment/Sex Changes:**
  - The Gender Reassignment Benefit (GRB) provides coverage for gender reassignment for the treatment of gender dysphoria. The GRB only offers benefits on an In-Network basis. There are no GRB benefits offered Out-of-Network.
  - The surgical benefit is available to employees and their Eligible Dependents age 18 and over enrolled in the Plan.
  - This GRB is available to the employee and their Eligible Dependents (age 18 and over for the surgical benefit) only one time during the entire time the employee/Eligible Dependent is covered under an American Airlines Medical Plan.
  - 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 (for the entire time you are covered under an American Airlines Medical Plan).

  - **GRB Coverage.** The Plan pays the following benefits:

- Continuous hormone replacement (hormones of the desired gender), including laboratory testing to monitor the safety of continuous hormone therapy.
- Evaluation and diagnosis by a psychological professional and psychotherapy, as set forth in standard treatment protocols.
  - One genital revision surgery (either male to female or female to male, as applicable) and one bilateral mastectomy or one bilateral augmentation mammoplasty, as applicable to the desired gender.

  - **Surgical Benefit.** Surgical benefits are limited to one bilateral mastectomy or bilateral augmentation mammoplasty, and one genital revision surgery (either male to female or female to male, as applicable) for the entire time the

employee is covered under this Plan. Subsequent surgical revisions, modifications or reversals are excluded from coverage. Coverage is limited to treatment performed by In-Network Providers.

- **GRB Prescription Drug and Mental Health Treatment.** Prescription drugs and mental health treatment associated with the GRB are considered under the Plan's behavioral and mental health and Prescription drug provisions; subject to applicable provisions, limitations and exclusions.
- **Travel Reimbursement.** See "Travel and Lodging Reimbursement" for information about when travel and lodging expenses may be reimbursed.
- **Pre-authorization 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 Prior Authorization **both** at the time you begin treatment and at the time you are admitted for surgery will result in denial of your claims. See "Prior Authorization" for additional information.
- **Cosmetic Surgeries:** Procedures primarily aimed to enhance appearance and/or physical modification, to resemble secondary sex characteristics of the chosen/reassigned gender such as hair removal, liposuction/body contouring, thyroid cartilage shaving, plastic surgery of eyelids/eyes/lips/chin, facial bone reduction, face lifts, voice modification surgery, nose modification, skin resurfacing, and any other cosmetic surgeries are not covered unless Medically Necessary.

- **Hearing care:** Covered expenses include hearing exams performed by an audiologist or Physician and hearing aids, subject to a maximum benefit of $3,500 per hearing aid. Replacement hearing aids are allowed once every 36 months and the maximum benefit for replacement is $3,500 per hearing aid (as long as you are enrolled in an American Airlines Medical Plan). Cochlear implants and/or osseointegrated hearing systems are also covered.
- **Hemodialysis:** Coverage provided for 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.
- **Hospice Care:** Eligible expenses 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 Testing and Diagnosis:** Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease.
- **Infertility Treatment services or treatment promoting fertility (other than testing and diagnosis):**
    - This benefit is subject to an overall $25,000 maximum per person for the entire time the person is covered under an American Airlines Medical Plan
    - Infertility Treatment or treatment promoting fertility includes the following services and procedures, if prescribed by your attending physician:

- Artificial Insemination (AI), Intrauterine Insemination (IUI), In-vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), Assisted Reproductive Technologies (ART), Intra Cytoplasmic Sperm Injection (ICSI) and other similar infertility procedures or procedures promoting fertility that are recommended by your attending physician.
- Egg, embryo, and sperm cryopreservation, thawing, transfer and storage, as requested by the member. There is to be no limit on the number of months of storage, subject to the $25,000 maximum for the entire time the person is covered under an American Airlines Medical Plan. Coverage is to be available for these services whether or not Medically Necessary.
- Reversal of a tubal ligation or vasectomy.
    - The following limitations apply:
- The service or procedure must be prescribed by the patient's In-Network Physician.
- The service or procedure must be performed by an In-Network Provider (unless a network gap exception has been approved by the Network/Claim Administrator).
- Expenses incurred by a donor or surrogate who is not the covered employee or the covered Eligible Dependent under the Plan are not Eligible Medical Expenses.
    - There is no coverage for Pre-implantation Genetic Screening (PGS). However, there is coverage for Pre-implementation Genetic Diagnosis (PGD).
    - See the "Excluded Expenses" section for Infertility Treatment

services or services promoting fertility that are excluded from coverage.

- **Infertility medications:** Medications used to treat infertility or to promote fertility are covered by the Plan, subject to an overall maximum of $15,000 per person, for the entire time such person is covered under an American Airlines Medical Plan.
- **Inpatient room and board expenses:** Eligible expenses are based on the negotiated rates with that particular In-Network Hospital (or specified percentage of such amount), or the amount determined by the independent dispute resolution process required under ERISA Section 716. For Out-of-Network, Eligible Expenses are determined based on the most common semiprivate room rate in that geographic area. Pre-certification is required for all Out-of-Network Hospitalizations. Failure to do so will result in a $250 penalty.
- **Intensive care, coronary care or special care units (including isolation units)**: Coverage includes room and board and services and supplies.
- **Intrauterine Device (IUD):** Insertion or removal of an IUD. Covered as a contraceptive method, described under "Prescription Drugs" later in this section.
- **Laboratory or pathology expenses:** Coverage is provided for 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 (Physician's office, lab, etc.), then these services are covered at 100 percent.
- **Mammograms (including 3-D mammograms) (non-preventive – not within the U.S. Preventive Services Task Force A or B recommendations/ diagnostic - required as part of a work-up for symptoms or a medical condition)**: Non-preventive/diagnostic mammograms are covered, regardless of age, under the Plan both In-Network and Out-of-Network.
- **Mammograms (including 3-D mammograms) (preventive):** In-Network, routine screening mammograms are covered under the Plan at 100 percent, as described in the U.S. Preventive Services Task Force A or B recommendations. Note that the guidelines may be specific to gender, age, or your personal risk factors for a disease or condition. Please click here to view those recommendations: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b- recommendations/
- **Mastectomy**: Mastectomy and certain reconstructive and related services after a mastectomy are covered. Additionally, under the Women's Health and Cancer Rights Act, covered reconstructive

services include:

- 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.
- **Mental health and chemical dependency care**: The Plan covers the following mental health and chemical dependency care:
  - **Inpatient mental health care**: When you use In-Network Providers under the Plan for Hospitalization for a Mental Health Disorder, expenses during the period of Hospitalization are covered the same as Inpatient hospital expenses (see "Covered Expenses" in this section).
- **Alternative Mental Health Care Center – residential treatment.**

  Residential treatment is covered if:
  - The stay satisfies the criteria for Medical Necessity; or
  - The stay is required for successful completion of a program designed to satisfy FAA Regulations (14 CFR 67.401) pertaining to special issuance of medical certificate.
- **Outpatient mental health care**
  - Chemical dependency rehabilitation
    - Chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be Inpatient, Outpatient or a combination. There are no limits on the number of chemical dependency rehabilitation programs a participant may attend

(regardless of whether the program is Inpatient or Outpatient).

- You must obtain approval from the American Airlines On-Site Employee Assistance Program for all cases resulting from regulatory or Company policy violations. In all other instances, American Airlines On-Site Employee Assistance Program approval is not required for an Inpatient or Outpatient chemical dependency rehabilitation treatment.
- The Plan does not cover expenses for a family member to accompany the patient being treated, although many Chemical Dependency Treatment Centers include family care at no additional cost.
    - **Detoxification**: Treatment is covered in the same way that other mental health and chemical dependency benefits are covered depending upon the type of services (i.e., Outpatient, In-Network; Outpatient, Out-of-Network; Inpatient, In-Network; Inpatient, In-Network; Inpatient, Out-of-Network; emergency services and pharmacy services).

- **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 Maximum Out-of-Network Charge (MOC) Fee Limits.
- **Newborn Nursery care**: The hospital expenses for a newborn baby are considered under the baby's coverage, not the mother's. Therefore, the baby must be enrolled in coverage for his/her newborn claims to be covered. The hospital expenses for a newborn baby are covered, provided you timely process a Life Event. To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. If you miss the 60 day deadline you will not be able to add your baby to your coverage until the next Annual Enrollment Period unless you experience another qualifying Life Event, even if you already have other Children enrolled in coverage. The filing or payment of a maternity claim does not automatically enroll the baby.
- **Penile prosthesis:** Surgical implantation of a penile prosthesis will be covered if the following conditions are met. All penile prosthesis require pre-authorization
    - Erectile dysfunction is due to one of the following:
        - Penile trauma
        - Spinal cord injuries
        - Sexual dysfunction as a result of treatment for prostate

cancer, and

- The following treatment has been exhausted:
  - Erectile dysfunction persisting for at least 6 months and,
  - A comprehensive history and physical exam has been completed, including appropriate lab work to determine the cause of the erectile dysfunction and,
  - There is a failure, contraindication or intolerance to FDA approved pharmacological remedies

- **Oral surgery**: Hospital charges in connection with oral surgery involving teeth, gums or the alveolar process, only if it is Medically Necessary to perform oral surgery in a hospital setting rather than in a Dentist's office. The Plan will pay room and board, anesthesia and miscellaneous Hospital charges. Oral surgeons' and Dentists fees are not covered under the Plan.
- **Outpatient surgery**: Charges for services and supplies for a 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.
- **Physical or occupational therapy**: Restorative and Rehabilitative Care by a licensed physical or occupational therapist when ordered by a Physician.

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

- **Physician's services**: Office visits and other medical care, treatment, surgical procedures and post-operative care for diagnosis or treatment of an illness or injury. The Plan covers office visits for certain preventive care, as explained under "Preventive Care," below.
- **Pregnancy**: Charges in connection with pregnancy, for employees, Spouses, Common Law Spouses, and covered Dependents of the employee. Prenatal care and delivery are covered when provided by a Physician or midwife who is registered, licensed or certified by the state in which he or she practices.
  - Routine prenatal expenses are covered at 100 percent In-Network. Labor, delivery and post-natal expenses are covered by the applicable Co-Insurance percentage.
  - 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 the

Plan.

- Federal law prohibits the Plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery. However, federal law does not require you to stay any certain length of time. If, after consulting with your Physician, you decide on a shorter stay, benefits will be based on your actual length of stay.

- **Prescription drugs**: Prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a Physician or Dentist for treatment of your condition.
    - This includes preventive Over-the-Counter medications covered with a Prescription if required by PPACA. Please click here to view the PPACA preventive services requirements: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b- recommendations/

    - The Plan is not required to cover preventive medications until the first Plan year (which begins on January 1) beginning on or after the date that is one year after the new recommendation or guideline is issued. For example, if the US Preventive Services Tasks Force issues an "A" or "B" recommendation for a preventive medication on February 15, 2020, the Plan is not required to cover the medication until January 1, 2022.
    - Please call ESI for the most up-to-date list of preventive Over-the-Counter medications that are covered by the Plan.
        - Prescriptions for the treatment of obesity or weight control are covered only for the diagnosis of morbid obesity.
        - Oral contraceptive drugs, patches, implants, transdermal, and intravaginal contraceptives are covered if purchased through mail order or at any local CVS or Safeway-owned retail pharmacies.
        - Medications provided, administered and entirely consumed in connection with care rendered in a Physician's office are covered as part of the office visit with the exception of certain specialty medications that are only covered under the Prescription Drug benefit.
        - Medications that are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital or similar institution that operates an on-premises pharmacy are covered as part of the facility's Ancillary Charges.
        - Medications that are administered as part of Home Health

Care.

- Diabetic supplies, including insulin, needles, chem-strips, lancets and test tape. These diabetic supplies are covered up to 100 percent if you or your covered dependents are participating in the StayWell Rx Prescription Program, and you purchased them from Mail Order or the Maintenance ChoiceProgram.
- Medications or products used for smoking or tobacco use cessation. All Participants under the Plan are eligible to receive two, 90-day courses of tobacco cessation medication, with a prescription from your doctor (either for drugs that are only available with a prescription or drugs that are available over-the-counter).
- Prescription medications that treat infertility or promote fertility are covered, subject to an overall $15,000 maximum per covered person for the entire time the person is covered by an American Airlines Medical Plan.
- Certain Hypertension, Diabetes and Asthma medications are covered at discounted rates if you or your covered Dependents are participating in the StayWell Rx Prescription Program.
- Certain types of medicines and drugs that are not covered by the Plan may be reimbursed under the Health Reimbursement Arrangement (see "Covered Expenses" in the *Health Reimbursement Arrangement* section).

- **Preventive care**: Covers preventive care, including well-child care, immunizations, routine screening mammograms, pap smears, male health screenings and annual routine physical exams for participants of all ages. Non- routine tests for certification, sports or insurance are not covered.
  - The Plan is a non-grandfathered group health plan that complies with the PPACA preventive care requirements.
  - Preventive care focuses on evaluating your current health status when you are symptom free.
  - Preventive services include those performed if you:
    - do not have symptoms and/or an existing condition that the screening is intended to diagnose
    - have had diagnostic screenings that were normal after which your Physician recommends future preventive screening
    - have a preventive service done that results in a therapeutic service done at the same time (e.g. polyp removal during a

preventive colonoscopy)

- The Company follows the USPSTF Grade A & B recommendations, CDC and HRSA guidelines for preventive care. To get a full list of In-Network preventive care covered at no cost to you, visit: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ or https://www.healthcare.gov/preventive-care-benefits/

- The Plan is not required to cover preventive services until the first Plan year (which begins on January 1) beginning on or after the date that is one year after the new recommendation or guideline is issued. For example, if the US Preventive Services Tasks Force issues an "A" or "B" recommendation for a preventive service on February 15, 2020, the Plan is not required to cover it until January 1, 2022.
- Please call your Network/Claim Administrator for the most up-to-date list of preventive services that are covered by the Plan.
  - Some preventive services have age and frequency limitations. These limitations can be based on Medical Necessity, medical review boards of the carriers in which we partner with to provide health care services and PPACA.
  - If you receive preventive care at any location other than a Physician's office, such as an outpatient hospital, Urgent Care or emergency room, or from an Out-of-Network Provider, services may not be covered at 100 percent.
  - Your health care Provider determines how you are billed for all health plan expenses. When a service is performed for the purpose of preventive screening and is appropriately billed as such by your Provider, then it will be covered under preventive services.

- **Private duty nursing care**: Coverage includes care by a licensed Nurse in a home setting.
- **Prostheses**: Prostheses (such as a leg, foot, arm, hand or breast) necessary because of illness, injury or surgery. Replacement prostheses are allowed once every 36 months unless the device was stolen, destroyed in a fire and/or natural disaster, is rendered non-repairable or non-functional, or prescription or condition has changed, or due to the natural growth of a Child.
- **Proton beam therapy**: Proton beam therapy (at In-Network Providers and In-Network facilities only) is covered for the treatment of prostate cancer and other diagnoses as determined by the Network/Claim Administrators' medical policy.

- This benefit is subject to an overall maximum of $50,000 per episode when used to treat prostate cancer (as long as the individual is enrolled in an American Airlines Medical Plan). If there is a recurrence of prostate cancer following a period of time when the cancer could not be detected, this is considered a different episode and coverage will be available again, up to the maximum of $50,000 per episode.
- The overall maximum of $50,000 applies only to the proton beam therapy delivery and does not apply to treatment planning, imaging, physician consultations, professional services or other associated charges.
- The following limitations apply:
  - The service or procedure must be performed by an In-Network Provider and be administered in an In-Network Provider and be administered in an In-Network facility (unless a network gap exception has been approved by the Network/Claim Administrator).
  - The benefit requires Prior Authorization. See "Prior Authorization" for additional information.
  - Services received at an Out-of-Network Provider or Out-of-Network facility are excluded. See the "Excluded Expenses" section, "Proton Beam Therapy" for details.

- **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 (Physician's office, imaging center, etc.), then these services are covered at 100 percent.
- **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 inside of retail pharmacies, the eligible expense is subject to the Physician's office visit Co-pay, or Deductible and Co-Insurance.
- **Sleep Studies**:
  - For employees: The Plan will cover sleep studies that are either home-based or facility-based/supervised, at your Physician's discretion.
  - For Eligible Dependents: The Plan will cover sleep studies that are home- based or unsupervised. The Plan will only cover sleep studies that are facility-based/supervised if the Eligible Dependent attempts a home-based or unsupervised sleep study first. After that, the Plan may approve a facility-based/supervised sleep study.
- **Speech therapy:** Restorative and Rehabilitative Care and treatment for Loss or Impairment of Speech due to an illness, injury, or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy. Maintenance treatments (once your maximum therapeutic benefit has been reached) are not covered.
- **Spinal Fusion Surgery:** You must obtain prior authorization before the Plan will cover spinal fusion surgery.
- **Stand-by Surgeon**: Only covered when the procedure makes it Medically Necessary to have a stand-by surgeon, and when the stand-by surgeon is physically present at the facility. See the Pre-determination procedure for additional information.
- **Surgery:** When performed in a hospital, Freestanding Surgical Facility or Physician's office.
- **Telehealth**: The Plan will offer live face to face video consultations for medical benefits for participants enrolled in the Plan. These medical benefits are offered by Doctor on Demand, a telehealth service offering video medical visits through a secure mobile application.
- **Temporomandibular joint dysfunction (TMJD):** Eligible expenses under the Plan include only the following:
  - Injection of the joints
  - Bone resection
  - Application of splints, arch bars or bite blocks if their only purpose is joint stabilization and not orthodontic correction of

a malocclusion

- Manipulation or heat therapy
- Temporomandibular joint replacement, ONLY if ALL of the following conditions are met:
  - It is the treatment of last resort ("salvage" treatment)
  - It has been documented by clinical records that all other medically appropriate lesser treatments have been performed and have failed (and the failure is not due to patient non-compliance)
  - The prosthetic implant system being used is a total implant system manufactured by either TMJ Concepts, Inc. or Walter Lorenz Surgical, Inc.
  - The patient meets all generally accepted medical/surgical criteria for total replacement of the TMJ
  - The TMJ replacement is not used on an Experimental or Investigational basis
  - Note that crowns, bridges or orthodontic procedures for treatment of TMJD are **not** covered.

- **Transplants**: Expenses for transplants or replacement of tissue or organs if they are not Experimental, Investigational, or Unproven Services. Benefits are payable for natural or artificial replacement materials or devices. Keep in mind that transplants must be Pre-authorized. The transplant will not be covered if Pre-authorization is not obtained.
  - 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. 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.

- **Travel Reimbursement.** See "Travel and Lodging Reimbursement" for information about when travel and lodging expenses may be reimbursed.
- **Artificial Cervical Disc Implantation**: Although disc implantation uses artificial disc materials, it is replacing the damaged natural disc tissue in the space between vertebrae in the spine and is categorized here as a transplant. It is subject to the same requirements as all other covered transplants. All of the following criteria must be met for the procedure to be covered:
  - The patient must use an FDA-approved prosthesis (if a two adjacent level implantation is planned, the prosthesis must be FDA-approved for use in a two-level procedure);
  - Implantation must be a either a single level in the cervical spine or two adjacent levels in the cervical spine;
  - Patient must be diagnosed with Degenerative Disc Disease with intractable radiculopathy (nerve root pain with weakness, numbness, movement difficulties) and/or myelopathy (inflammation causing neural deficit in the spinal cord);
  - Patient must be skeletally mature;
  - Patient must have either a herniated disc OR osteophyte formation;
  - Patient must have documented history of neck and/or arm pain and/or functional impairment at the corresponding cervical level; and
  - Patient must have failed at least six weeks of non-operative treatment.

The following transplants are covered if they are not Experimental, Investigational, Unproven or otherwise excluded from coverage under the Plan, as determined in the sole discretion of the Plan Administrator and its delegate, the Network/Claim Administrator:	
Artery or vein Artificial Cervical Disk Implantation (see information above) Bone Bone marrow or hematopoietic stem cell Cornea Heart Heart and lung Heart valve replacements Implantable prosthetic lenses in connection with cataract surgery Intestine	Kidney Kidney and pancreas Liver Liver and kidney Liver and intestine Lung Pancreas Pancreatic islet cell (allogenic or autologous) Prosthetic bypass or replacement vessels Skin
This is not an all-inclusive list. It is subject to change. Contact the 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.
- **Travel and Lodging Reimbursement:**
    - Travel and lodging assistance is only available if:
        - (1) You receive care at an eligible Center of Excellence (COE) for one of the following :
            - Transplant
            - Cancer
            - Congenital heart disease
            - Bariatric surgery
        - Or (2) you receive care at an In-Network surgery Provider for gender reassignment surgery.
    - These treatments and procedures are performed at limited locations in the United States, and most patients will need to travel outside their immediate home area. If travel is required

for a treatment or procedure because it is not offered in your immediate home area, travel to an In-Network Provider (for gender reassignment surgery) or a Center of Excellence (COE) and lodging expenses will be reimbursed up to a maximum of $10,000, regardless of your Network/Claims Administrator, even if you change administrators. This $10,000 maximum benefit applies for the entire time the person is covered under an American Airlines Medical Plan. To be eligible for reimbursement, travel must be over 50 miles away from your home and must be by air, rail, bus or car. The $10,000 covers you and one caretaker to travel with you for In-Network surgery only (for gender reassignment surgery) or a treatment or procedure at a Center of Excellence. You are only allowed to travel In-Network (for gender reassignment surgery) or to a Center of Excellence within the 48 contiguous United States. 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.

- **Tubal ligation and vasectomy**: These procedures are covered; Reversal of these procedures is covered under the infertility benefit only. See “Infertility Treatment services (other than testing and diagnosis),” above.
- **Urgent/Immediate Care**: Charges for services and supplies provided at an Urgent Treatment Clinic are covered.
- **Well-Child care**: Initial Hospitalization following birth, immunizations, and well- child care visits.
- **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 MOC Fee Limits, Deductibles, Co-Pays, Co-Insurance and Out-of-Pocket limits. The maximum benefit available for wigs and hairpieces is $1,000 per episode (as long as the individual is enrolled in an American Airlines Medical Plan). Hair transplants, styling, shampoo and accessories are excluded.

Excluded Expenses

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

- **Allergy testing:** Specific testing (called provocative neutralization testing or therapy), which involves injecting a patient with varying

dilutions of the substance to which the patient may be allergic.

- **Alternative and/or Complementary Medicine**: Evaluation, testing, treatment, therapy, care and medicines that constitute Alternative or Complementary Medicine, including but not limited to herbal, holistic and homeopathic medicine.
- **Claim forms**: The Plan will not pay the cost for anyone to complete your claim form.
- **Care not Medically Necessary**: All services, procedures, and supplies considered not Medically Necessary.
- **Cosmetic surgery**: Unless Medically Necessary and required as a result of Accidental Injury or surgical removal of diseased tissue.
- **Cosmetic treatment**: Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction and sclerotherapy for varicose veins or spider veins).
- **Custodial Care**: Custodial Care is not covered.
- **Custodial Care items**: Custodial Care items such as incontinence briefs, liners, diapers and other items when used for custodial purposes are not covered, unless provided during an Inpatient confinement in a hospital or Convalescent or Skilled Nursing Facility.
- **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 (except for ABA Therapy). This exclusion applies regardless of the condition being treated.
- **Experimental, Investigational, or Unproven Treatment**: Medical treatment, procedures, drugs, devices or supplies that are generally regarded as Experimental, Investigational, or Unproven Treatments.
- **Eye care**: Eye exams, refractions, eyeglasses or the fitting of eyeglasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training and vision therapy.
- **Foot care**: Diagnosis and treatment of weak, strained or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses or toenails. (This exclusion does not apply to the removal of nail roots.)
- **Free care or treatment**: Care, treatment, services or supplies for which payment is not legally required.
- **Government-paid care**: Care, treatment, services or supplies

provided or paid by any governmental plan or under any law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

- **Infertility Treatment services**: The following Infertility Treatment services or services promoting fertility are not covered:
    - Expenses related to a donor or surrogate, unless the donor or surrogate is a covered member of the Plan.
    - Experimental or Investigational Services or Supplies.
    - Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
- **Lenses:** No lenses are covered except the first pair of Medically Necessary contact lenses or eyeglasses following cataract surgery.
- **Massage therapy:** All forms of massage and soft-tissue therapy, regardless of who performs the service.
- **Medical records:** Charges for requests or production of medical records.
- **Missed appointments:** If you incur a charge for missing an appointment, the Plan will not pay any portion of the charge.
- **Non-Emergency or Non-Urgent Care While Traveling Outside the United States:** Any non-emergency or non-Urgent Care such as routine Physician care or preventive care, or care, treatment, or procedures that you arrange before you arrive in a foreign country, is not covered when you travel abroad, for employees on the U.S. payroll. Note that this exclusion does not apply to expatriates who are living abroad. Please see the section "Care While Traveling Out of the Country" for more information.
- **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."
- **Over-the-Counter-medication (OTC):** Over-the-Counter medications are not covered under the Plan, except preventive Over-

the-Counter- medications covered with a prescription if required by PPACA.

- **Prescription Drugs**:
    - Drugs that are not required to bear the legend “Caution-Federal Law Prohibits Dispensing Without Prescription.”
    - Covered drugs in excess of the quantity specified by the Physician or any refill dispensed after one year from the Physician’s order.
    - Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy, if there is a prescription); however the Plan does provide coverage for folic acid and oral fluoride supplements in accordance with PPACA, if prescribed by a physician.
    - Drugs prescribed for cosmetic purposes (such as Minoxidil).
    - Drugs labeled “Caution-Limited by Federal Law to Investigational Use,” drugs not approved by the Food and Drug Administration (FDA), or Experimental drugs, even though the individual is charged for such drugs
    - Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis
    - Additional medications or products used for smoking or tobacco use cessation beyond the two, 90-day courses.
    - Prescription medications not FDA approved for the condition being treated
    - Prescription medications compounded with ingredients not approved by the US Food and Drug Administration (FDA); Prescription medications prescribed and/or utilized or administered in a manner other than what has been FDA-approved for the medication; Prescription medications utilized or administered with quantities, dosages, or routes of administration not approved by the FDA
- **Preventive care**: Not all preventive care may be covered. Consult your Network/Claim Administrator to learn what preventive care is not covered.
- **Proton Beam Therapy**: Proton beam therapy is excluded if you use an Out-of- Network Provider or if you do not receive pre-certification approval from the Network/Claim Administrator. Coverage is also excluded when metastases are present.
- **Relatives**: Coverage is not provided for treatment by a medical

practitioner (including, but not limited to: a Nurse, Physician, physiotherapist or speech therapist) who is a close relative (Spouse, Child, brother, sister, parent or grandparent of you or your Spouse, including adopted and step relatives).

- **Reversal of tubal ligation and vasectomy**: Reversal of these procedures is not covered unless related to the infertility or fertility promotion benefit. See “Infertility Treatment services (other than testing and diagnosis),” under “Covered Expenses.”
- **Services related to occupation**: including, but not limited to: physical or Federal Aviation Administration exams, Department of Transportation exams, Occupational Health and Safety testing, performance testing and work hardening programs.
- **Speech therapy**: Except as described in “Covered Expenses,” expenses are not covered for losses or impairments caused by conditions such as learning disabilities, developmental disorders or progressive loss due to old age. Speech therapy of an educational nature is not covered.
- **Temporomandibular joint dysfunction (TMJD)**: Except as described in “Covered Expenses,” diagnosis or treatment of any kind for temporomandibular joint disease or disorder (TMJD), or syndrome by a similar name, including orthodontia, crowns, bridges or orthodontic procedures to treat TMJD.
- **Transportation**: Transportation by regularly scheduled airline, air ambulance or train for more than one round trip per illness or injury.
- **War-related**: Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.
- **Weight reduction**: Hospitalization, surgery, treatment and medications for weight reduction other than for approved treatment of diagnosed morbid obesity.
- **Wellness items**: Items that promote well-being and are not medical in nature and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas and health club memberships). Also excluded are:
    - Services or equipment intended to enhance performance (primarily in sports- related or artistic activities), including strengthening and physical conditioning
- **Wilderness/adventure therapy programs, residential or non-residentia**l: Programs of group and/or individual therapy (irrespective of whether the diagnosed conditions or psychiatric, substance use/abuse, relationship issues, or other behavioral issues) focused on outdoor therapy, adventure therapy, wilderness therapy, “survival”

therapy, “boot camp” therapy, and/or similar type of treatment protocols and programs.

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

Filing Claims

How to File a Claim

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. 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.
- Submit the completed form to your Network/Claim 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. In most cases, the EOB will be mailed to you and the payment mailed to your Provider. EOBs are also available on your Network/Claim Administrator’s website.
If you have questions about your coverage or your claim under the Plan, contact the Network/Claim Administrator (see “Contact Information” in the *Reference Information* section).

Please see the "Claims Procedures" chapter for a detailed description of the claims procedures.

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 HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Predetermining Care for Certain Medical Services

Predetermination of Benefits

A Pre-determination allows you and your provider to find out if:

- **The recommended service or treatment is covered by the Plan.**
    - Your Provider's proposed charges fall within the Plan's usual fees (applies only to Out-of-Network expenses under the Plan). If you are receiving discounted Provider's fees, or if you are using In-Network Providers, the Provider's fees are not subject to Maximum Out-of-Network Charge Fee Limits.

To obtain a Predetermination, your provider may submit a CheckFirst Pre-determination of Medical Benefits form before your proposed treatment.

Please note that even if you or your provider, obtain a Predetermination, 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.).

If you are having surgery, your Network/Claim Administrator (as part of your Network/Claim Administrator's hospital Predetermination 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.

For hospital stays, the Pre-determination does not pre-authorize the length of a hospital stay or determine Medical Necessity. Your provider must request pre-authorization for the length of a hospital stay or medical necessity.

The Predetermination list is determined by your Network/Claim Administrator and is subject to change based on their respective medical policies.

Prior Authorization

You or your Provider acting on your behalf may be required to request a Prior Authorization from your Network/Claim Administrator. If you are using In-Network Providers, your Provider will call for you.

If you are using Out-of-Network Providers, you must call the Network/Claim Administrator yourself (or a family member can call on your behalf). If your Physician recommends surgery or Hospitalization, ask your Physician for the following information if you intend to call yourself:

- 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 requesting Prior Authorization, 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 Medically Necessary and appropriate for your condition
- The number of approved days of Hospitalization

If you obtain Prior Authorization, your expenses are still subject to review and if not Medically Necessary, will not be covered under the Plan**. Failure to request a Prior Authorization will result in a $250 penalty per Out-of-Network 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. 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.

Please note that 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 U.S. enrolled medical and dental coverage, emergency and Urgent Care will be covered under the Plan when you travel out of the country.

Before leaving the country, contact your Network/Claim Administrator for details on coverage and services:

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

Emergency Care: 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.

Urgent or Immediate Care: If you need urgent or immediate (not emergency) care, you should call the Network/Claim Administrator for assistance. If it is after hours, seek treatment and call the Network/Claim Administrator,

Non-Emergency or Non-Urgent Care: Any non-emergency or non-Urgent Care such as routine Physician care, preventive care, or care, treatment, or procedures you arrange before you arrive in the foreign country, is not covered when you travel abroad. Note that this exclusion does not apply to expatriates who are living abroad.

Additional Rules That Apply to Your Plan Coverage

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

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

Statement of Rights Under the Newborns' and Mothers' 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 or Network/Claim 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 Co-Insurance applicable to other medical and surgical benefits provided under this Plan. See the Cost-Sharing section for further information.

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

Prescription Drug Program

How the Prescription Drug Benefit Works

Prescription drug coverage is based upon a formulary. The amount of Co-Insurance you pay under the Plan is based upon whether the medication is a generic drug, a preferred brand drug or a non- preferred brand drug.

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

Preferred brand name drugs are CVS Caremark formulary drugs.

Non-preferred are brand names that are CVS Caremark non-formulary. They have preferred alternatives (either generic or brand) that are in the CVS Caremark formulary. CVS Caremark (CVS) is the Prescription drug vendor for the Plan. Drugs prescribed by a Physician may be purchased either at retail pharmacies or through the Mail Order Prescription Drug benefit. CVS Caremark has a broad Network of pharmacies throughout the United States, Puerto Rico and the U.S. Virgin Islands. To request a list of participating pharmacies, visit the CVS Caremark website or call them at 1-844-758-0767.

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

Prescription drugs are payable before you've met your Deductible.

Please note that 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.

Retail Drug Coverage

Overview

To maximize your prescription drug benefit under the Plan, always try to have your Prescriptions filled at a Network pharmacy or through Mail Order. You must present your CVS Caremark ID card when you purchase Prescription drugs in order to receive the discounted medication rates and to have your pharmacy claim processed at the time of purchase. If you do not present your CVS Caremark ID card at the time of purchase, you will have to pay the full cost. By showing your CVS Caremark ID card, the pharmacy will process your claim at the time of purchase and you will only pay your Co- Insurance portion. Showing your CVS Caremark ID card also allows your Out-of-Pocket pharmacy expense to be applied toward satisfaction of your annual Out-of-Pocket Maximum.

The Co- 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.

Please see the chart below for the Co-Insurance requirements for retail drug coverage under the Plan.

Features	In-Network	Out-of- Network
RETAIL Pharmacy (typically a 30-day supply)	**Generic:** 20% Co-insurance ($10 min / $40 max) **Preferred Brand:** 30% Co-insurance ($30 min / $100 max) **Non-Preferred Brand:** 50% Co-insurance ($45 min / $150 max)	**Generic:** 20% Co-insurance ($10 min / $40 max) **Preferred Brand:** 30% Co-insurance ($30 min / $100 max) **Non-Preferred Brand:** 50% Co-insurance ($45 min / $150 max)

Filling Prescriptions for Retail Drugs

Follow these steps to fill Prescriptions:

- Network pharmacies**:**
    - Present your CVS Caremark ID card at the In-Network pharmacy
    - Pay your portion of the cost for the Prescription
    - CVS Caremark will notify your Network/Claim Administrator of all amounts applied to the Out-of-Pocket Maximum, if you present your CVS Caremark prescription ID card when you fill your 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 CVS Caremark. See Filing Claims for Prescriptions below for more information on how to file a claim.
    - **Note:** If you purchase Prescription drugs at an Out-of-Network pharmacy, you will be reimbursed based on the CVS

Caremark discount price, **not** the actual retail cost of the medication, which means the amount you'll have to pay for your Prescription will be greater than if you used an In-Network retail pharmacy.

Retail Refill Allowance – Long-Term Medications

You and your covered dependents will pay 50 percent 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 Maintenance ChoiceProgram (see below for additional information). 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. 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 CVS Caremark website or call them at 1-844-758-0767.

Retail Prescription Clinical Programs

CVS Caremark uses a number of clinical programs that help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, they are subject to change. Some medications may require Prior Authorization (pre-approval), some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period), and some medications may require step therapy. For example, erectile dysfunction medications are covered up to a maximum of six (6) pills per month.

When a Prescription for a medication requiring Prior Authorization or step therapy, or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these clinical programs and the specific drugs subject to these programs can be obtained from CVS Caremark (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 CVS Caremark to determine Medical Necessity before you can obtain them at a participating pharmacy or through the Mail Order Prescription Drug benefit. Examples of medications requiring prior authorization include growth hormones and rheumatoid arthritis drugs. CVS Caremark will advise you whether your prior authorization is approved or denied, and will explain the reason if it is denied.

When you fill your Prescription, your pharmacist will call CVS Caremark. Your pharmacist and an CVS Caremark pharmacist will review the request for approval. CVS Caremark will send you and your Physician a letter with the authorization review determination and the length of approval, if applicable. When the renewal date approaches, you should contact CVS Caremark for renewal instructions.

Ask your Physician to contact CVS Caremark or to complete CVS Caremark Prior Authorization Form with the following information:

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

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

Specialty Pharmacy Services

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

CVS Specialty Pharmacy, a subsidiary of CVS Caremark, is designed to help you meet the particular needs and challenges associated with the administration and handling of these medications. CVS Caremark 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.
Whether these Prescriptions are self-administered or administered in a Physician's office, the Prescriptions to treat the above conditions are not reimbursed through the medical portion of the Plan and must be filled a through CVS Specialty Pharmacy Mail Order Prescription Drug benefit for you to receive Prescription Drug benefits. CVS Specialty Pharmacy Mail Order Prescription Drug benefit 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. If you are taking a specialty medication and do not fill through CVS Specialty Pharmacy your medication will not be covered.

Prescriptions prescribed to manage medical conditions such as the following **must** be filled at one of CVS Specialty Pharmacy pharmacies (mail order) through CVS Caremark:

- Anemia
- Growth hormone
- Hemophilia
- Hepatitis C
- 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.

The applicable Co-Insurance associated with the Prescription Drug benefit will apply to the Specialty Pharmacy Prescriptions.

Specialty Pharmacy Copay Assistance Program

The Plan includes a specialty pharmacy copay assistance program[3] to help offset the cost of **select specialty pharmacy medications**. These specialty pharmacy medications will be reimbursed by the manufacturer at no cost to participants enrolled in the Plan once you enroll by contacting Saveon SP at 1-800-683-1074. Manufacturer-funded copay assistance for widely distributed specialty drugs are considered "non-essential health benefits" under the Plan and will not be considered an out-of-pocket cost for participants. Therefore, these amounts will not count toward the annual Deductible or Out-of-Pocket Maximum. Only the amount you pay will be applied to your Deductible and/or Out-of-Pocket Maximum.

For a full list of specialty medications eligible for this program visit www.saveonsp.com/aa.

[3] "Copay assistance" may also be referred to as financial assistance, manufacturer coupons, discount programs, and/or coupon programs.

Maintenance Choice Program

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

CVS Caremark Mail Order Prescription Drug Benefit

Overview

You and your covered Dependents are also eligible for Mail Order Prescription Drug benefit, which is an alternative to the Maintenance Choice Program. You may use this mail service option to order Prescription drugs you take on an ongoing basis such as allergies, arthritis, contraceptives, diabetes, emphysema, heart disease, high blood pressure, thyroid disease and ulcers. You may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration. A registered pharmacist fills your Prescription. Ordering medications on a 90-day supply basis through Mail Order Prescription Drug benefit will often save you more money than if you fill your Prescriptions at a retail pharmacy on a 30-day basis.

You may order up to a 90-day supply of your Prescription drug (but no more than the number of days prescribed by your Physician). You pay Co-Insurance (with no annual Deductible) for each Prescription or refill. Please see the chart below for Co-Insurance requirements.

For Mail Order Prescriptions, you *must* purchase through Mail Order Prescription Drug benefit; otherwise, you'll have to pay 100 percent of the cost yourself and the Plan will not pay any of the cost. As an alternative to Mail Order, you can utilize the Maintenance Choice Program, discussed above.

There are no Out-of-Network Mail Order benefits.

Oral contraceptives, transdermal, and intravaginal contraceptives are covered at 100 percent under the Plan through Mail Order Prescription Drug benefit, when filled at a local CVS or Safeway-owned pharmacy, or if purchased from a retail pharmacy not affiliated with the Maintenance Choice program (for up to three fills only). If you are taking contraceptives specifically for the purpose of preventing pregnancy, please be aware some services have age and frequency limitations. These limitations can be based on Medical Necessity, which is determined by medical review boards of the carriers in which we partner with to provide health care services and PPACA. If you purchase contraceptives for reasons other than the prevention of pregnancy, the appropriate Co-Insurance will apply.

Features	In-Network	Out-of- Network
MAIL ORDER[4] (typically a 90-day supply)	**Generic:** 20% Co-insurance ($5 min / $80 max) **Preferred Brand:** 30% Co-insurance ($60 min / $200 max) **Non-Preferred Brand:** 50% Co-insurance ($90 min / $300 max)	Not covered

Mail Order Prescription Clinical Programs

CVS Caremark uses a number of clinical programs to help ensure clinically appropriate coverage and drug cost controls. Because new clinical programs are continuously being developed and existing programs enhanced, the drugs subject to these clinical programs may change. Some medications may require Prior Authorization (pre-approval), some medications may have quantity limitations (such as the number of pills or total dosage allowed within a specific time period), and some medications may require step therapy. For example, erectile dysfunction medications are covered up to a maximum of six (6) pills per month.

When a Prescription for a medication requiring Prior Authorization or step therapy, or having quantity limitations is submitted, more information will be requested to determine if your use of the medication meets the coverage conditions. Additional information about these programs may be obtained from CVS Caremark (see "Contact Information" in the *Reference Information* section).

[4] Applies to Specialty Drugs when applicable.

Generic Drugs

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

Ordering Prescriptions by Mail

- **Initial order**: 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 CVS Caremark 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,
        - Personal check or money order, or
    - 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 CVS Caremark website or call CVS Caremark (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 or send electronically new Prescriptions directly to CVS Caremark.
- **Internet Refill Option:** You have online access to Mail Order 24-hours a day, seven days a week. At the CVS Caremark 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 CVS

Caremark 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 1-844-758-0767 to request a refill. You will be asked for your CVS Caremark ID number, current mailing address and CVS Caremark Rx Services Prescription number.
    - Complete and mail in your Mail Order Form, found on Jetnet. Attach your 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.

Manufacturer Discount Cards/Coupons

The following expenses are not applied toward the annual In-Network Out-of-Pocket maximum: Funds you may receive from drug manufacturers, state assistance programs (where permitted by law), pharmacy discount programs or other third parties to assist you in purchasing prescription drugs.

Claims Filing Deadline

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

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

Reimbursement of Co-Insurance

Your mail order Prescription Drug 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 Plan. However, your Co-Insurance may be eligible for reimbursement under your HRA benefit. See the Health Reimbursement Arrangement section for more information.

Health Reimbursement Arrangement

Overview

When you enroll in the Plan, you are automatically enrolled in the medical and prescription drug portion of the Plan as well as the Health Reimbursement Arrangement ("HRA"). An HRA is a financial account that allows the Company to reimburse you for "qualified" health expenses paid by you and your Eligible Dependents to offset out-of-pocket health care costs. Your HRA is paid for entirely by the Company. Contributions toward your medical coverage are not used to finance any part of your HRA. The Company will credit $500 to your HRA each year after you complete an annual physical by one of the Plan's Network providers. The balance in your HRA rolls over from year to year, and remains available to you as long as you remain an Employee of the Company, even if you enroll in another Company-sponsored medical plan option or disenroll from Company-sponsored medical coverage. Once you retire from the Company, any benefits remaining in your HRA will roll over to your Retiree HRA if eligible and enrolled as described in the American Airlines, Inc. Retiree HRA Plan. Please see the American Airlines, Inc. Retiree HRA Plan SPD for additional details.

Your HRA is an account on the Company's records; it is not funded and does not bear interest or accrue earnings of any kind.

HRA Reimbursements

Reimbursements from the HRA shall only be made for Medical Expenses incurred by you or your Eligible Dependent. Each Medical Expense must be substantiated by you or your Eligible Dependent as described later in this Section. The HRA will reimburse you for the actual amount of Medical Expenses incurred by you or your Eligible Dependent, up to the amount in your HRA. No payment will be made to the extent that it would reduce your HRA below zero.

Medical Expenses that may be reimbursed by the HRA include expenses for the diagnosis, cure, mitigation, treatment, or prevention of any disease, or for the purpose of affecting any structure or function of the body that are not reimbursed through any other plan or source including, but not limited to, the following:

(1) Out-of-pocket expenses such as deductibles, co-insurance, or co-pays under another medical, dental or vision plan;

(2) Prescription drugs;

(3) Over-the-Counter medicine/drugs used to alleviate or treat personal injuries or sickness of you and/or your Eligible Dependents. For instance, pain reliever, antacid, allergy medicine, cold medicine or insulin;

(4) Hearing and vision expenses;

(5) Dental expenses;

(6) Medical devices or items you may purchase, such as, bandages, crutches and contact lens solution, and the like; and

(7) Menstrual Care Products, as defined in Code section 223(d)(2)(D).

Refer to the list of eligible items by visiting the Smart-Choice Accounts website.

Some expenses may not be reimbursed through your HRA, including, but not limited to the following:

(1) Long-term care facility fees (long-term care insurance premiums are eligible);

(2) Non-health insurance premiums (e.g., life insurance, auto insurance, short- or long-term disability coverage);

(3) Health club, exercise classes, and social activity fees and memberships (except in rare cases for treatment of medically diagnosed obesity where weight loss is part of the program);

(4) Vacation or travel for health reasons;

(5) Certain other health care items and services such as:

(A) Cosmetic medical treatment, surgery, and Prescriptions and cosmetic Dental procedures, such as cosmetic tooth bonding or whitening;

(B) Electrolysis;

(C) Massage Therapy;

(D) Personal care items including cosmetics and toiletries;

(E) Vitamins and nutritional supplements, unless prescribed by a doctor;

(F) Weight loss programs (unless for treatment of medically diagnosed obesity);

(G) Wheelchair ramps; and

(H) Whirlpools.

(6) A Medical Expense that is:

(A) Attributable to a deduction allowed under Code section 213 for any prior taxable year;

(B) Incurred before the effective date of this Plan;

(C) Incurred before you are a Participant in this Plan; or

(D) Reimbursed by another health plan, including premiums for coverage with another employer.

Coordination of Benefits Under the HRA

In the event you are covered under this Plan and a Company-sponsored health flexible spending accountt ("FSA") under which you made salary reduction contributions to the FSA during a Plan Year, in no case may you be reimbursed for the same Medical Expense by both this HRA and the FSA during such Plan Year. Reimbursements shall first be made from the FSA, and only when the FSA is exhausted shall reimbursements be made under this HRA.

Enrollment in other Company-Sponsored Medical Plans Option

You can continue to use the HRA for reimbursement of Medical Expenses even if you enroll in a different Company-Sponsored Medical Plan or disenroll for coverage entirely. If you do not enroll in a Company-Sponsored Medical Plan Option, you can continue to use the HRA for reimbursement of all Medical Expenses except for individual health insurance coverage.

Termination of Employment

If you terminate employment with the Company, you will need to elect COBRA continuation coverage in order to continue to have access to the HRA. If you do not elect COBRA, you will have 365 days to submit claims for eligible expenses incurred during your employment. If you elect COBRA continuation coverage, in addition to the reimbursement amount already available, the Company will continue to contribute to your HRA at the same time and by the same increment as for similarly situated non-COBRA beneficiaries.

Repayment of Excess Reimbursements

If it is determined that you have received payments under this Plan that exceed the amount of Medical Expenses that have been substantiated by you during the Plan Year, the Plan Administrator shall give prompt written notice of any such excess amount, and you shall repay the amount of such excess to the Employer in accordance with procedures established by the Plan Administrator. The Plan Administrator may offset future benefits by an amount equal to the excess reimbursement. If all attempts to recover the excess reimbursement are unsuccessful, the Plan Administrator may direct the Company to include such amounts in your gross income.

Death of Employee and Dependents of Deceased Employees

Your HRA provides survivor benefits that depend on who is covered under this Plan at the time of your death, as follows:

- Your HRA may be transferred to your Spouse if your Spouse continues coverage under COBRA following your death. If coverage is not continued, your estate may submit claims for reimbursement of eligible expenses incurred up to your date of death.

- Your Spouse may assume your HRA Account and can use it to reimburse expenses for him/herself and your dependent child(ren) until it is exhausted. When Your Spouse dies, any remaining balance is forfeited.

- Your Spouse may not add new dependents.

- If your Dependent Child(ren) are the only Eligible Dependents upon your death, any remaining balance is forfeited (regardless of whether or not the dependent continues to be eligible).

- Forfeitures are treated by the Company in a manner that complies with applicable provisions of ERISA and the Code.

Using Your HRA

You have three options to use the balance in your HRA:

1. Smart-Choice Accounts Card

You will use the Smart-Choice Accounts debit card to access your HRA. You will receive your Smart-Choice Accounts debit card in the mail. Always be sure to save your receipts, as you may be required to submit documentation. This should be in the form of a paid, itemized receipt from the provider. Credit card receipts are not accepted as proof of payment or substantiation. Explanation of Benefits (EOB) are accepted as proof of payment or substantiation, as long as you supply the complete EOB, including the footnotes.

2. Automatic Reimbursement

If you select the automatic reimbursement method, your HRA will automatically reimburse you (via check or direct deposit) whenever you have a claim for eligible healthcare expenses under the Plan.

3. Submit Manual Claims

You may submit eligible healthcare claims for reimbursement online, by mail, or by fax. Visit the American Airlines Benefits Service Center Smart-Choice Accounts site or call **Smart-Choice Accounts at 888-860-6178** for instructions and claim submission information.

You must submit a claim for reimbursement no later than 365 days following the date of service, If you don't submit your claim within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. The time limit does not apply if you are legally incapacitated.

Additional Rules That Apply to the Plan

Overview

Unless otherwise stated in this SPD, the following rules apply to employees covered under the Plan.

Qualified Medical Child Support Orders (QMCSO) Procedures

The following procedures have been adopted and amended with respect to medical child support orders received by group health benefits and plans maintained for U.S. based employees of American Airlines, Inc. These procedures shall be effective for medical child support orders issued on or after the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) relating to employer-provided group health plan benefits. This notice applies to the health care components of the following plans: American Airlines, Inc. Plus Plan for Active Employees, American Airlines, Inc. Health & Welfare Plan for Active Employees, the Supplemental Medical Plan for Employees of Participating American Airlines Group Subsidiaries, the American Airlines, Inc. Health and Life Plan for Retirees, the TWA Retiree Health and Life Benefit Plan, the American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees, the American Airlines Inc. Flexible Benefit Plan for Certain Legacy Employees, and any other group health plan for which American Airlines, Inc. ("American") or its delegate serves as Plan Administrator (collectively, the "Plan").

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 an employee who is eligible for a Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.
- The term "Alternate Recipient," as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.
- The term "Order," as used in these procedures, refers to a "medical child support order," which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security

Act (as added by section 13822 of OBRA ’93) with respect to a group health plan.

- The term “QMCSO” or “NMSN,” as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these Procedures, or a notice from a state agency ordering the coverage of an Alternate Recipient under health benefits with respect to a Participant under a plan and that meets the requirements to be an NMSM decreed to be a QMCSO.
- The term “Plan Administrator,” as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures upon Receipt of Qualified Medical Child Support Order (QMCSO) or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at:

American Airlines QMCSO PO BOX 1542
Lincolnshire, IL 60069-1542
Fax#: 847.442.0899

In addition, QMCSOs or NMSNs should be delivered to the same address.

Upon receipt (or within 15 days of receipt) by the Plan Administrator of a request for information on health coverage or a state agency notice to enroll a child, the Plan Administrator will send out a letter notifying the requesting party that it has received the order or notice and describing the Plan’s procedures for determining whether the order is qualified or a notice is received, whether the coverage is available under the Plan to the child and the steps to be taken by the custodial parent or agency to effectuate coverage.

Upon receipt of an Order, or upon request, the Plan Administrator will advise each person or party specified in the medical child support order that, in order to be a QMCSO or NMSN, the Order must satisfy the requirements of ERISA and OBRA ’93 before the Plan Administrator is obligated to comply with its terms. These requirements state that the Order:

- Must be a “medical child support order”, which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an

administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) (OBRA '03)) with respect to a group health plan.

- Must relate to the provision of medical child support and create or recognize the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a Plan and that meets the requirements set out in these procedures.
- Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.
- Does not require the Plan to provide any type or form of benefit or option that is not otherwise available under the Plan.
- Must clearly specify:
    - The name and last known mailing address of the employee and the name and address of each Alternate Recipient covered by the Order
    - A reasonable description of the coverage that is to be provided by the Plan to each Alternate Recipient or the manner that the coverage shall be determined
    - The period to which the Order applies (if no date of commencement of coverage is provided, or if the date of commencement of coverage has passed when the Order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the Order)
    - The name of each Plan to which the order applies (or a description of the coverage to be provided)
    - A statement that the Order does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan (except as a condition of receiving federal assistance for Medicaid)
    - The fact that all Plan contributions with regard to the Alternate Recipient shall be deducted from the Participant's pay.

American Airlines, Inc. does not provide interim coverage to any employee's dependent during the pendency of a QMCSO or NMSN review. A dependent's entitlement to benefits under the Plan prior to the approval of a QMCSO or an NMSN is determined by the dependent's eligibility and enrollment in the Plan in accordance with the terms of the Plan. Without a QMCSO or NMSN, the Company cannot be held liable if an employee's dependent is either (i) not enrolled in coverage in the Plan, or (ii) is eliminated from coverage in the Plan. In addition, neither American Airlines, Inc. nor the Plan has any obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) an employee's dependent except upon application by the employee in accordance with the terms of the Plan, or in accordance with a QMCSO or NMSN. If the requesting party needs assistance in preparing or submitting a QMCSO or NMSN, he or she may contact the Plan Administrator or go to the 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 Summary Plan Description and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipient, at the issuing agency's address. If the Participant is not enrolled, the Plan Administrator shall enroll the Participant, as well as the child in the coverage.

Notification will occur within 40 business days of receipt of the Order or notice.
If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Participant, the Alternate Recipient, the state agency issuing the notice or any designated representative in writing of such fact within 40 business days of receipt of the Order or notice. The notification will state the reasons the Order or notice is not a QMCSO or NMSN and that the Plan Administrator shall treat the Participant's benefits as not being subject to the Order. Any subsequent determination that an Order is a QMCSO will be administered prospectively only.

Appeal Process

If the Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he or she must file an Application for Appeal within 60 days of receiving notification of denial of the medical child support order's or medical support notice's qualification. Appeals will be reviewed by the Employee Benefits Committee (EBC) or its authorized delegate in accordance with ERISA and the terms and provisions of the Plan and notify the Participant or Alternate Recipient within 60 days of receipt of the appeal of their decision. A copy of the Plan's appeal procedures, as set forth in the Summary Plan Description, shall be provided upon request.

Coordination of Benefits

This section explains how the Plan coordinates coverage between the Plan and any other benefits/plans that provide coverage for you or your Eligible Dependents.
If you or any other covered dependents have primary coverage (see "Which Plan Is Primary" in this section) under any other group medical plans, the Plan 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 the Plan were your only coverage.

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

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

If you or your dependent is hospitalized when coverage begins under this Plan, your prior coverage is responsible for payment of medical services until you are released from the hospital. If you have no prior coverage, the benefit program will pay benefits only for the portion of the hospital stay occurring after you became eligible for benefit program coverage. The Plan's coordination of benefits rules apply regardless of whether a claim is made under the other plan. If a claim is not made, benefits under the Plan may be delayed or denied until an explanation of benefits is issued showing a claim made with the primary plan.

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

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

The Plan has first priority with respect to its right to reduction, reimbursement and subrogation.

The Plan will not coordinate benefits with an HMO or similar managed care plan where you only pay a copayment or fixed dollar amount.

Other Plans

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

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

Which Plan Is Primary

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

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan

if it covers the individual as an employee.

- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.
- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under this Plan are paid according to federal regulations. In case of a conflict between this Plan and federal law, federal law prevails.
- The Plan is always secondary to any motor vehicle policy that may be available to you, including personal injury protection (PIP coverage) or no-fault coverage. If the Plan pays benefits as a result of injuries or illnesses resulting from the acts of another party, the Plan has a right of reimbursement or subrogation as to the benefits paid. Please see the Plan's Subrogation and Reimbursement provision.
- If the coordination of benefits is on behalf of a covered Child:
    - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise.
- For a stepchild or Special Dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the other plan has a gender rule, that plan determines which plan is primary.
- When a person is covered under a right of continuation coverage pursuant to federal or state law (such as the Consolidated Omnibus Budget and Reconciliation Act) and also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary.
- When none of the above establishes an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time will be primary.

Coordination with Medicare

If you (or one of your dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare benefits for Prescription drug benefits), the Plan is the primary payer if:

- You are currently working for American Airlines, Inc.;
- You become eligible for Medicare due to your (or your dependent) having end- stage renal disease, but only for the first 30 months of Medicare entitlement due to end-stage renal disease; or
- You become eligible for Medicare due to becoming eligible for Social Security Disability and your coverage under this Plan is due to the current employment status of the employee. (For this purpose, you will only be considered to have current employment status during the first six months in which you receive Company paid disability benefits that are subject to FICA tax. Generally, Medicare does not begin to pay benefits until after this period ends.)

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

- You (or your dependent) are covered by Medicare, do not have end-stage renal disease, and you are not currently working for American Airlines, Inc. or deemed to have coverage because of current employment status.
- You become eligible for Medicare due to you (or your dependent) having end- stage renal disease, but only after the first 30 months of Medicare entitlement due to end-stage renal disease is exhausted.

If you (or your dependent) are age 65 or over and the Plan would otherwise be the primary payer because you are still working, you or your dependent may elect Medicare as the primary payer of benefits. If you do, benefits under the Plan will terminate.

Benefits for Disabled Individuals

If you stop working for American Airlines, Inc. because of a disability and you are eligible for Social Security Disability Benefits, or if you retire before age 65 and subsequently become disabled and you are eligible for Social Security Disability Benefits, you must apply for Medicare Parts A, B and D, or Parts C and D, whichever is applicable. Medicare Part A provides inpatient hospitalization benefits, Medicare Part B provides outpatient medical benefits, such as doctor's office visits, and Medicare Part D provides prescription drug benefits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the Plan, the Plan will

pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the Plan considers eligible, the Plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any. When Medicare is the primary payer, no benefits will be payable under the Plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement. By enrolling in the Plan and applying for benefits from the Plan, you and your covered dependents (including minor dependents) agree and acknowledge that benefits are not payable to or on behalf of a covered person or dependent when the injury or illness occurs through an act or omission of another person, party, or entity, and any such payments made or advanced by the Plan are subject to the following terms and conditions:

Subrogation applies when the Plan has paid benefits on your behalf for a sickness or injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. The Plan has the right to subrogate 100 percent of the benefits paid or to be paid on your behalf.

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100 percent of any benefits you received for that sickness or injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable

or legal liability theory.

You further agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
    - Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with us. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- By accepting benefits from this Plan, you agree that the Plan has established an equitable lien by agreement and has a first priority right to receive payment on any claim against a third party before you receive payment from that third party, whether obtained by judgment, award, settlement, or otherwise. The Plan has the right to 100 percent reimbursement in a lump sum and has the right to recover interest on the amount paid by the Plan because of the actions of a third party.

Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's lien exists at the time the Plan pays benefits, and if you or your covered dependents file a petition for bankruptcy, you and your

covered dependents agree that the Plan's lien existed prior to the creation of the bankruptcy estate.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and the Plan is not responsible for your attorney's fees, expenses and costs. The Plan is not subject to any state laws or equitable doctrines, including but not limited to the so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine," which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable doctrine or state law shall limit or defeat the Plan's subrogation and reimbursement rights.
- If this Section applies, the Plan will not cover either the reasonable value of the services to treat such an injury, sickness or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By accepting benefits from this Plan, you and your covered dependents automatically assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury, including another group health plan, insurer or

individual. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

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

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

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Notice of Privacy Rights

This notice describes how your protected health information or PHI may be used or disclosed under the privacy and security rules of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). It applies to the health care components of the following plans: American Airlines, Inc. Plus Plan for Active Employees, American Airlines, Inc. Health & Welfare Plan for Active Employees, the Supplemental Medical Plan for Employees of Participating American Airlines Group Subsidiaries, the American Airlines, Inc. Health and Life Plan for Retirees, the TWA Retiree Health and Life Benefit Plan, the American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees, the American Airlines Inc. Flexible Benefit Plan for Certain Legacy Employees, the American Airlines, Inc. DFW ConnectedCare Plan, and any other group health plan for which American Airlines, Inc. ("American") or its delegate serves as Plan Administrator (collectively, the "Plan").

Uses and Disclosures of Your Information

The following uses and disclosures of your PHI may be made by the Plan:

For Treatment, Payment, and Health Care Operations. The Plan may use or disclose your PHI for the purposes of routine treatment, payment, or health care operations related to the Plan. For example, the Plan may use your PHI for management activities related to the Plan, including auditing, fraud and abuse detection, and customer service. The Plan also may use or disclose your PHI in order to pay your claims for benefits. For example, the Plan may use your information to make eligibility determinations and for billing and claims management purposes. Note that the Genetic Information Nondiscrimination Act ("GINA") prohibits using PHI that is genetic information for underwriting purposes.

To the Plan Sponsor. The Plan may disclose your PHI to the Plan Sponsor so that the Plan Sponsor can perform administrative functions on behalf of the Plan, such as facilitating claims or appeals.

When Required or Permitted by Law. The Plan may also disclose or use your PHI where required or permitted by law. Federal law, under HIPAA, generally permits health plans to use or disclose PHI for the following purposes:

- To family members, other relatives and your close personal friends that you have identified and who are directly involved with your care or payment for that care.
- To notify a family member or other individual involved in your care of

your location, general condition, or death or to a public or private entity authorized by law or its charter to assist in disaster relief efforts to make such notifications.

- When required by law.
- For purposes of public health activities.
- To report abuse, neglect or domestic violence to public authorities.
- To a public health oversight agency for oversight activities.
- Pursuant to judicial or administrative proceedings.
- For certain law enforcement purposes.
- For a coroner, medical examiner, or funeral director to obtain information about a deceased person.
- For government-approved research activities.
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- To comply with Workers' Compensation laws.
- For organ, eye, or tissue donation purposes.
- For certain government functions, such as related to military service or national security.

Pursuant to Your Authorization. Any other use or disclosure of your PHI will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The Plan will obtain your written authorization to use or disclose PHI for marketing purposes where the Plan receives financial remuneration, for the sale of PHI, or with respect to psychotherapy notes, except for limited health care operations purposes.

Stricter State Privacy Laws. Under the HIPAA privacy and security rules, the Plan is required to comply with State laws, if any, that also are applicable and are not contrary to HIPAA (for example, where state laws may be stricter).

Rights You May Exercise

You have several rights with respect to your PHI, which are described below. Please call the privacy contact listed below if you have questions about your rights.

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. The Plan generally is not required to agree to your requested restriction, except in limited circumstances.

To Access. You have the right to request access to your PHI and to inspect and copy your PHI in the designated record set under the policies and procedures established by

the Plan or to request an electronic copy. The Plan may charge a reasonable, cost-based fee for such copies. You or your personal representative will be required to make a written request to request access to the PHI in your designated record set.

To Amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than the Plan.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those you have authorized or for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request.

To Obtain a Paper Copy of This Notice. An individual who receives or has consented to receive an electronic copy of this notice has the right to obtain a paper copy of this notice from the Plan upon request.

To Request Confidential Communication. You have the right to request confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

Our Duties With Respect to Your Individually Identifiable Health Information

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

Organized Health Care Arrangement

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

Questions?

If you have questions or would like more information about the Plan's privacy policies, you may contact the American Airlines Benefits Service Center at 888-860-6178
You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You cannot be retaliated against for filing such a complaint.

***Effective Date of Notice**: January 1, 2022*

Plan Service Providers

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

Rescission in Event of Fraud

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

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-543-7669 (1-877-KIDS NOW)

or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan. If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-3272.

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ 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: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

COBRA

Overview

If your coverage under the Plan would otherwise end because of certain Qualifying Events (described below), you may elect to continue your health benefits as part of your continuation of coverage options available through Alight Solutions, the COBRA administrator. Alight Solutions will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your medical coverage through COBRA, claims incurred after the date of your termination are not payable.

The Plan provides for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain Qualifying Events (described below). If you and/or your dependents have coverage at the time of the Qualifying Event, you may be eligible to elect continuation of coverage under the Plan.

The coverage under COBRA is identical to coverage provided under the benefits or plans for similarly situated employees or their dependents, including future changes.

Eligibility

Eligibility for continuation of coverage depends on the circumstances that result in the loss of existing coverage for you and your Eligible Dependents. The sections below explain who is eligible to elect continuation of coverage and the circumstances that result in eligibility for this coverage continuation.

Continuation of Coverage for You and Your Dependents (Qualifying Events)

You may elect continuation of coverage for yourself and your Eligible Dependents for a maximum period of 18 months, if your coverage would otherwise end because of the following Qualifying Events:

- Layoff or termination of your employment for any reason (except in the event of termination for gross misconduct).

If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you (or any Eligible Dependent) are disabled at any time during the first 60 days of continuation of coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself and your dependents. To qualify for this additional coverage, the Qualified Beneficiary must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (Alight Solutions) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.

Continuation of Coverage for Your Dependents Only (Qualifying Events)

Your covered dependents may continue coverage for a maximum period of 36 months if coverage would otherwise end because of the following Qualifying Events:

- Your divorce or legal separation

- Becoming enrolled in Medicare benefits
- Loss of eligibility because the dependent no longer meets the Plan's definition of a dependent (for example, if a Child reaches the Plan's limiting age). The dependent loses coverage on the last day of the month in which they attain age 26.
- Your death

If you experience more than one of these Qualifying Events, your maximum continuation of coverage is the number of months allowed by the Qualifying Event that provides the longest period of continuation.

How to Elect Continuation of Coverage

Solicitation of Coverage Following Layoff or Termination

In the event that your employment ends through layoff or termination, you will automatically receive information from Alight Solutions, the COBRA administrator, about electing continuation of coverage through COBRA.

Solicitation of Coverage Following a Qualifying Event

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

Enrolling for Coverage

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

solicitation information.

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

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

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

Note: If you are 65 or older and Medicare-eligible, Medicare will become the primary payer, even if you have not enrolled in Medicare. COBRA is secondary to Medicare and only covers what Medicare does not. You can enroll in Medicare when your active coverage ends, even outside of the annual enrollment period. If you do not have Medicare coverage, or have only Medicare Part A, when your group health plan coverage ends, you can still enroll in Medicare Part B during a "Medicare Special Enrollment Period" without having to pay a Medicare Part B premium penalty. To avoid paying this premium penalty, you need to enroll in Medicare Part B either at the same time you enroll in Medicare Part A or during a Medicare Special Enrollment Period after your group health plan coverage ends. You avoid the premium penalty by documenting your employment based group health plan coverage by completing a form supplied by the Social Security Administration. This form (https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS-L564E.pdf) will need to be submitted to the American Airlines Benefits Service Center for completion.

If you are eligible for Medicare and decide to elect COBRA coverage anyway, and you wait until the COBRA coverage ends before enrolling in Medicare Part B, you will have to pay a Medicare Part B premium penalty.

Processing Life Events after Continuation of Coverage Is in Effect

If you elect continuation of coverage for yourself and later marry, give birth, or adopt a Child while covered by continuation of coverage, you may elect coverage for your newly acquired dependents after the Life Event. To add your dependents, contact the American Airlines Benefits Service Center within 60 days of the marriage, birth, or adoption.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29 or 36 months, depending on the Qualifying Event). This new dependent will not have the right to continue coverage on his or her own if there is a divorce or another event that causes loss of coverage. You may add a newborn Child or a Child newly placed for adoption to your COBRA continuation of coverage. You should notify the American Airlines Benefits Service Center of the newborn Child or Child newly placed for adoption within 60 days of the Child's birth or placement for adoption.

All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to continuation of coverage.

Paying for COBRA Coverage

To maintain COBRA continuation of coverage, you must pay the full cost of continuation of coverage on time, including any additional expenses permitted by law. Your first payment is due within 45 days after you elect continuation of coverage. Premiums for subsequent months of coverage are due on the first day of each month for that month's coverage. If you elect continuation of coverage, you will receive payment coupons or invoices from Alight Solutions 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 the American Airlines Benefits Service Center immediately, but no later than three months after you make your first COBRA premium payment in order to be eligible for a refund. Payments will not be refunded after this three-month period, regardless of the reason.

If claims have been paid during this three-month period, the Plan will request reimbursement from you. If the amount of your premium payments for continuation of coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the Plan receives reimbursement for your claim, the Plan will refund your premiums.

This time limit for refunds also applies if the Company discovers that continuation of coverage has been provided to you or your dependent in error.

When Continuation of Coverage Begins

If you or your dependents elect continuation of coverage within 60 days of receiving your election forms, the coverage becomes effective on the date your other coverage

would otherwise end. Thus, the first premium for continuation of coverage includes payment for this retroactive coverage period.

When Continuation of Coverage Ends

Continuation of coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29 or 36 months) expires. (See "Processing Life Events After Continuation of Coverage Is in Effect" in this section.)
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement.
- The Plan Participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a Pre-Existing Condition Limitation that affects the Plan Participant. In that event, the Participant is eligible for continuation of coverage up to the maximum time period.
- The Plan Participant continuing coverage becomes enrolled in Medicare
- The Company no longer provides the coverage for any of its employees or their dependents

See "Dependent Eligibility Criteria" in the *General Eligibility* section.

Keep Us Informed of Address Changes

In order to protect you and your family's rights, your address should be kept up to date.

- Employees must update their personal information through Employee Central via Jetnet
- If you are separated from the Company, you must contact the Team Member Service Center at 1-800-447-2000
- Dependents may be updated online through the American Airlines Benefits Service Center.

Impact of Failing to Elect Continuation of Coverage on Future Coverage

In considering whether to elect continuation of coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise

eligible (such as a plan sponsored by your Spouse ’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 (PPACA). You will also have the same special enrollment rights at the end of continuation of coverage if you get continuation of coverage for the maximum time available to you.

Additional Questions

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

Claims Procedures

Time Frame for Initial Claim Determination

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

For claims under the Plan, the processing rules vary by the type of claim. For **Urgent Care claims** and **pre-service claims** (claims in which the service has not yet been rendered and/or that require approval of the benefit or precertification before receiving medical care), the Network/Claim 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); and
- Fifteen days after receipt of a **pre-service claim**.

For **post-service claims** (claims that are submitted for payment after you receive medical care), the Network/Claim 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 with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Network/Claim 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 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 determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Network/Claim 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 sends you an extension notification until the date you respond to the request for additional information.

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

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

Urgent Care Claims

Urgent Care claims are those that, unless the special Urgent Care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function; or
- In the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the Urgent Care definition has been satisfied. However, if a Physician with knowledge of the patient's medical condition determines that the claim involves Urgent Care, it must be considered an Urgent Care claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

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

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

If You Receive an Adverse Benefit Determination the Network/Claim Administrator will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination,
- References to the specific Plan provisions on which the benefit determination is based,
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary,
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request,
- If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits,
- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim,
- The Network/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,

- Date of service, the health care Provider, the claim amount,
- The denial code and corresponding meaning,
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for internal appeal or external review, and will not trigger the start of an internal appeal or external review),
- A description of the Claims Administrator's standard, if any, used in denying the claim,
- A description of the external review process, if applicable,
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes.

Appealing a Denial

You must file your appeal within the deadlines set forth below.

Important Information about Health Care Provider's Appeals

Health care Providers may not pursue appeals on your behalf, unless you designate your Provider as your authorized representative. The Plan prohibits the assignment of any benefit or any legal claim or cause of action (whether known or unknown). (See "Anti-Assignment of Benefits" in the Plan Administration chapter.)

Appealing an Enrollment or Eligibility Status Decision

American Airlines, Inc. or its delegate will determine Enrollment and Eligibility appeals (also referred to as "Administrative appeals") under the following process:

- **First Level Appeal:** If your request for eligibility or enrollment in a benefit under the Plan has been denied, you may submit a First Level Appeal to Alight Solutions. You have 180 days from the date of the denial within which the file a First Level Appeal. An application for a First Level Appeal can be found at https://www.my.aa.com/appeals, which must accompany your request for a First Level Appeal. Alight Solutions will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing within 30 days of receipt

of your First Level Appeal.

- **Second Level Appeal:** Upon your receipt of the First Level Appeal decision notice upholding the prior denial, you may submit a Second Level Appeal to the Employee Benefits Committee (EBC). You have 180 days from the date of the First Level Appeal decision within which to file a Second Level Appeal. An application for a Second Level Appeal can be found at https://www.my.aa.com/appeals, which must accompany your request for a Second Level Appeal. The EBC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing within 60 days of receipt of your Second Level Appeal.

American Airlines, Inc. reserves the right to change its process for determining enrollment and eligibility appeals at any time and without prior notice.

Appealing an Adverse Benefit Determination

American Airlines, Inc., as Plan Sponsor and Plan Administrator of the Plans, has a two- tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the Network/Claim Administrator or benefit vendor that rendered the adverse benefit determination. Second Level Appeals are also conducted by the Network/Claim Administrator.

This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document. The one exception to this mandatory two-tiered process is an appeal for an Urgent Care claim – for Urgent Care claim appeals, only Second Level Appeals are required – no First Level Appeals are necessary. Employees must use both levels of appeal (or the Second Level Appeal for Urgent Care claims) and must exhaust all administrative remedies to resolve any claim issues.

First Level Appeal

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Network/Claim 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/Claim Administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination. For Urgent Care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

Information about filing a First Level Appeal can be found at https://my.aa.com/appeals.

The Network/Claim Administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For pre-service claims – within 15 days of receipt of your First Level

Appeal

- For post-service claims – within 30 days of receipt of your First Level Appeal
- For Urgent Care claims – within 72 hours of receipt of your First Level Appeal

Second Level Appeal

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

You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the Network/Claim Administrator, please complete an application for Second Level Appeal, and include with the application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. Information about filing a second level appeal can be found at https://my.aa.com/appeals.

The Network/Claim Administrator will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within 15 days of receipt of your Second Level Appeal
- For post-service claims, within the 30 days of receipt of your Second Level Appeal
- For Urgent Care claims, within the 72-hour time period allotted for completion of both levels of appeal

Upon its receipt, your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the Network/Claim Administrator.

Rights on Appeal

In the filing of appeals under the Plan, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all

documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:

  - Was relied upon in making the benefit determination
  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination

- Be allowed to review your claim file documents and to present evidence/testimony
- Receive from the Plan Administrator or 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 Administrator has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is Experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision

- In the case of a claim for Urgent Care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
    - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

You also have the following rights:

- Before the Plan issues an adverse benefit determination on review, the Plan shall provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination (or at the direction of the Plan or such other person) in connection with the claim. Such evidence will be provided as soon as possible to give you a reasonable opportunity to respond prior to the date on which the notice of adverse benefit determination on review is required to be provided.
- Before the Plan issues an adverse benefit determination on review based on a new or additional rationale, the Plan shall provide you, free of charge, with the rationale. The rationale will be provided as soon as possible to give you a reasonable opportunity to respond prior to the date on which the notice of adverse benefit determination on review is required to be provided.

Notice of Determination

If your appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will set forth:

- The specific reason(s) for the adverse benefit determination,
- References to the specific Plan provisions on which the benefit determination is based,
- A description of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination,
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request,
- If the adverse benefit determination was based on a Medical Necessity or Experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the

adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits,

- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits,
- A description of any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures,
- Date of service, the health care Provider, the claim amount,
- The denial code and correspondent meaning,
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for external review, and will not trigger the start of external review),
- A description of the Claims Administrator's standard, if any, used in denying the claim,
- A description of the external review process, if applicable, and
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes.

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

If the Plan Administrator or Network/Claim Administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may initiate a request for external review, you may pursue a civil action under ERISA §502(a). However, keep in mind that the claim and appeal process won't be deemed exhausted based on *de minimis* violations of law (as long as the Plan Administrator or 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.

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 the Plan 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 U.S. Preventive Services 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)

Your external review will be conducted by an independent review organization not affiliated with the Plan. Your appeal denial notice will include more information about your right to file a request for an external review on contact information. You must file your request for an external review *within four months* of receiving your final internal appeal determination.

An external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

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

Deadline to Bring Legal Action

You must use and exhaust the Plan’s administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plan’s prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit *within two years* of the date after the adverse benefit determination is made on final appeal.

Plan Administration

Administrative Information

Plan Name & Number

American Airlines, Inc. Plus Plan for Active Employees 1-888-860-6178

Plan Sponsor

American Airlines, Inc., or its authorized delegate

Mailing address:
Mail Drop 8A203
P.O. Box 619616
DFW Airport, TX 75261-9616

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

Plan Administrator

The Employee Benefits Committee

Mailing address:
Mail Drop 8A203
P.O. Box 619616
DFW Airport, TX 75261-9616
General Phone: 1-800-433-7300

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

The Plan Administrator has delegated certain administrative functions to Alight Solutions, including answering questions about eligibility on behalf of American Airlines, Inc. They can be reached at: 1-888-860-6178.

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

shall not in any way be deemed to require the Plan Administrator (or its delegate(s)) to do so in similar cases.

Agent for Service of Legal Process

Vice President, Compensation and Benefits American Airlines, Inc.
Mailing address:
Mail Drop 8A204
P.O. Box 619616
DFW Airport, TX 75261-9616

Express Delivery address:
1 Skyview DriveMail Drop 8A204 –
Fort Worth, TX 76155

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Plan Type

Health and welfare benefits, including medical and prescription drugs.

Plan Funding

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

Other Legal Information

Plan Amendment and Termination

The Company or its authorized delegate has the sole authority to adopt new employee benefit plans, amend existing plans, and terminate plans. The Company may at any time amend the Plan by written instrument executed by an officer of the Company. Further, the Company reserves the right to terminate the Plan at any time. On or after the effective date of a termination, no further benefits shall be payable to or on behalf of any participant to whom such termination applies.

No Commitment to Employment

Nothing in the Plan shall be construed as a commitment or agreement upon the part of any person to continue his employment with the Company, and nothing contained in the Plan shall be construed as a commitment on the part of the Company to any rate of

compensation of any person for any period, and all employees of the Company shall remain subject to discharge to the same extent as if that Plan had never been put into place.

No Precedent

Except as otherwise specifically provided, no action taken in accordance with the provisions of the Plan by the Plan Administrator or the Company shall be construed or relied upon as precedent for similar action under similar circumstances.

Severability

If a provision of the Plan is held illegal or invalid, the illegality or invalidity does not affect the remaining parts of the Plan and the Plan must be construed and enforced as if the illegal or invalid provision had not been included in the Plan.

Anti-Assignment of Benefits

You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care Providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care Providers are not, and shall not be construed as, either "participants" or "beneficiaries" under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

Confidentiality of Claims

The Company and its agents (including the Network/Claim Administrator) will use the information you furnish to substantiate your claim and determine benefits. The information may be forwarded to independent consultants for medical review or appropriate medical follow-up. In addition, certain individuals within the Company will have access to this information to carry out their duties to administer the coverages properly.

The Company treats your medical information as confidential and discloses it only as may be required for the administration of the Plans or as may be required by law.

For more information about the confidentiality of your Protected Health Information under the Health Insurance Portability and Accountability Act (HIPAA), see "Notice of Privacy Rights**".**

Payment of Benefits

Benefits will be paid to you unless you have authorized payment to your service Provider. Benefits are paid after the 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 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 under the Plan (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

The right to benefits under the Plan may not be exchanged for, or substituted for, other benefits or cash compensation.

Right to Recovery

The Plan and 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 described in "Subrogation." If the participant or former participant, or any other person or organization, does not repay to the Plan the amount owed in a lump sum within 30 days of receiving notice, then notwithstanding any provision in this SPD to the contrary and without limiting any other remedies available to the Plan, the Plan may reduce the amount of any benefits that become payable to the participant or the participant's service Providers to recover the amount owed to the Plan.

The 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 institution, Physician, or other service Provider
- Any other organization.

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 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 661052

Dallas, TX 75266-1052

1-888-860-6178

For information about your claims, contact the appropriate Network/Claim Administrator or Plan Administrator at the addresses and phone numbers located in the “Contact Information” in the *Reference Information* section.

Benefits under the Plan and Contact Information

The Network/Claim Administrator for each benefit under the Plan vary and are listed below. The chart below also describes how benefits under the Plan are funded.

Benefit	Network/Claim Administrator and Plan Funding
Medical and Mental Health/Chemical Dependency Coverage	
HRA Plan	**Network/Claim Administrators:** **BlueCross and BlueShield of Texas** P.O. Box 660044 Dallas, TX 75266-0044 Website: https://www.bcbstx.com/americanairlines **UMR** American Airlines, Inc. Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551 Website: americanairlines.welcometouhc.com Please contact the above Network/Claim Administrators for CheckFirst (Predetermination of Benefits) and QuickReview (Pre-authorization for Hospitalization). **Plan Funding:** Self-funded through the general assets of the Company and employee contributions
Telehealth	For more information about Telehealth services and technological requirements, visit Doctor on Demand via Website: doctorondemand.com Phone: 1-800-997-6196.
Prescription Drugs	
Mail Service Drug Option (Mail Order Pharmacy Service)	**CVS Caremark** – Customer Care Correspondence P.O. Box 6590 Lee's Summit, MO 64064-6590 Phone: 1-844-758-0767 (American Airlines CVS number) Phone: 1-800-552-8159 (General CVS Customer Care) Website: www.caremark.com

Health Reimbursement Account (HRA)	
	Alight Solutions Your Spending Account Services P.O. Box 785040 Orlando, FL 32878-5040 Fax: 1-888-211-9900 Reimbursements are paid from the Company's general assets.

More Information About:	Contact
General questions Dependent eligibility Information updates	**American- Airlines, Inc. Benefits Service Center** P.O. Box 661052 Dallas, TX 75266-1052 Phone: 1-888-860-6178
Online Help from a Benefits Service Center Representative	**American Airlines, Inc. Benefits Service Center Chat** my.aa.com or newjetnet.aa.com Click on Team Member Services, then Health & Benefits, click Benefits Service Center, click on "chat" at the bottom of the screen.
Forms, Guides and Contact Information	my.aa.com (Benefits Information page)
Qualified Medical Child Support Orders (QMCSO)	**American Airlines QMCSO** P.O. Box 1542 Lincolnshire, IL 60069-1542 Fax: 1-847-442-0899 (Include a cover sheet with the employer name and employee name)

More Information About:	Contact
Provider Directories	**If your Network/Claims Administrator is:** BlueCross BlueShield of Texas bcbstx.com/americanairlines **UMR** americanairlines.welcometouhc.com
Continuation of Coverage (COBRA) Direct billing while on Leave of Absence	**COBRA Administrator:** Alight Solutions P.O. Box 1345 Carol Stream, IL 60132-1345 Phone: 1-888-860-6178 Fax: 1-847-554-1884
Appeals	**BlueCross and BlueShield of Texas** Attn: Appeals Department PO Box 660044 Dallas, TX 75266-0044 Phone: 1-833-346-3929 Fax: 801-994-1083 Email: Send a secure email using the Message Center by logging into Blue Access for Members℠ (BAM) at bcbstx.com **CVS Caremark** Attn: CVS/caremark Appeals Department P.O. Box 5200, MC109 Phoenix, AZ 85072-2000 Phone: 1-855-344-0930 Fax: 1-855-633-7673

More Information About:	Contact
	American- Airlines, Inc. Benefits Service Center Enrollment or Eligibility Status Decisions, Benefit Changes Secondary to Life Events, Benefit Contributions (including payment of contributions while on leave of absence), or Benefit Changes Outside the Annual Enrollment Period, Elections, etc. **Attn: Claims and Appeals Management** **American Airlines** P.O. Box 1407 Lincolnshire, IL 60069-1407 Phone: 1-888-860-6178

Glossary of Terms

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 Alternative and/or Complementary 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).

American Airlines Benefits Service Center or Benefits Service Center (Alight Solutions): The online enrollment tool, available via my.aa.com.

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.

Annual Enrollment or **Annual Enrollment Period:** The period, usually in the fall of each year, during which employees make benefit elections for the next Plan year.

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

- (1) Federally funded trials. The study or investigation is

approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(a) The National Institutes of Health.

(b) The Centers for Disease Control and Prevention.

(c) The Agency for Health Care Research and Quality.

(d) The Centers for Medicare & Medicaid Services.

(e) Cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

(f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(g) Any of the following if certain conditions are met:

- The Department of Veterans Affairs.
- The Department of Defense.
- The Department of Energy.

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

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

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

Child: Your

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

Chiropractic Care: Medically Necessary diagnosis, treatment or care for an injury or illness when provided by a licensed chiropractor practicing 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 Plan pays the remaining percentage, after you meet your deductible.

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 or Co-Payments: 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 the 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 Plan. The services are delivered under a defined set of Physician- approved policies and procedures or clinical protocols.

Disabled Dependent Child: A Child who meets all of the criteria listed in the section "Coverage for a Disabled Dependent Child."

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, respirators, and custom orthotics.

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 intervention 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 Dependent: Dependent eligibility requirements differ depending on the benefit coverage you elect. See the section "Dependent Eligibility" in the chapter "Eligibility and Enrollment" for information on dependent eligibility requirements.

Eligible Medical Expenses or Eligible Expenses: The 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 Medical Condition: A medical condition involving acute symptoms (including severe pain) that are severe enough so a prudent layperson, with average knowledge of health and medicine, could reasonably expect that lack of immediate medical attention will result in:

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

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

Gender Reassignment Benefit (GRB): Provides coverage for gender reassignment for the treatment of gender dysphoria. For more information, see the section "Covered Expenses".

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

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.

In-Network: Refers to benefits and services you receive from Providers that directly or indirectly contract with the Network/Claim Administrators as of the incurred date of service of a relevant claim. Generally, your benefits under the Plan are higher (and your Out-of-Pocket expenses lower) when you use In-Network services.

Individual Annual Deductible: An annual Deductible is the amount of Eligible Expenses you must pay each year before the Plan will start reimbursing you. After you satisfy the Deductible, the Plan pays the appropriate percentage of eligible covered medical services.

Infertility Treatment: 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 and treatment promoting fertility includes, but is not limited to: all forms of in-vitro fertilizations, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer and reversals of tubal ligations or vasectomies, drug therapy, including drug treatment for ovarian dysfunction and infertility drugs, such as Clomid, Pergonal, Lupron or Repronex.
Inpatient or Hospitalization: Medical treatment or services provided at a hospital when a patient is admitted and confined, for which a room and board charge is incurred.

Life Event: Certain circumstances or changes that occur during your life that allows you or your dependents to make specific changes in coverage options outside the Annual Enrollment Period. The Internal Revenue Service dictates what constitutes Life Events.

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

Loss or Impairment of Speech or Hearing: Loss or damage of verbalization or hearing, or 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, and 3-D Mammography.

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

Maximum Out-of-Network Charge (MOC): The MOC is the amount that your Network/Claim administrator will use in determining how much the Plan will pay toward Out-of-Network services. Except as provided under ERISA section 716 (which applies to certain emergency services and certain charges from nonparticipating providers practicing in provider facilities), the MOC for individual providers is either a rate negotiated by the Network/Claim Administrator or 140% of the rate that the federal Medicare program would pay for the service. The MOC for Out-of-Network facilities will be limited to 140% of the amount the federal Medicare program would have paid for the same service, or an amount based on 60% of the reasonable and customary charge as determined by your Network/Claim Administrator using its internal claims databases. Your Network/Claim Administrator will determine the MOC based on this formula.

Medical Expense: Medical care expenses as defined under Code section 213(d) or Code section 223(d)(2)(D) (menstrual care product) that are incurred by you or your Eligible Dependents.

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 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 inpatient confinement must meet all of the following criteria:

- Ordered by a Physician (although a Physician's order alone does not make a service Medically Necessary)
- Appropriate (commonly and customarily recognized throughout the Physician's profession) and required for the treatment and diagnosis of the illness, injury or pregnancy
- Unavailable in a less intensive or more appropriate place of service, diagnosis, or treatment that could have been provided instead of the service, supply or treatment
- Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications
- Provided in a clinically controlled research setting using a specific

research protocol that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening or seriously debilitating condition. The treatment must be considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications.

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

In the case of inpatient confinement, the length of confinement and hospital services and supplies are considered Medically Necessary to the extent the 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.

Network/Claim Administrators: The third-party organizations with which the Company maintains contracts to process benefit claims, determine Medical Necessity, and manage a Network of Providers and care facilities.

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.

Out-of-Network: Refers to benefits and services received from Providers that are not directly or indirectly contracted with the Network/Claim Administrators' networks as of the incurred date of service of a relevant claim. Generally, your benefits under the Plan are lower (and your Out-of-Pocket expenses higher) when you use Out-of-Network services.

Out-of-Pocket/Out-of-Pocket Maximum: Out-of-Pocket is the portion of covered expenses that you have to pay during the Plan Year. Out-of-Pocket Maximum is the most you will pay for covered expenses during the Plan Year.

Outpatient: Medical treatment or services provided at a hospital or clinic for a patient who is not admitted to the hospital for an overnight stay.

Over-the-Counter (OTC): Drugs, products and supplies that do not require a Prescription by federal law.

Physician: A licensed or certified practitioner of the healing arts acting within the scope of his or her license or certification. The term includes but is not limited to the following licensed individuals:

- Audiologist
- Certified social worker or advanced clinical practitioner
- Chiropractor
- Clinical psychologist
- Doctor of Dental Medicine (DMD)
- Doctor of Dental Surgery (DDS)
- Doctor of Osteopathy (DO)
- Doctor of Medicine (MD)
- Nurse anesthetist
- Nurse practitioner
- Physical or occupational therapist
- Physician Assistant (PA)
- Speech pathologist or speech language pathologist or therapist

The term does not include:

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

Plan Administrator: American Airlines, Inc., or its authorized delegate, is the Plan Administrator. The Plan Administrator maintains sole responsibility for the Plan and the benefits it provides. The Plan Administrator has the sole discretion to determine all

matters relating to eligibility, coverage and benefits under the Plan, including entitlement to benefits. The Plan Administrator also has the sole discretion to determine all matters relating to interpretation and operation of the Plan and may contract with third parties to provide some or all of these services to participants.

Plan Document: A formal written document or documents that establish the terms of employer sponsored group coverage. The American Airlines, Inc. Plus Plan Document for Active Employees serves as the Plan Document for the Plan, together with the documents that it incorporates by reference.

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

PPACA: The Patient Protection and Affordable Care Act.

Preferred Provider Organization (PPO): 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 and self-administered specialty drugs.

Primary Care Physician (PCP): An In-Network Physician who specializes in family practice, general practice, internal medicine, pediatrics, or OB/GYN and who may coordinate all of the In-Network medical care for a participant in the Plan.

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.

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.

Qualifying Event: A change in your status that causes you to lose eligibility for Plan coverage and would qualify you to be eligible for COBRA Continuation of Coverage. Qualifying Events are defined by COBRA. For examples, see "Continuation of Coverage" in the Additional Health Benefit Rules section.

Qualified Medical Child Support Order (QMCSO): An order, decree or judgment from a court or administrative body, which directs the Plan to provide coverage to the Child of a participant under the Plan.

Regular Employee: An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, or a Flexible Work Arrangement, depending on the business needs of the organization or the terms of the applicable labor agreement. A Regular Employee is eligible for the benefits and privileges that apply to his or her workgroup or as outlined in his or her applicable labor agreement.

Reliable Evidence: Reliable Evidence includes:

- Published reports and articles in the authoritative peer reviewed medical and scientific literature including: American Medical Association (AMA) Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Dispensing Information and National Institutes of Health, and 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 or certified by the state as a psychiatric and/or substance abuse Residential Treatment Center, or accredited by one of the following entities: the Commission on Accreditation of Rehabilitation Facilities ("CARF"), the Joint Commission on the Accreditation of Health Care Organizations, or the Council on Accreditation ("COA").

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.

Retiree Benefit Guide: Retiree Benefit Guide and Summary Plan Description for American Airlines, Inc. Group Life and Health Plan for Retirees and American Airlines, Inc. Supplemental Medical Plan.

School: A school or 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).

Specialist: A Specialist is any Provider or entity, other than a Primary Care Physician.

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

Spouse: Refers to both a "Spouse" and a "Common Law Spouse," as those terms are defined in the section "Determining a Spouse (SP) or Common Law Spouse Eligibility (CLSP)."

Summary Plan Description (SPD): A document provided to participants outlining terms of employer sponsored group coverage. This document serves as the Summary Plan Description for the Plan, along with any other benefits summary published by the Company that contains a description of this Plan. In our efforts to provide you with multimedia access to benefits information, American Airlines, Inc. has created online versions of the Summary Plan Descriptions for our benefit plans. If there is any discrepancy between the online version and the official hard copy of this document, then the official hard copy, plus official notices of Plan changes/updates will govern.

Telehealth: Live face–to-face video consultations for medical visits offered by Doctor on Demand for participants enrolled in the Plan.

Timely Pay or Timely Payment: Timely Payment means payment of the full amount of contribution or premium due by the payment due date or before the end of the 30-day grace period for payment (as reflected on the invoice or payment coupon). Payments rejected due to insufficient funds (e.g., "bounced" checks) are also considered not Timely Paid.

Urgent Care or Immediate Care: Care required because of an illness or injury that is serious and requires prompt medical attention, but is not life threatening. The Network/Claim Administrators determine whether care is Urgent Care or Immediate Care.

Unproven Service, Supply or Treatment: Any medical 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.

Workers' Compensation: Insurance that provides cash benefits and/or medical care for employees who are injured or become ill as a direct result of their employment.