

**VOLUNTARY
SUPPLEMENTAL
MEDICAL &
CUSTODIAL CARE
BENEFIT PLAN** (Effective Jan. 1, 2014)



**ALLIED PILOTS
ASSOCIATION**

January 2014



**ALLIED PILOTS ASSOCIATION
VOLUNTARY SUPPLEMENTAL MEDICAL AND
CUSTODIAL CARE BENEFIT PLAN**

JANUARY 2014

INTRODUCTION	1
SUMMARY OF SUPPLEMENTAL MEDICAL COVERAGE.....	3
SUMMARY OF OPTIONAL CUSTODIAL CARE BENEFITS.....	8
PLAN ELIGIBILITY, PARTICIPATION AND TERMINATION PROVISIONS	9
INITIAL PLAN ELIGIBILITY	9
Employee or Member Eligibility	9
Spouse Eligibility.....	9
Dependent Child Eligibility	10
Eligibility Restrictions	11
Reinstatement of Optional Custodial Care Benefits Coverage.....	12
No Discrimination Due to Health	13
ENROLLMENT IN THE PLAN	13
Enrollment.....	13
Special Enrollment.....	13
Re-Enrollment.....	14
Reinstatement.....	15
EXECUTIVE NON-MEMBER RETURNING TO MEMBER	15
Eligibility After Being an Executive Non-Member.....	15
Dependent Eligibility	15
Optional Custodial Care Benefit Re-Enrollment	16
Effective Date of Coverage.....	16
PARTICIPATION PROVISIONS.....	17
Required Contributions	17
Effective Date of Participation.....	17
TERMINATION OF PARTICIPATION	17
Termination of Member, Employee, Retired Member or Retired Employee Participation.....	17
Prohibited Rescission of Coverage	18
Termination of Furloughed Member Participation	18
Termination of Spouse Participation	19
Termination of Surviving Spouse Participation.....	19
Termination of Dependent Child Participation.....	20
BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS	21
WHEN BENEFITS ARE PAYABLE	21
DEDUCTIBLE	21
Medical Deductible.....	21
Retiree Dental Deductible.....	21
COORDINATION OF BENEFITS	22
Medicare	22
TRICARE	23

HMO	23
OUT-OF-POCKET MAXIMUM	23
ELIGIBLE MEDICAL EXPENSES.....	23
SURGICAL EXPENSE BENEFITS	27
ORAL SURGERY	27
WELL CHILD CARE.....	28
MENTAL OR NERVOUS DISORDER	28
In-Patient.....	28
Out-Patient	28
Psychiatric Day Treatment Facility	28
Mental Health Parity Act of 1996.....	28
CHEMICAL DEPENDENCY TREATMENT.....	28
HUMAN ORGAN AND TISSUE TRANSPLANT BENEFITS	29
SKILLED NURSING OR CONVALESCENT CARE FACILITY BENEFITS	29
HOME HEALTH CARE BENEFITS	29
HOSPICE CARE	29
BEREAVEMENT COUNSELING	29
EXCLUDED MEDICAL EXPENSES	29
PREFERRED PROVIDER NETWORK OVERLAY.....	33
VOLUNTARY CASE MANAGEMENT.....	33
PHARMACY BENEFIT PROGRAM.....	34
Retail Pharmacy Benefit	34
Mail Order Pharmacy Benefit.....	34
WHEN NOT ELIGIBLE FOR MEDICARE.....	34
Using an In-Network Pharmacy.....	34
Using a Non-Network Pharmacy	35
Using the Mail Order Pharmacy Benefit	35
WHEN ELIGIBLE FOR MEDICARE AND MEDICARE PART D ELECTED	35
Using an In-Network Pharmacy.....	35
Using a Non-Network Pharmacy	35
Using the Mail Order Pharmacy Benefit	35
When a Prescription Drug is NOT Covered Under the Medicare Part D Plan.....	35
WHEN ELIGIBLE FOR MEDICARE AND MEDICARE PART D NOT ELECTED	36
Using an In-Network Pharmacy.....	36
Using a Non-Network Pharmacy	36
Key Points About the Pharmacy Benefit Program	36
Who Administers the Pharmacy Benefit Program?.....	36
ORTHODONTIA BENEFITS.....	37
RETIREE DENTAL BENEFITS	39

OPTIONAL CUSTODIAL CARE BENEFIT PROVISIONS	41
CLAIMS PROCESSING PROVISIONS	42
TIME LIMIT FOR FILING A CLAIM	42
HOW TO FILE A CLAIM	42
WHAT HAPPENS TO YOUR CLAIM	43
CLAIMS PROCESS	44
APPEAL PROCESS FOR DENIED CLAIMS	44
VISION CARE BENEFITS.....	47
VSP BENEFITS	47
LOW VISION BENEFIT	47
VSP COPAYS	47
VSP EXCLUSIONS AND LIMITATIONS	48
HOW TO USE VSP BENEFITS	48
COMPLAINTS AND GRIEVANCES	49
CLAIM PAYMENTS AND DENIALS	49
IMPORTANT NOTE.....	50
GENERAL PLAN PROVISIONS	51
ERISA RIGHTS	51
Receive Information About Your Plan and Benefits	51
Continue Group Health Plan Coverage.....	51
Prudent Action by Plan Fiduciaries	51
Enforce Your Rights	51
Assistance with Your Questions	52
PLAN INTERPRETATION	52
PLAN CONTINUANCE	52
RELATIONSHIP BETWEEN PLAN PARTICIPANTS AND THE APA.....	52
PLAN TRUST FUND AND TRUSTEE	53
MANAGEMENT OF PLAN	53
CURRENCY	53
OPTION TO PROVIDE NON-COVERED SERVICES OR SUPPLIES	53
SUBROGATION AND REIMBURSEMENT RIGHTS	53
ASSIGNMENT OF CLAIM PAYMENTS UNDER THE SUPPLEMENTAL MEDICAL COVERAGE	54
NON-ASSIGNMENT OF CLAIM PAYMENTS UNDER CUSTODIAL CARE BENEFITS	54
RECOVERY OF OVERPAYMENTS	54
RIGHT TO SELECT MEDICAL PROVIDER	55
GOVERNING LAW, ETC.....	55
ADDRESS FOR NOTICES.....	55
PLAN EXPENSES	55
RELIANCE ON OTHER PROFESSIONALS	55

OBLIGATIONS OF APA	55
NOTICE OF PLAN’S EXEMPTION FROM THE AFFORDABLE CARE ACT	55
NEED HELP?	56
GENERAL PLAN INFORMATION	57
DEFINITIONS.....	59
APPENDIX A: COBRA CONTINUATION OF COVERAGE.....	77
APPENDIX B: HIPAA PRIVACY STATEMENT	81
APPENDIX C: HIPAA PORTABILITY REGULATIONS.....	84
APPENDIX D: HIPAA SECURITY REGULATIONS	85
APPENDIX E: QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs).....	86



ALLIED PILOTS ASSOCIATION VOLUNTARY SUPPLEMENTAL MEDICAL AND CUSTODIAL CARE BENEFIT PLAN

INTRODUCTION

Health care is important to each and every one of us. Over the years, the leadership of the Allied Pilots Association (“APA”) has worked hard to ensure that its Members and Employees have access to Medical Care when it is needed. One method that has worked well for APA Members and Employees is to provide a safety net of coverage when employer-provided coverages are exhausted or are inadequate to defray a Plan Participant's medical expenses.

The **Voluntary Supplemental Medical and Custodial Care Benefit Plan** (“Plan”) allows you to purchase additional medical protection for you and your Eligible Dependents. The **Plan’s Supplemental Medical Coverage** provides an additional layer of medical protection against a catastrophic Sickness or Injury affecting you and your Eligible Dependents. In addition to the Supplemental Medical protection, this coverage provides vision care, supplemental orthodontia and retiree dental benefits. The **Plan’s Optional Custodial Care Benefit** provides a layer of financial protection against the high cost of a long term Confinement in a Custodial Facility.

This Plan is your Plan and for your benefit but you must know what is covered, what is not covered, and how to protect it from abuse. You must follow the procedures and requirements of the Plan to obtain claim payments on your Eligible Expenses.

The medical and custodial benefits provided by this Plan are described in this booklet. APA has hired WebTPA Employer Services, LLC to process claims for the Plan. If you have any questions about the Plan, please contact WebTPA at the following address and phone number:



WebTPA Employer Services, LLC
P. O. Box 1987
Grapevine, TX 76099-1987
(800) 477-8957

Throughout this booklet any reference to the terms “he” or “him” shall also mean “she” and “her”. When the text references another section, every letter in the section that is referenced is capitalized. When the text references another subsection, the first letter of each word in the subsection that is referenced is

capitalized and the entire heading is in quotations. Toward the end of this booklet is a DEFINITIONS section of commonly used terms. These terms are capitalized throughout this booklet. Please review the DEFINITIONS to fully understand the terms in this booklet.

This booklet constitutes the complete and official Plan document and summary Plan description. It is intended to give you a description of the benefits provided by the Plan, how to File a claim for benefits and your rights under the Plan. **APA reserves the right to amend or terminate this Plan at any time through a resolution approved by the APA Board of Directors; provided, however, that any amendment required by law can be approved by the President of APA with no APA Board of Directors action required. The APA Board of Directors can delegate to the APA President and/or the Benefits Review and Appeals Board (“BRAB”), and the APA President can delegate to the BRAB, the authority to implement any resolution or action amending the Plan by preparing Plan documents (e.g., Plan amendments, Plan restatements, summaries of material modifications, etc.) and Plan-related documents (e.g., explanations, announcements, information, correspondence, etc.) consistent with such resolution or action and by taking such other actions as are reasonable and necessary to implement such resolution or action. Such amendment shall be effective as of: (A) the date of approval of the resolution by the APA Board of Directors, if no effective date is stated in the resolution, or (B) the effective date expressly set forth in the resolution, or (C) for an amendment required by law, the effective date expressly set forth in writing by the APA President.**

The next section contains a summary of the benefits under the:

- Supplemental Medical Coverage, which includes
 - Medical Benefits
 - Orthodontia Benefits
 - Retiree Dental Benefits
 - Vision Care Benefits
 - Optional Custodial Care Benefits

You should carefully review this section for a better understanding of the Plan's benefits.

Before this Plan pays any Supplemental Medical Coverage, a Plan Participant must satisfy one of the conditions contained in the “When Benefits Are Payable” subsection on page 21. After meeting this requirement and the Deductible, where applicable, the Plan will pay the specified percentage of Eligible Expenses Incurred by Plan Participants while they are covered under the Plan up to the specified Lifetime Maximum, as applicable.

SUMMARY OF SUPPLEMENTAL MEDICAL COVERAGE

SUMMARY OF PROVISIONS

AMOUNT OF COVERAGE

LIFETIME MAXIMUM BENEFIT

For each active Employee, Active Member,
Furloughed Member, TAG Member and their Eligible
Dependents

Unlimited

For each retired Employee, Retired Member,
Surviving Spouse and their Eligible Dependents

\$1,000,000 per Plan Participant

ANNUAL DEDUCTIBLE

\$150 per Plan Participant, up to \$400 per family⁽¹⁾⁽²⁾

OUT-OF-POCKET MAXIMUM

Per Plan Participant

\$10,000 per calendar year

MAXIMUM DAILY ALLOWANCES

Hospital Room

80% of the lesser of:
(A) Actual charge; or
(B) Semi-private Room rate

Intensive Care Unit

80% of the lesser of:
(A) Actual charge; or
(B) Semi-private Room rate

Skilled Nursing or Convalescent Care Facility

One-half of the maximum Hospital room
allowance for up to 30 days per Confinement

MENTAL OR NERVOUS DISORDERS ⁽³⁾

LIFETIME MAXIMUM BENEFIT

For each active Employee, Active Member,
Furloughed Member, TAG Member and their Eligible
Dependents

Unlimited

For each retired Employee, Retired Member,
Surviving Spouse and their Eligible Dependents

\$25,000 per Plan Participant

In-patient

80% of Eligible Expenses

Out-patient

50% of Eligible Expenses for up to 60 visits per
calendar year

SUMMARY OF PROVISIONS

AMOUNT OF COVERAGE

Psychiatric Day Treatment Facility ⁽⁴⁾ (i.e., when treatment is not more than eight hours in a 24-hour period)	50% of the lesser of: (A) Actual charge; or (B) The in-patient benefit
CHEMICAL DEPENDENCY TREATMENT ⁽³⁾ (One Confinement maximum per Plan Participant per lifetime)	
For each active Employee, Active Member, Furloughed Member, TAG Member and their Eligible Dependents	80% of Eligible Expenses
For each retired Employee, Retired Member, Surviving Spouse and their Eligible Dependents	80% of Eligible Expenses up to \$10,000 per Plan Participant per lifetime
HOME HEALTH CARE	
Calendar year maximum visits <i>per Plan Participant</i> (Maximum one visit per day)	50 visits
Lifetime Maximum visits <i>per Plan Participant</i>	100 visits
Percentage payable	80% of Eligible Expenses
HOSPICE CARE	
Benefit period (can be extended if Physician certifies Terminally Ill)	90 days
Percentage payable	80% of Eligible Expenses
BEREAVEMENT COUNSELING	
Maximum following Hospice Care	90 days
Percentage payable	80% of Eligible Expenses
ALL OTHER ELIGIBLE EXPENSES (See "Eligible Medical Expenses" beginning on page 23)	
	80% of Eligible Expenses

SUMMARY OF PROVISIONS

AMOUNT OF COVERAGE

ORTHODONTIA BENEFIT ⁽⁵⁾

Benefit amount	50% of unreimbursed Eligible Expenses up to Lifetime Maximum
Lifetime Maximum for Dependent Child of active Employee, Active Member, Furloughed Member, or TAG Member	One Orthodontia Treatment per Dependent Child
Lifetime Maximum for active Employee, Active Member, Furloughed Member, or TAG Member and their Spouse	\$1,000 per Plan Participant
Lifetime Maximum for Surviving Spouse and their Eligible Dependents	\$1,000 per Plan Participant

RETIREE DENTAL BENEFIT ⁽⁶⁾

Annual Deductible	\$50.00 per calendar year
Benefit amount	80% of Retiree Dental Benefits (see page 39)
Annual maximum <i>per Plan Participant</i>	\$1,000

BASIC VSP BENEFITS ⁽⁷⁾

USING VSP NETWORK

USING NON-VSP PROVIDERS

Vision Examination (available every calendar year)	\$25 copay	Up to \$45.00 after copay
Lenses ⁽⁸⁾ (available every calendar year)	\$35 copay	After copay, up to:
Single Vision		\$ 30.00
Bifocal		\$ 50.00
Trifocal		\$ 65.00
Lenticular		\$125.00
Tints		\$ 5.00
Low vision benefit		25% of cost

Dependent Child(ren) under age 26 are eligible for polycarbonate lenses at no additional cost.

Frames (available every other calendar year)	Covered up to \$130.00 (Retail price) after copay	Up to \$70.00 after copay
Contact Lenses (in lieu of all other vision benefits)	Using VSP Network	Using Non-VSP Network
Medically Necessary (as defined below in this section)	Vision exam and materials covered (after \$25.00 exam copay and \$35.00 materials copay)	Up to \$45.00 for exam after \$25.00 exam copay; plus up to \$210.00 for contact lens evaluation fee, fitting costs and materials (after \$35.00 copay)

**BASIC VSP
BENEFITS****Elective****USING VSP
NETWORK**

Vision exam covered (after \$25.00 exam copay), plus up to \$130.00 toward contact lens evaluation fee, fitting costs and materials (materials copay does not apply)

**USING NON-VSP
PROVIDERS**

Up to \$45.00 for exam (after \$25.00 exam copay), plus up to \$105.00 for contact lens evaluation fee, fitting costs and materials (materials copay does not apply)

MONTHLY PLAN PARTICIPANT CONTRIBUTIONS ⁽⁹⁾**2014
Monthly****(A) Group 1:****(1) Active Members**

\$20.00

(2) Members Disabled on and after February 1, 2004

\$20.00

(3) Active Employees

\$20.00

(4) Eligible Spouses of (A)(1)-(A)(3)

\$20.00

(5) Dependent Child(ren) of (A)(1)-(A)(3)

\$15.00

(B) Group 2:

\$55.00

(1) Retired Member Not Eligible for Medicare**(2) Retired Employee Not Eligible for Medicare**

\$55.00

(3) Eligible Spouse Not Eligible for Medicare

\$55.00

(4) Members Disabled Prior to February 1, 2004

\$55.00

(5) Dependent Child(ren) of (B)(1)- (B)(4)

\$55.00

(C) Group 3:**(1) Medicare-Eligible Retired Member**

\$100.00

(2) Medicare-Eligible Retired Employee

\$100.00

(3) Medicare-Eligible Spouse

\$100.00

(4) Medicare-Eligible Surviving Spouse

\$100.00

(D) Group 4:

\$140.00

(1) Furloughed Member**(2) Member Terminated Awaiting Grievance (TAG)**

\$140.00

(3) Eligible Spouse of (D)(1) or (D)(2)**(4) Surviving Spouses Not Eligible for Medicare**

\$140.00

\$140.00

(5) Eligible Spouse of (C)(1), (C)(2) Not Eligible for Medicare

\$140.00

(6) Dependent Child(ren) of (C)(1), (C)(2), (C)(4) or (D)(1), (D)(2), (D)(4)

\$140.00

The Board will annually review and adjust the contribution rates as necessary for any participant category under the Plan.

Any Plan Participant who provides proof of unlimited medical coverage under any Other Group Health Coverage (“OGHC”) that pays before the Plan pays will be charged Group I rates, the same rate that is charged for active Plan Participants.

Notes:

- (1) The Plan Participant must first meet one of the conditions contained in the “When Benefits Are Payable” subsection under the BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS section (on page 21).
- (2) Wellness benefits (Mammograms, PSA test and Well Child Care), Orthodontia Treatment and Vision Care Benefits are excluded from the annual Deductible.
- (3) Refer to the special rule described in the “Mental or Nervous Disorder” subsection (on page 28). The \$25,000 Lifetime Maximum benefit for Mental or Nervous Disorder and the \$10,000 Lifetime Maximum benefit for Chemical Dependency Treatment is a part of, and not in addition to, the \$1,000,000 Lifetime Maximum benefit per Plan Participant.
- (4) Alternative mental health centers include Psychiatric Day Treatment Facilities and crisis stabilization units. Treatment cannot exceed eight hours in a 24-hour period.
- (5) For Active Members, active Employees, Surviving Spouses, and their Eligible Dependents who are Plan Participants.
- (6) For Retired Members, retired Employees, Surviving Spouses and their Eligible Dependents who are Plan Participants.
- (7) Vision Care Benefits provided through an administrative services agreement with Vision Service Plan Insurance Company.
- (8) Subject to “VSP Exclusions and Limitations” on page 48.
- (9) The contribution for Dependent Child(ren) is per family and not per child. However, the contribution for each Eligible Dependent Child who is covered under the Plan will be the same contribution as the Member rate when the Eligible Dependent Child loses coverage under the Company’s medical plan or has Other Group Health Coverage (“OGHC”) that provides less than \$300,000 in lifetime medical benefits, except for exhaustion of the lifetime medical maximum. (For example, an Eligible Dependent Child who loses coverage under the Company’s medical plan after the Member’s 65th birthday must pay the Member rate to continue coverage under this Plan.)

SUMMARY OF OPTIONAL CUSTODIAL CARE BENEFITS

No individual can enroll or re-enroll in the Optional Custodial Care Benefits portion of the Plan. After meeting the requirement for payment under the OPTIONAL CUSTODIAL CARE BENEFIT PROVISIONS section, the Plan will pay the dollar amount shown below to the Plan Participant for each day of Confinement while covered under the Plan, up to the Lifetime Maximum.

SUMMARY OF PROVISIONS

AMOUNT OF COVERAGE

DAILY BENEFIT MAXIMUM

\$50.00 per day

LIFETIME MAXIMUM BENEFIT

1,095 days (three years) per Lifetime
or \$54,750

BENEFITS BEGIN

First day of Confinement

CUSTODIAL CARE BENEFIT PLAN PARTICIPANT CONTRIBUTIONS⁽¹⁾

Member or Employee Under Age 60	<u>Monthly</u>
Member or Employee	\$10.42
Eligible Spouse	\$10.42
Dependent Child(ren)	\$ 5.00
Member or Employee Age 60 or Older	<u>Monthly</u>
Member or Employee	\$20.84
Eligible Spouse	\$20.84
Dependent Child(ren)	\$ 5.00

Notes:

⁽¹⁾ Contributions for the Member or Employee and Eligible Spouse are determined solely on the Member's or Employee's age. If the Member or Employee is deceased, contributions are based on the Surviving Spouse's age. The contribution for Dependent Child(ren) is per family and not per child.

PLAN ELIGIBILITY, PARTICIPATION AND TERMINATION PROVISIONS

APA designed this Plan to enable Members and Employees to purchase an additional layer of financial protection for a medical crisis. This Plan offers two coverage options: the Supplemental Medical Coverage and the Optional Custodial Care Benefits.

The Supplemental Medical Coverage consists of supplemental medical, dental, orthodontia, and Vision Care Benefits. With the exception of the dental, orthodontia and Vision Care Benefits, the Supplemental Medical Coverage provides this additional coverage after all OGHG has been exhausted. Thus, Plan Participants must satisfy at least one of the conditions in the "When Benefits Are Payable" subsection on page 21 to receive reimbursement for Eligible Expenses.

This section contains the provisions covering eligibility, enrollment, coverage and termination under the Plan.

INITIAL PLAN ELIGIBILITY

Employee or Member Eligibility

A Member or Employee is initially eligible for coverage under the Plan, provided he:

- (A) is Actively at Work (see page 59); and is
 - (1) under age 55; or
 - (2) age 55 or older and:
 - (a) has not completed six months of active service with the Company or APA; or
 - (b) enrolls within the six-month period beginning on the return to Actively at Work status, if he was a Furloughed Member under age 55 at the time of Furlough; or
 - (c) re-enrolls within the six-month period beginning on the return to Actively at Work status, if he was a Furloughed Plan Participant age 55 or older at the time of Furlough; and
- (B) if a Member, is not in bad standing as defined in the APA Constitution and Bylaws.

A Member or Employee who is a Plan Participant shall continue to participate in the Plan until his participation terminates as provided in the "Termination of Member, Employee, Retired Member or Retired Employee Participation" subsection on page 17.

An Employee who is furloughed and maintains his rights to recall, a Furloughed Member, a Retired Member, or a Retired Employee, as applicable, can continue Plan participation after such Furlough or Retirement. Such participation will continue until the date participation terminates under one of the events in the "Termination of Furloughed Member Participation" or the "Termination of Member, Employee, Retired Member or Retired Employee Participation" on page 17, as applicable.

Except as otherwise provided in the "Special Enrollment" subsection, a Member or Employee must meet the conditions of this subsection to be initially eligible for coverage under the Plan.

Spouse Eligibility

The Spouse of a Member or Employee who is a Plan Participant is initially eligible for coverage under the Plan provided:

- (A) on the date of enrollment or re-enrollment, the Member or Employee is:

- (1) under age 55, or
- (2) age 55 or older and:
 - (a) has not completed six months of active service with the Company or APA, or
 - (b) the Spouse and the Member or Employee have been married for less than one year; or
 - (c) enrolled within the six-month period beginning on the date he returned to Actively at Work status, if he was a Furloughed Member under age 55 at Furlough; or
 - (d) re-enrolls within the six-month period beginning on the date he returned to Actively at Work status, if he was a Furloughed Plan Participant age 55 or older at Furlough and the Spouse was either:
 - (1) acquired during Furlough; or
 - (2) previously a Plan Participant; and

(B) if such Spouse is a pilot for the Company, the Spouse is also a Member.

A Spouse who is a Plan Participant shall continue to participate in the Plan until his participation terminates as provided in the "Termination of Spouse Participation" section on page 19.

A deceased Member's or deceased Employee's Spouse who is a Plan Participant at the time of the Member or Employee's death can continue Plan participation after the death of the Member or Employee. Such participation will continue until the date participation terminates under one of the events in the "Termination of Surviving Spouse Participation" subsection below.

Except as otherwise provided in the "Special Enrollment" subsection, a Spouse must meet the conditions of this subsection to be initially eligible for coverage under the Plan.

Dependent Child Eligibility

The Dependent Child of a Member or Employee who is a Plan Participant is initially eligible for coverage under the Plan, provided either:

- (A) The Dependent Child is under age five; or
- (B) If the Dependent Child is age five or older and either (1) the child or (2) the child's parent who is a Member or Employee does not meet the conditions described in subparagraph (C), (D) or (E) below, the Dependent Child is initially eligible for coverage under the Plan in general, but will not qualify for the Orthodontia Treatments listed on pages 37-38 until the Dependent Child has been a Plan Participant for three consecutive years, provided that when a Dependent Child re-enrolls under the "Re-Enrollment" subsection, the following exception applies: the re-enrolled Dependent Child's three years of enrollment are not required to be consecutive and previous full and partial years of enrollment will count toward the three year requirement; or
- (C) If on the date of enrollment or re-enrollment the Member or Employee is under age 55 and has not completed his second year of active service with the Company or APA; or

- (D) If on the date of enrollment or re-enrollment the Member or Employee is age 55 or older and;
 - (1) has not completed six months of active service with the Company or APA; or
 - (2) enrolled within the six-month period beginning on the date he returned to Actively at Work status, if he was a Furloughed Member under age 55 at Furlough; or
 - (3) re-enrolls within the six-month period beginning on the date he returned to Actively at Work status, if he was a Furloughed Plan Participant age 55 or older at Furlough and the Dependent Child was either:
 - (a) acquired during Furlough; or
 - (b) previously a Plan Participant. If the Dependent Child is age five or older at the time of re-enrollment, he will not qualify for the Orthodontia Treatments listed on pages 37-38 until the Dependent Child has been a Plan Participant for three years, including the re-enrolled Dependent Child's previous full and partial years of enrollment prior to re-enrollment; or
- (E) The Dependent Child has been a Dependent Child of the Plan Participant for less than 12 months; or
- (F) The Dependent Child has primary OGHC (unless he is covered as a Dependent Child of a Surviving Spouse, Furloughed Member or a Retired Member age 65 or older).

A Dependent Child who is a Plan Participant shall continue to participate in the Plan until his participation terminates as provided in the "Termination of Dependent Child Participation" subsection on page 20.

A deceased Member's or deceased Employee's Dependent Child who is a Plan Participant at the time of the Member's or Employee's death can continue Plan participation after the death of the Member or Employee. Such participation will continue until the date participation terminates under one of the events in the "Termination of Dependent Child Participation" subsection on page 13.

A deceased Member's or deceased Employee's Dependent Child who is not a Plan Participant at the time of the Member's or Employee's death will not be initially eligible for coverage under the Plan thereafter, although such Dependent Child may be eligible for coverage under the "Special Enrollment" subsection below.

Except as otherwise provided in the "Special Enrollment" subsection, a Dependent Child of a Plan Participant must meet the conditions of this subsection to be initially eligible for coverage under the Plan.

Eligibility Restrictions

Notwithstanding any other provision in the Plan, the following restrictions shall apply:

- (A) When both Spouses are pilots for the Company or Employees of APA, the following special rules apply:
 - (1) Each Spouse is individually eligible under the Plan as a Member or Employee and cannot be eligible as a dependent of the other Spouse.
 - (2) If one Spouse is Furloughed or ends employment as a pilot with the Company, for any reason other than a medical disability that prevents the Member from performing his duties as a pilot for the Company, or Retirement, such Spouse may be an Eligible Dependent of the Plan Participant effective on the date that the Furlough began or the date that Spouse's participation under the Plan would have terminated.

- (3) A Plan Participant whose participation under the Plan terminates solely as a result of termination of APA membership cannot become eligible for coverage as a dependent of a Plan Participant or as a Surviving Spouse.
 - (4) A Spouse who is or was a pilot for the Company and who fails to become a Member of APA or resigns as a Member of APA is not eligible to participate in the Plan.
- (B) A Spouse is not initially eligible for coverage under the Plan unless the Member or Employee is a Plan Participant.
 - (C) Eligible Dependent Child(ren) can only be eligible as dependents of either the Member or the Employee, but not both; however, both parents must be Plan Participants in order for such a Dependent Child to become an Eligible Dependent Child. The Eligible Member or Employee can designate which parent will enroll the Dependent Child(ren).
 - (D) Dependent Child(ren) are not initially eligible for coverage under the Plan unless both the Member or Employee, as applicable, and Spouse, if married, or Surviving Spouse are Plan Participants.
 - (E) If a Member or Employee under age 55
 - (1) has Dependent Child(ren) participating in the Plan and later marries, participation for the Dependent Child(ren) will end on the day following the first anniversary of the marriage, unless the Member or Employee either
 - (a) enrolls the new Spouse prior to the first anniversary of the marriage; or
 - (b) pays contributions on the Spouse retroactively to the first anniversary of the marriage; or
 - (2) had his Dependent Child(ren) terminated due to non-timely enrollment of his Spouse and he pays contributions for his Spouse retroactively to the first anniversary of his marriage; then:
 - (a) his Dependent Child(ren) are retroactively reinstated to the date previously terminated (provided retroactive contributions are paid for Dependent Child(ren)); or
 - (b) his Dependent Child(ren) are re-enrolled effective the first of the month following receipt of a completed enrollment form by the Claims Processor.
 - (F) Except as otherwise provided under the "Special Enrollment" subsection, Dependent Child(ren) who were not Plan Participants at the time of the Member's or Employee's death are not eligible for coverage.
 - (G) Except as otherwise provided under the "Special Enrollment" subsection, Dependent Child(ren) must have primary OGHC (unless they are covered as a Dependent Child of a Surviving Spouse, Furloughed Member or a Retired Member age 65 or older) before they are initially eligible for coverage under the Plan, or if participating, must have primary OGHC to continue to participate in the Plan (unless the Lifetime Maximum under such OGHC has been exhausted).

Reinstatement of Optional Custodial Care Benefits Coverage

Any Plan Participant whose Optional Custodial Care Benefits coverage terminated on or after November 1, 2012 due to termination of participation under the Supplemental Medical Coverage, shall have the option to reinstate the Optional Custodial Care Benefits coverage provided that such Plan Participant notified the Claims Processor of his desire to reinstate this coverage within 60 days of the date of the reinstatement notification letter and pays the applicable contribution retroactive to the date coverage terminated.

No Discrimination Due to Health

The Plan shall not establish rules for eligibility (including continued eligibility) for benefits for any individual under the Plan that are based on one or more Health Status-Related Factors of the individual or his Eligible Dependent(s).

The Plan shall not require an individual (as a condition of enrollment or continued participation in the Plan) to pay a premium or otherwise contribute an amount that exceeds the amount paid by a similarly situated individual solely due to a Health Status-Related Factor of the individual; provided, however, that these nondiscrimination rules regarding Health Status-Related Factors will not restrict the amounts that can be charged under the Plan for coverage, prevent contribution discounts or rebates, or prevent modified Plan Deductibles and copayments in return for adherence to programs of health promotion and disease prevention.

ENROLLMENT IN THE PLAN

Enrollment

Subject to the "Eligibility Restrictions" and the "Special Enrollment" subsections, any Eligible Member, Eligible Employee, Eligible Spouse or Eligible Dependent Child can enroll in the Supplemental Medical Coverage by submitting a completed enrollment form to the Claims Processor. Participation will be effective as described in the "Effective Date of Participation" subsection on page 17.

Special Enrollment

Special enrollment must be permitted for an Eligible Dependent of a Plan Participant if the Eligible Dependent became an Eligible Dependent, as a result of marriage, birth, adoption or being placed for adoption, of an Eligible Member, Eligible Employee, or of a Surviving Spouse, who is already a Plan Participant. A Plan Participant has a 30-day special enrollment period for each such Eligible Dependent beginning on the date of marriage, birth, adoption or being placed for adoption, as applicable.

Participation that begins as a result of a special enrollment period shall be effective (A) if due to birth, on the date of birth, (B) if due to adoption or being placed for adoption, the date it occurred and (C) if due to marriage, on the first day of the month after receipt of the completed enrollment request under the Plan.

In addition, Special Enrollment must be permitted for Employees, Members and Dependents who are eligible to enroll in the Plan if they (A) lose eligibility for Medicaid or the State Children's Health Insurance Program ("SCHIP") coverage or (B) become eligible to participate in a premium assistance program under Medicaid or SCHIP. In either case, the Employee or Member must request Special Enrollment within 60 days immediately following the occurrence of one of the events in (A) or (B) of this paragraph.

An Employee, Member, or Surviving Spouse (or Eligible Dependent) will qualify for special enrollment if:

- (A) the Employee, Member, or Surviving Spouse (or Eligible Dependent) is otherwise eligible for initial coverage under the Plan;
- (B) the Employee, Member, or Surviving Spouse (or Eligible Dependent) had OGHC at the time he was initially eligible under this Plan;
- (C) the Employee, Member or Surviving Spouse (or Eligible Dependent) declined participation under the Plan because he had the OGHC;
- (D) the OGHC was Continuation Coverage under COBRA that has expired, or the OGHC (or the individual's employer's or former employer's contribution toward the cost of such coverage) has terminated; and

- (E) the Employee, Member or Surviving Spouse (or Eligible Dependent) requests special enrollment in writing within 30 days after the date he loses his OGHC (either due to loss of eligibility under his OGHC or because his employer no longer contributes toward health coverage).

Re-Enrollment

Subject to the “Eligibility Restrictions” and “Special Enrollment” subsections, the former Plan Participant must satisfy all of the following conditions as described in the “Effective Date of Participation” subsection on page 17:

- (A) The former Plan Participant must be an Eligible Member, Eligible Employee, or Eligible Dependent; and
- (B) Participation will be effective as described in the “Effective Date of Participation” subsection.

In addition, a former Plan Participant whose Supplemental Medical Coverage terminates cannot re-enroll for a period of five years from the date prior participation ceased, except as otherwise provided in the “Special Enrollment” subsection on page 13. The five-year waiting period will not apply to:

- (1) A Plan Participant whose participation terminated while the Employee was on a leave of absence covered by the Family and Medical Leave Act of 1993 (“FMLA”); or
- (2) A Plan Participant whose participation terminated while the Employee was on a leave of absence covered by the Uniformed Services Employment and Re-Employment Rights Act of 1994, as amended; or
- (3) A Plan Participant whose participation terminated while the Member was on a leave of absence covered by the Service members Civil Relief Act, formerly the Soldiers’ and Sailors’ Civil Relief Act of 1940 (“SSCRA”), as amended, provided the Plan Participant re-enrolls in the Plan within 120 days (the time limit specified by SSCRA) after release from service; or
- (4) A Dependent Child who re-enrolls in the Plan as long as he does not exceed the maximum age limit (age 26) and has OGHC (unless covered as a Dependent Child of a Surviving Spouse, Furloughed Member or a Retired Member age 65 or older) at the time of re-enrollment; or
- (5) A Furloughed Member and his Eligible Dependents who re-enroll in the Plan within six months from his return to Actively at Work status; or
- (6) A Dependent Child who re-enrolls in accordance with paragraph (E) of the Eligibility Restrictions subsection and who previously qualified for the Orthodontia Treatments listed on pages 37-38 will continue to qualify immediately upon re-enrollment; or
- (7) A Dependent Child who re-enrolls in accordance with paragraph (E) of the Eligibility Restrictions subsection and who previously did not qualify for the Orthodontia Treatments listed on pages 37-38 will receive credit for his prior full and partial years of Plan Participation toward the three-year requirement.

Except for those described in subparagraphs (1) - (7) above, and as otherwise provided in the “Special Enrollment” subsection, Plan Participants whose Supplemental Medical Coverage terminates after the Member, Employee or Surviving Spouse attained age 55 cannot re-enroll following termination of participation.

In addition, a former Plan Participant whose Custodial Care Coverage terminates cannot re-enroll, except for a Furloughed Member and his Eligible Dependents who re-enroll in the Plan within six months from his return to Actively at Work status.

Reinstatement

Any Plan Participant who terminated Plan participation effective on or after December 31, 2012 may reinstate Plan participation as if participation had not been terminated, provided that the Claims Processor receives the request for reinstatement on or before the later of:

- (A) March 31, 2013, or
- (B) 60 days after the bankruptcy court's ruling on the Company's request to modify the Company's retiree medical plan for existing retirees and dependents. Prior to reinstatement of Plan participation, the Plan Participant must pay all contributions for the period from the date that his Plan participation terminated to the effective date of his reinstatement in the Plan.

EXECUTIVE NON-MEMBER RETURNING TO MEMBER

Eligibility After Being an Executive Non-Member

- (A) A Returning Executive Non-Member will have up to six months from the date he ceases to be an Executive Non-Member to submit a completed enrollment form to the Claims Processor to re-enroll in the Plan, subject to the applicable re-enrollment provisions under the Plan, except the following requirements shall not apply:
 - (1) The requirement that the Member must be under age 55 at re-enrollment, or if age 55 or older, has not completed six months of active service with the Company or APA prior to re-enrollment; and
 - (2) The requirement that a former Plan Participant cannot re-enroll for a period of five years from the date the prior participation ceased.
- (B) A Member who was not a Plan Participant and was under age 55 on the date that his APA membership status changed from Member to Executive Non-Member will have up to six months from the date he ceases to be an Executive Non-Member to submit a completed enrollment form to the Claims Processor to enroll or re-enroll in the Plan, subject to the applicable enrollment or re-enrollment provisions under the Plan, except the requirement that the Member must be under age 55 at enrollment, or if age 55 or older, has not completed six months of active service with the Company or APA prior to enrollment.
- (C) Any Member who was age 55 or older on the date that his APA membership status changed to Executive Non-Member and who was not a Plan Participant on that date will not be eligible to enroll or re-enroll in the Plan.

Dependent Eligibility

The following provisions apply to Eligible Dependents of a Member who has been an Executive Non-Member:

- (A) A Returning Executive Non-Member who was under age 55 on the date that his APA membership status changed to Executive Non-Member status can enroll or re-enroll his Eligible Dependents, provided he submits a completed enrollment form to the Claims Processor to enroll or re-enroll the Eligible Dependent(s):
 - (1) within the six-month period that begins on the date that he ceases to be an Executive Non-Member; or
 - (2) prior to attaining age 55, if later,

and subject to the applicable enrollment provisions under the Plan, except as provided in paragraphs (D), (E) and (F) below.

- (B) A Returning Executive Non-Member who was age 55 or older on the date of the change to Executive Non-Member status can only re-enroll Eligible Dependents that were covered by the Plan at the time of the change to Executive Non-Member status or can enroll Eligible Dependents acquired during the period that he was an Executive Non-Member, provided that he submits a completed enrollment form to the Claims Processor to enroll or re-enroll the Eligible Dependent(s) within the six-month period beginning on the date he ceases to be an Executive Non-Member, and subject to the applicable enrollment provisions under the Plan, except as provided in paragraphs (D), (E) and (F) below.
- (C) A Member who was not a Plan Participant and was under age 55 on the date that his APA membership status changed from Member to Executive Non-Member will have up to six months from the date he ceases to be an Executive Non-Member to submit a completed enrollment form to the Claims Processor to enroll or re-enroll his Eligible Dependents, subject to the applicable enrollment and re-enrollment provisions under the Plan, except the requirement that the Member must be under age 55, or if age 55 or older, has not completed six months of active service with the Company or APA.
- (D) Dependent Child(ren) who re-enroll under subparagraphs (A), (B) or (C) above and who previously qualified for the Orthodontia Treatments listed on pages 37-38 will continue to qualify for such Orthodontia Treatments immediately upon re-enrollment.
- (E) Dependent Child(ren) who re-enroll under subparagraphs (A), (B) or (C) above and who previously did not qualify for the Orthodontia Treatments listed on pages 37-38 will receive credit for their prior period(s) of Plan Participation toward the three-year requirement for such Orthodontia Treatments.
- (F) Eligible Dependents who re-enroll under subparagraphs (A), (B) or (C) above will not be subject to the Plan's requirement that a former Plan Participant cannot re-enroll for a period of five years from the date the prior participation ceased.

Optional Custodial Care Benefit Re-Enrollment

Any Returning Executive Non-Member and/or Eligible Dependent who re-enrolls in the Plan during the six-month period referred to in subparagraph (A) in the "Eligibility after Being an Executive Non-Member" subsection and/or subparagraphs (A) or (B) in the "Dependent Eligibility" subsection, shall be allowed to re-enroll in the Optional Custodial Care Benefit coverage provided they do so within such six-month period.

Effective Date of Coverage

Coverage for a Member and his Eligible Dependents, as applicable, shall be effective on the first day of the month following the later of:

- (A) The date a Member described in subparagraphs (A) or (B) of the "Eligibility After Being an Executive Non-Member" subsection submits a completed enrollment or re-enrollment form to the Claims Processor, provided that the date on which such Member submitted his application to APA to return as an APA member is not later than the date he submitted his completed enrollment or re-enrollment form to the Claims Processor; or
- (B) For a Member described in subparagraph (A) above, the date that APA membership status changes to APA Member.

Contributions shall be required from the date that such Member's Plan coverage is effective.

PARTICIPATION PROVISIONS

Required Contributions

The Plan is voluntary and requires contributions from Plan Participants. The amount of the required contributions is shown in the SUMMARY OF SUPPLEMENTAL MEDICAL COVERAGE and the SUMMARY OF OPTIONAL CUSTODIAL CARE BENEFITS. Unless he is eligible to begin participating in the Plan due to special enrollment, a Plan Participant who initially becomes eligible for coverage under the Plan on or after the date the Member or Employee attains age 55 must pay contributions back to the date the Member or Employee attained age 55, as follows:

- (A) Eligible Members or Eligible Employees who join the Plan at or after age 55 must pay contributions back to age 55.
- (B) An Eligible Spouse of such Member or Employee must pay contributions back to the later of the Member's or Employee's age 55 or the date of marriage.
- (C) Eligible Dependent Child(ren) of such Member or Employee must pay contributions back to the later of the Member's or Employee's age 55 or the date they became Dependent Child(ren).

Effective Date of Participation

An Eligible Member, Eligible Employee or Eligible Dependent becomes a Plan Participant on the first day of the month coincident with, or next following, the latest of the following dates:

- (A) The day that the completed enrollment or re-enrollment form for the Supplemental Medical Coverage is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date the Claims Processor receives the completed enrollment or re-enrollment form for the Supplemental Medical Coverage; and
- (B) The day for which the required contributions are made; and
- (C) For an Eligible Spouse, the day the Eligible Member or Eligible Employee becomes a Plan Participant; and
- (D) For an Eligible Dependent Child, the day that both the Eligible Member (or Eligible Employee, if applicable) and Eligible Spouse become Plan Participants.

A Plan Participant who has Dependent Child(ren) participating in the Plan and later adds a Dependent Child must notify the Claims Processor within 90 days of the date the child becomes a Dependent Child for participation to be effective from the date the child became a Dependent Child. Otherwise, participation for the new Dependent Child will begin on the date of notification.

Following initial eligibility for coverage and enrollment in the Plan, a Plan Participant shall continue to participate in the Plan until his participation terminates under the "Termination of Participation" section below.

TERMINATION OF PARTICIPATION

Termination of Member, Employee, Retired Member or Retired Employee Participation

A Member's, Employee's, Retired Member's, or Retired Employee's participation shall automatically cease at midnight on the earliest of the following dates:

- (A) The day membership or employment with APA terminates (except for Grandfathered Executive Members) as provided in paragraph (G) below; or

- (B) The day following the Member's, Employee's, Retired Member's or Retired Employee's death; or
- (C) The end of the period for which a contribution has been paid unless a required contribution is paid within 60 days of the last month of coverage for which a contribution has been paid; or
- (D) The first of the month coincident with or next following the date the request to terminate participation is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date the Claims Processor receives the request to terminate participation. Notwithstanding the above, Plan Participants who desired to terminate from the Plan effective December 31, 2012, but were not able to provide notice until January 2013 may terminate participation retroactive to December 31, 2012, and receive a refund of any Plan contributions deducted, provided the request to terminate is received by the Claims Processor prior to January 31, 2013; or
- (E) The day a disabled Plan Participant (except a Grandfathered Executive Member) ceases to be Totally Disabled and fails to qualify as a Member, Employee, Retired Member or Retired Employee; or
- (F) The day that the Plan or any coverage under the Plan is terminated for all Plan Participants or a given class of Plan Participants of which the Participant is a member; or
- (G) For Members who have been terminated by the Company and are awaiting the final settlement of their grievance for reinstatement ("TAG") until 60 months from the date of termination by the Company, or
- (H) 30 days following the date on the APA certified letter notifying the Plan Participant of (1) an Overpayment under the Plan, or (2) an overpaid benefit under any Other APA-sponsored Plan, if the Plan Participant fails to return such Overpayment or overpaid benefit or enter into a Reimbursement Agreement in accordance with the administrative practices established by the BRAB; a copy of those administrative practices is available on request from the Claims Processor; or
- (I) The end of the month following the month a payment is due but unpaid to any Other APA-sponsored Plan in accordance with a Reimbursement Agreement with the Plan or any Other APA-sponsored Plan, unless the Plan Participant can show, to the satisfaction of, and in the sole discretion of, the BRAB, that failure to make such payment was not within his reasonable control.

Prohibited Rescission of Coverage

Notwithstanding the above, a Plan Participant's coverage shall not terminate retroactively unless the Plan Participant has performed an act, practice, or omission that constitutes fraud, or unless such Plan Participant makes an intentional misrepresentation of material fact to either obtain or avoid termination of coverage under this Plan. The Plan Administrator will provide at least 30 days advance written notice to each Plan Participant who would be affected before coverage can be rescinded. For purposes of this provision, the termination of coverage retroactively due to a Plan Participant's failure to pay a required contribution, including a COBRA contribution, is not considered a rescission of coverage.

Termination of Furloughed Member Participation

A Furloughed Member's participation shall automatically cease at midnight on the earliest of the following dates:

- (A) The day the Furloughed Member loses or relinquishes his rights of recall; or
- (B) The day the Furloughed Member becomes eligible under any OGHC, including the group plan of an employed Spouse or subsequent employer; or

- (C) 24 months from the day of Furlough; or
- (D) The day that (A) - (F) and (H) - (I) under the "Termination of Member, Employee, Retired Member, or Retired Employee Participation" subsection occurs.

Termination of Spouse Participation

Spouse participation shall automatically cease at midnight on the earliest of the following dates:

- (A) The day that the individual ceases to qualify as an Eligible Dependent; or
- (B) The day following the Spouse's death; or
- (C) The first of the month coincident or next following the date the request to terminate is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date the Claims Processor receives the request to terminate participation; or
- (D) The day the Member or Employee terminates participation, except when participation continues as a Surviving Spouse; or
- (E) The end of the period for which a contribution has been paid unless a required contribution is paid within 60 days of the last month of coverage that a contribution has been paid; or
- (F) The day that the Plan or any coverage (including Dependent Coverage) under the Plan is terminated for all Plan Participants or a given class of Plan Participants of which such Spouse is a member.

Termination of Surviving Spouse Participation

Surviving Spouse participation shall automatically cease at midnight on the earliest of the following dates:

- (A) The day the Surviving Spouse remarries; or
- (B) The day following the Surviving Spouse's death; or
- (C) The first of the month coincident with or next following the date the request to terminate is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date the Claims Processor receives the request to terminate participation; or
- (D) The end of the period for which a contribution has been paid unless a required contribution is paid within 60 days of the last month of coverage that a contribution has been paid; or
- (E) The day that the Plan or any coverage under the Plan is terminated for all Plan Participants or a given class of Plan Participants of which such Surviving Spouse is a member; or
- (F) 30 days following the date on the APA certified letter notifying the Plan Participant of (1) an Overpayment under the Plan or (2) an overpaid benefit under any Other APA-sponsored Plan, if the Plan Participant fails to return such Overpayment or overpaid benefit or enter into Reimbursement Agreement in accordance with the administrative practices established by the BRAB (a copy of which is available on request from the Claims Processor), or
- (G) The end of the month following the month a payment is due in accordance with a Reimbursement Agreement with the Plan or any Other APA-sponsored Plan, unless the Plan Participant can show, to the satisfaction of, and in the sole discretion of, the BRAB, that failure to make such payment was not within his reasonable control.

Termination of Dependent Child Participation

Dependent Child participation shall automatically cease at midnight on the earliest of the following dates:

- (A) The day that the individual ceases to qualify as an Eligible Dependent; or
- (B) The day following the Dependent Child's death; or
- (C) The first of the month coincident with or next following the date the request to terminate is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date the Claims Processor receives the request to terminate participation; or
- (D) The day the Member, Employee, Spouse or Surviving Spouse terminates participation, except for the death of the Member, Employee or Surviving Spouse; or
- (E) The day at the end of the period for which contributions have been made unless a required contribution is paid within 60 days of the last month of coverage for which a contribution has been paid; or
- (F) The day that the Plan or any coverage (including Dependent Coverage) under the Plan is terminated for all Plan Participants or a given class of Plan Participants of which the Eligible Dependent is a member; or
- (G) The day OGHC is voluntarily terminated for the Dependent Child; or
- (H) The day following the first anniversary of the Member's or Employee's marriage, if the new Spouse is not a Plan Participant prior to the first anniversary of the marriage.

BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS

This section contains the provisions of the Supplemental Medical Coverage. This coverage was designed to enable Plan Participants to purchase an additional layer of medical, dental, and vision care protection against a catastrophic Sickness or Injury affecting you or your Eligible Dependents.

WHEN BENEFITS ARE PAYABLE

The Supplemental Medical Coverage reimburses a Plan Participant a percentage (see SUMMARY OF SUPPLEMENTAL MEDICAL COVERAGE section) of Eligible Expenses up to the Lifetime Maximum, as applicable. To qualify for reimbursement under this coverage, a Plan Participant must satisfy at least one of the following conditions:

- (A) Except for Plan Participants who are or become eligible for Medicare as their primary coverage (see "Medicare" on page 22), the Plan Participant must exhaust the Lifetime Maximum benefits of the Company's group medical plan, the APA Catastrophic Major Medical Benefit Plan, and any OGHC under which the Plan Participant is covered or has the option to obtain coverage (this provision does not apply to "Vision Care Benefits" on page 47, "Orthodontia Benefits" on page 37, or "Retiree Dental Benefits" on page 39); or
- (B) The Furloughed Member or his Eligible Dependents Incur an Eligible Expense when no OGHC is available (such as, from either the Furloughed Member's subsequent employment or his Spouse's employment). Neither Furloughed Members nor their Eligible Dependents will be required to continue their Company-provided coverage through COBRA during their Furlough to remain eligible to receive coverage under the Plan; or
- (C) The Surviving Spouse and his Eligible Dependent Child(ren) Incur an Eligible Expense when no OGHC is available (such as through his employment). Neither Surviving Spouses nor their Eligible Dependent Child(ren) will be required to continue the Company-provided coverage under COBRA to remain eligible to receive coverage under the Plan.

DEDUCTIBLE

Both the Medical Benefit Coverage and the Retiree Dental Benefit Coverage require a Plan Participant to satisfy an annual Deductible before the Plan pays a benefit. No benefits will be payable under the Plan for Eligible Expenses until the Plan Participant satisfies the Deductible. The following subsection describes the medical Deductible. Wellness benefits (Mammograms, PSA test and Well Child Care), Orthodontia Benefits, and Vision Care Benefits are excluded from the annual Deductible.

Medical Deductible

The medical Deductible for all Plan Participants and their Eligible Dependents is \$150 per Plan Participant up to \$400 per family per calendar year.

Retiree Dental Deductible

The Retiree Dental Deductible for all Retired Members, Surviving Spouses and their Eligible Dependents is \$50 per Plan Participant per calendar year.

COORDINATION OF BENEFITS

This section describes how the Plan coordinates benefit payments and coverage with Medicare, TRICARE and HMOs.

Medicare

All active Plan Participants enrolled with Medicare shall have benefits paid as primary under the Supplemental Medical Coverage and secondary under Medicare, regardless of age. Medicare shall be the primary plan for retired Plan Participants age 65 or older. The Plan, when secondary, will determine benefits after considering what Medicare would have paid under Parts A, B and D, whether or not the Plan Participant has enrolled for Parts A, B and D. If a Plan Participant is entitled to benefits under Medicare because of renal dialysis or kidney transplant, coverage under this Plan will be primary during the Medicare coordination period (currently 30 months), that starts the first month he is eligible to receive Medicare because of kidney failure (usually the fourth month of dialysis), even if not enrolled in Medicare, and secondary thereafter. Any benefits payable under this Plan and Medicare are made pursuant to Federal regulations. Whenever there is a conflict in Plan provisions and Federal law about coordination with Medicare, Federal law will govern.

Except for Retirees, Spouses and Surviving Spouses paying Group I contribution rates, Medicare-eligible Plan Participants' claims will be coordinated with the payments made by: (1) Medicare Parts A, B and D, and (2) by either the Company's retiree medical plan or any OGHC. The Plan will pay any remaining Eligible Expense upon submission of a completed claim form, the Explanation of Benefits from both Medicare and from either the Company's retiree medical plan or the OGHC.

The Plan pays 80% of Eligible Expenses but not more than 100% of Eligible Expenses when coordinated with payments from Medicare and either the Company's retiree medical plan or any OGHC.

- (1) **Example 1:** Assume a Medicare-eligible Participant incurred a claim of \$1,000 and all Deductibles have been met. The payments would be:

Plan	Amount
Claim	\$1,000
Medicare Paid (80%)	\$800
AA RSMP	\$0
APA Plan	\$200

Medicare pays 80% or \$800 and the Company's Retiree Standard Medical Plan ("RSMP") pays \$0 (the Company RSMP calculates the amount payable under the Company RSMP and then subtracts the amount paid by Medicare and pays any remaining balance; thus $\$800 - \$800 = \$0$.) In this case the Plan would pay \$200 ($\$1,000 - \800 the amount paid by Medicare = \$200).

- (2) **Example 2:** Assume the same scenario as in Example 1, but the Plan Participant has exceeded the Out of Pocket Maximum under the Company RSMP. The payments would be:

Plan	Amount
Claim	\$1,000
Medicare Paid (80%)	\$800
AA RSMP	\$200
APA Plan	\$0

Because the Participant has met the Company RSMP's Out of Pocket Limit (\$1,000, after the deductible of \$150), the Company RSMP would cover 100% of eligible claims not paid by Medicare for the balance of the year.

- (3) **Example 3:** Assume the same scenario as in Example 1, but the claim is not eligible for reimbursement under Medicare but is eligible for reimbursement under the Company RSMP. The payments would be:

Plan	Amount
Claim	\$1,000
Medicare Paid (80%)	\$0
AA RSMP	\$800
APA Plan	\$200

TRICARE

When required by law, this Plan is primary to TRICARE.

HMO

Since HMOs have no Lifetime Maximum benefit provisions and provide coverage for pre-existing conditions, with the exception of the Retiree Dental Benefits, Orthodontia Benefits and the Vision Care Benefits, benefits under the Supplemental Medical Coverage generally cannot be used while a Plan Participant is covered under an HMO.

OUT-OF-POCKET MAXIMUM

After a Plan Participant pays **\$10,000** for Eligible Expenses covered by this Plan during a calendar year, the Plan will pay **100%** of the Plan Participant's Eligible Expenses for the remainder of the calendar year, up to the Plan's Lifetime Maximum, as applicable. Except for the Vision Care Benefits, this limit applies to Eligible Expenses Incurred under the Supplemental Medical Coverage only. There is no similar limit for the Vision Care Benefits or the Optional Custodial Care Benefits.

ELIGIBLE MEDICAL EXPENSES

The Plan reimburses **80%** of Eligible Expenses Incurred while a Plan Participant. The following Eligible Expenses will be covered under the Supplemental Medical Coverage, unless excluded under another provision of this Plan:

- (A) Expenses charged by a Hospital, on its own behalf, for Room and Board (incubator charges shall be considered Room and Board charges) and routine nursing services. If private accommodations are used, any amount of daily Room and Board expenses that exceed the Hospital's allowed Semi-private Room rate will not be covered.
- (B) Expenses charged by a Hospital, on its own behalf, for necessary other Hospital services and supplies other than Room and Board.
- (C) Expenses charged by a Physician. Expenses by a Physician are **not eligible** if the Physician is (1) related by blood, marriage, or by legal adoption to either a Plan Participant or Spouse (e.g., child, brother, sister, or parent); or (2) care or treatment is provided by any person who ordinarily resides with a Plan Participant.
- (D) Expenses charged by a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), Licensed Practical Nurse (L.P.N.) or a Certified Registered Nurse Anesthetist (C.R.N.A.) for nursing services including Medically Necessary private-duty nursing by an R.N. Expenses charged by a nurse are **not Eligible Expenses** if the nurse has the same legal residence as or is related (by blood, marriage, or legal adoption) to a Plan Participant or Spouse (e.g., child, brother, sister, or parent).
- (E) Except as provided under the Pharmacy Benefit Program (see page 34) and Prescription Drug, as defined in the DEFINITIONS section (see page 72).
- (F) Diagnostic X-Ray and laboratory examinations, excluding dental X-Rays.

- (G) Examination, treatment, or therapy by X-ray, chemotherapy, radiation, radium, radioactive isotope and other radioactive substances.
- (H) Kidney dialysis, including the training of an attendant to perform kidney dialysis at home, even if the attendant is a family member.
- (I) Expenses Incurred for cardiopulmonary rehabilitation programs, when prescribed after a heart attack or surgery.
- (J) Expenses for the following care, but only to the extent as described later in this BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS section:
 - (1) Surgical Expense Benefits
 - (2) Oral Surgery
 - (3) Well Child Care
 - (4) Mental or Nervous Disorders
 - (5) Chemical Dependency Treatment
 - (6) Human Organ and Tissue Transplants
 - (7) Skilled Nursing Facility or Convalescent Care Facility
 - (8) Home Health Care
 - (9) Hospice Care
 - (10) Bereavement Counseling
- (K) Expenses Incurred for chiropractic care.
- (L) Maternity expenses, including birthing center expenses, Incurred for Pregnancy or Complications of Pregnancy for a Plan Participant who is a Member, Employee, or Spouse. Maternity expenses Incurred for Complications of Pregnancy by a Dependent Child who is a Plan Participant are covered. Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally will not 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 normal vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the Plan Participant's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable.

- (M) Prostate Specific Antigen (PSA) tests and mammograms whether or not administered for diagnostic screening if not covered under the Company or any OGHC. PSA tests are limited to one per year for male Plan Participants age 45 or over. Mammograms are covered according to the following schedule:

Age	Schedule
Up to age 40	One baseline mammogram
Age 40 through 49	Once every two years (or once per year if Medically Necessary)
Age 50 and older	Once per year

- (N) Expenses for an abortion for a Plan Participant who is a Member, Employee, Spouse or Surviving Spouse. Abortion Expenses for a Plan Participant who is a Dependent Child are not covered unless Medically Necessary.

- (O) Certain limited Eligible Expenses for the treatment of infertility when the infertility is a side effect of an underlying medical condition involving the male or female reproductive system such as:

- (1) Polycystic ovarian disease;
- (2) Dysfunctional uterine bleeding;
- (3) Malignancy of the genitourinary tract;
- (4) Endometriosis;
- (5) Specified endocrine disorder.

See Excluded Medical Expenses for excluded infertility testing and treatment.

- (P) Expenses Incurred for an elective sterilization, male or female. Sterilization reversals are not covered.
- (Q) Expenses for Medically Necessary eye surgery because they have been determined to have an Injury or Sickness including a lens implant (following surgery). This includes the initial purchase of eyeglasses or contact lenses (hard or soft) following cataract surgery, unless covered under the Vision Care Benefits provisions of this Plan. Except as covered under the Vision Care Benefits provisions on page 47, this coverage **does not include** any expenses in connection with eye refractions, eyeglasses, contact lens, myopia, refraction errors, orthoptics or visual training, radial keratotomy and eye examinations for the purpose of determining visual acuity.
- (R) Hearing examinations and rehabilitative speech therapy services of an audiologist or speech-language pathologist if Medically Necessary after Sickness or Injury. No other speech or hearing therapy or devices are covered.
- (S) Rental of Durable Medical Equipment when Medically Necessary for therapeutic use not to exceed the purchase price (e.g., respirators, breathing machines, hospital bed, traction equipment, wheel chair, walker, crutches). **Repair and maintenance are not covered.** Replacement because they have been determined to have a change in patient's medical condition or natural growth is covered. Also covered are elastic stockings, to a maximum of three pairs per year (new prescription is required each year).

- (T) Prosthetic appliances and orthopedic (or orthotic) appliances such as artificial arms, legs, and accessories, artificial eyes, braces, and cervical collars. Purchase, repair and replacement of artificial limbs, but not the part of the cost that exceeds the price of the least expensive functional limb available. Replacements are covered if Medically Necessary because of:
- (1) A change in the patient's condition; or
 - (2) Growth or wear.
- Repair or maintenance of an appliance is **not covered**.
- (U) Expenses Incurred for Transcutaneous Electrical Nerve Stimulator (TENS) treatment supplies when used to control chronic intractable skeletal or muscular pain.
- (V) Expenses for acupuncture by a certified acupuncturist.
- (W) Medically Necessary professional ground and air ambulance services when used to transport the Sick or Injured Plan Participant:
- (1) From the place where he is Injured by an accident or disease to the nearest Hospital appropriately equipped and staffed for treatment of the accident or disease; or
 - (2) For out-patient care following an accidental Injury; or
 - (3) From the Hospital to the patient's home.
- Ambulance services are covered only once per Sickness or Injury and only in an emergency when care is required en route to or from the Hospital.
- (X) Blood transfusions, blood processing costs, blood handling expenses, and the cost of blood and blood plasma. Any credit allowable for replacement of blood plasma by a donor or blood insurance will be deducted from the total of Eligible Expenses. Procurement and storage of one's own blood is also covered if prior to a planned surgery.
- (Y) Expenses for Medically Necessary treatment, under a specified treatment program reviewed by a Physician, for morbid obesity when the patient's weight exceeds the recommended body weight by 75% or 100 pounds and documented medical problems exist that can be improved with weight reduction. There is a maximum of two treatment plans per Plan Participant per Lifetime.
- (Z) Medically Necessary rehabilitative occupational and physical therapy when performed by a qualified physical therapist or a Physician, but **not to include** the services of a chiropractor, masseur, physical culturist or physical education instructor. The therapy must be required as a result of a Sickness or Injury. No other occupational or physical therapy is covered.
- (AA) Expenses for mastectomy-related services as required by the Women's Health and Cancer Rights Act of 1998, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Refer to paragraph C under the "Surgical Expense Benefits" subsection on page 27 for more details.
- (BB) Expenses for allergy care, which covers charges for Medically Necessary Physician's office visits, allergy testing, shots and serum. See the "Excluded Medical Expenses " subsection for excluded allergy care.

- (CC) Detoxification is covered when Chemical Dependency is sufficiently severe to require immediate in-patient medical and/or nursing care services.

SURGICAL EXPENSE BENEFITS

- (A) Primary surgeon expenses are paid as any other Eligible Expense subject to the following limitations:
- (1) The second Surgical Procedure shall be reimbursed at **75%** of the Usual and Prevailing amount of the benefit percentage payable for that procedure; and
 - (2) The third (and any additional) Surgical Procedure will be reimbursed at **50%** of the Usual and Prevailing amount of the benefit percentage payable for that procedure.
- (B) Assistant surgeon's expenses are to be paid at a rate equal to **25%** of the maximum amount allowed the primary Physician for the procedure(s) performed.
- (C) Cosmetic surgery or treatment is only covered in the following situations:
- (1) When required as a result of an accidental Injury; or
 - (2) In the case of a Plan Participant who received or is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, the Plan shall provide coverage for:
 - (a) Reconstructing the breast on which the mastectomy has been performed; and
 - (b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (c) Prosthesis and physical complications of all stages of mastectomy, including lymphedemas;in a manner determined in consultation with the attending Physician and the patient. Such coverage will be subject to the annual Deductible and all other Plan provisions consistent with other benefits under the Plan; or
 - (3) Expenses Incurred while a Plan Participant for a reduction mammoplasty, if Medically Necessary.

ORAL SURGERY

Medical Expenses Incurred in connection with dental work or oral surgery are covered if they are for the prompt repair of sound natural teeth or other body tissue, required as a result of a Non-Occupational accidental Injury. An Injury sustained as a result of biting or chewing will not be considered an accidental Injury. Dental Eligible Expenses Incurred in connection with oral surgery procedures listed below is also covered under this Plan. In-patient expenses are only covered when the Hospital Confinement is Medical Necessary due to the patient's condition. No other dental benefits, except the following, are covered under the Plan:

- (A) Excision of nondental related neoplasm, including benign, malignant and premalignant lesions, tumors, and cysts; or
- (B) Incision and drainage of facial cellulitis; or
- (C) Accessory sinuses, salivary glands and ducts; or
- (D) Surgical removal of impacted teeth that have not grown out, including the related expenses such as the facility, Physician, oral surgeon, or an anesthesiologist's services; or

- (E) Expenses (e.g., injections, surgery and x-rays) Incurred by a Plan Participant for diagnostic or surgical treatment for Temporomandibular Joint Dysfunction are covered. Except as otherwise provided, crowns, splints, dental services, dentures, orthodontics or appliances are not covered.

WELL CHILD CARE

A Member, Employee, Spouse, or Surviving Spouse who is a Plan Participant will be eligible for this Well Child Care coverage, provided the Plan Participant has satisfied the following conditions:

- (A) Such Plan Participant is covered under the Company's retiree medical plan or has no coverage similar to this Plan's Well Child Care coverage under any OGHC available (such as during Furlough, or, for Surviving Spouses, after the Company's coverage ceases).
- (B) The Plan Participant must notify the Claims Processor within **90 days** of the date of birth in order for coverage to be effective retroactively to the date of birth; otherwise, Well Child Care for that Dependent Child will be effective on the date the Claims Processor receives notification.

Under this Well Child Care provision, the Plan reimburses eighty percent (**80%**) of the Eligible Expenses Incurred for a Dependent Child through age two for the initial hospitalization, seven routine visits by a Physician, and immunizations.

MENTAL OR NERVOUS DISORDER

Expenses Incurred in connection with treatment for a Mental or Nervous Disorder are covered under the Plan subject to the following limitations:

In-Patient

The Plan reimburses **80%** of Eligible Expenses Incurred while confined in a Hospital.

Out-Patient

For Eligible Expenses Incurred while not confined in a Hospital or Psychiatric Day Treatment Facility, the Plan reimburses **50%** of the Eligible Expenses (after the Deductible is satisfied) for up to 60 visits per calendar year.

Psychiatric Day Treatment Facility

For Eligible Expenses Incurred at a Psychiatric Day Treatment Facility (i.e., when treatment is not more than eight hours in a 24-hour period), the Plan reimburses up to the **lesser of:**

- (A) The actual charge; or
- (B) 50% of the in-patient benefit.

Mental Health Parity Act of 1996

In accordance with the Mental Health Parity Act of 1996, the Lifetime Maximum benefit for a Mental or Nervous Disorder under the Plan shall be at least equal to the Lifetime Maximum benefit for medical and surgical benefits under the Plan, unless one or more of the exceptions set forth in the Mental Health Parity Act of 1996 applies.

CHEMICAL DEPENDENCY TREATMENT

For each retired Employee, Retired Member, Surviving Spouse and their Eligible Dependents, expenses Incurred for Chemical Dependency Treatment are payable at **80%** up to **\$10,000** per Plan Participant per lifetime for out-patient treatment and includes an in-patient Confinement maximum of one Hospital or Chemical Dependency Treatment Center admission.

For each active Employee, Active Member, Furloughed Member, TAG Member and their Eligible Dependents, expenses Incurred for Chemical Dependency Treatment are payable at 80% for out-patient

treatment and includes an in-patient Confinement maximum of one Hospital or Chemical Dependency Treatment Center admission.

HUMAN ORGAN AND TISSUE TRANSPLANT BENEFITS

Expenses for transplants or replacement of tissue or organs are covered if they are Medically Necessary and not experimental services. Benefits are payable for natural or artificial replacement materials or devices.

If both the donor and the recipient are Plan Participants, the donor's and recipient's Medical Care expenses are Eligible Expenses. If the donor is not a Plan Participant and the recipient is a Plan Participant, the donor's Medical Care expenses will be considered Eligible Expenses only to the extent that the donor's expenses are not covered under any other medical plan. The total of the donor's and recipient's Medical Care expenses will not be more than any maximums under this Plan applicable to the recipient. If the donor is a Plan Participant but the recipient is not a Plan Participant, neither the donor's expenses nor the recipient's expenses are considered Eligible Expenses.

IF ANY TRANSPLANT IS EXPECTED, THE CLAIMS PROCESSOR SHOULD BE CONTACTED IN ADVANCE TO VERIFY THE EXTENT OF COVERAGE.

SKILLED NURSING OR CONVALESCENT CARE FACILITY BENEFITS

Eligible Expenses Incurred in a Skilled Nursing Facility or Convalescent Care Facility are limited to **50%** of the semi-private Usual and Prevailing Hospital expense for up to **30 days** per Confinement.

HOME HEALTH CARE BENEFITS

Eligible Expenses Incurred for Home Health Care (including Medically Necessary Private Duty Nursing) are payable at **80%** of the Usual and Prevailing Expenses up to a maximum of **50 visits** (limit one visit per day) per Plan Participant per calendar year or the remaining Home Health Care Lifetime Maximum, if less. The Home Health Care Lifetime Maximum is **100 visits** (limit of one visit per day) per Plan Participant.

HOSPICE CARE

Eligible Expenses Incurred for Hospice Care are payable at **80%** of the Usual and Prevailing Expenses to a maximum of **90 days** per Plan Participant per Lifetime. This 90-day period can be extended if the Physician certifies that the Plan Participant is Terminally Ill.

BEREAVEMENT COUNSELING

Following the death of a Plan Participant, Eligible Expenses Incurred for Bereavement Counseling for the Plan Participant's immediate family members are payable at 80% of the Usual and Prevailing Expenses up to a maximum of **90 days**.

EXCLUDED MEDICAL EXPENSES

No Medical Care benefits are provided under the Plan for expenses in connection with a Sickness or Injury that is/are:

- (A) In excess of the Usual and Prevailing Expenses, expenses exceeding the Lifetime Maximum, as applicable, or an amount over and above the benefit limits shown in the SUMMARY OF SUPPLEMENTAL MEDICAL COVERAGE.
- (B) Resulting from war, declared or undeclared, including armed aggression resisted by the forces of any country or combination of countries, or any act incident to war. This exclusion does not apply to a Plan Participant Injured while in a commercial aircraft that is attacked (e.g., shot at while flying near war zones) by hostile forces.

- (C) For any Sickness or Injury that a Plan Participant is entitled to benefits under a Workers Compensation Act, occupational disease law, or other similar law or for expenses resulting from accidental Injury arising out of, or in the course of, employment for wages or profit.
- (D) An expense that the Plan Participant is not legally obligated to pay.
- (E) For Medical Care furnished without charge, paid for or reimbursed by or through national, state or local political subdivision, or any instrumentality or agency of such a government.
- (F) Expenses for military service-related Injuries or Sickness (past or present) furnished by a Hospital or facility operated by any foreign government agency or the United States Government or any authorized agency of the United States Government or furnished at the expense of such government or agency. All other treatment other than a military service-connected Injury or Sickness shall be covered under the Plan and paid as primary benefits but only when the Plan Participant is legally obligated to pay and has met one of the conditions in the "When Benefits Are Payable" subsection on page 21.
- (G) Expenses by any person, Hospital or entity that would not normally charge for such service in the absence of insurance or financial ability of the Plan Participant. This limitation will not apply where specifically prohibited by applicable statute.
- (H) Expenses for services, supplies or treatments:
 - (1) Not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of a Sickness or Injury including but not limited to housekeeping and Custodial Care; or
 - (2) Expenses for procedures, surgical or otherwise, that are specifically listed by the American Medical Association as having no medical value.
- (I) Not treated by a legally qualified Physician or surgeon.
- (J) Expenses incurred after coverage is terminated or no longer in force.
- (K) For any expenses not specifically included in the "Eligible Medical Expenses" subsection beginning on page 23 or if included in that section, any amounts exceeding the relevant limits.
- (L) Expenses for the following care to the extent in excess of, or not as described previously, in this BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS section:
 - (1) Surgical Expenses
 - (2) Oral Surgery
 - (3) Well Child Care
 - (4) Mental or Nervous Disorders
 - (5) Chemical Dependency Treatment
 - (6) Human Organ and Tissue Transplants
 - (7) Skilled Nursing Facility or Convalescent Care Facility
 - (8) Home Health Care

- (9) Hospice Care
- (10) Bereavement Counseling.
- (M) Expenses for Custodial Care.
- (N) For any Expenses Incurred for infertility testing and treatment (except as previously described under the “Eligible Medical Expenses” subsection on page 23), artificial insemination, surrogate parenting, in-vitro fertilization or GIFT, sterilization reversal, IUD, elective Norplant removal, or Depo-Provera injections.
- (O) An expense in connection with radial keratotomy, eye refractions, myopia, errors of refraction, orthoptics, visual training, examinations for the purpose of determining visual acuity, routine eye examinations, eyeglasses or contact lens (except as previously described under the “Eligible Medical Expenses” subsection on page 23 or as described under the Vision Care Benefits subsection on page 47).
- (P) An expense in connection with testing, treatment, or devices for hearing loss (e.g., hearing exams or hearing aids) to the extent in excess of or not as previously described under the “Eligible Medical Expenses” subsection on page 23.
- (Q) An expense in connection with testing, treatment, or devices for speech loss (e.g., non-rehabilitative speech therapy or speech devices) to the extent in excess of or not as previously described under the “Eligible Medical Expenses” subsection on page 23.
- (R) For arch supports, orthotic appliances and corrective shoes (or expenses for the casting, molding or fitting thereof), except for treatment of manifest skeletal disorder. Only orthotic appliances that are Medically Necessary are covered.
- (S) Structural changes to a house or vehicle.
- (T) Expenses for hypnosis.
- (U) Charges for treatment of learning disabilities including, but not limited to, treatment for scholastic improvement, vocational training, speech development, visual or motor coordination.
- (V) Expenses for the following forms of counseling: marriage and family, pastoral, financial, child, or career.
- (W) Equipment for environmental control or general household use, such as air filters or food liquidizers.
- (X) Services for or related to the following types of treatment are not covered:
 - (1) Primal therapy; or
 - (2) Psychodrama; or
 - (3) Megavitamin therapy; or
 - (4) Vision perception training.
- (Y) For any expenses, including surgery, clinics or drugs, relating to obesity or weight control except as previously described under the “Eligible Medical Expenses” subsection on page 23. Also not

covered are vitamins, diet supplements, recreational therapy, educational therapy, non-medical self-care or self-help training or enrollment in a health, athletic, or similar club.

- (Z) Services or supplies for treatment outside the United States of America or its possessions (collectively referred to as "USA") when traveling for specific services, supplies, or treatment.
- (AA) Expenses for services or supplies for training or education such as pre-natal classes, diabetic training, behavior testing or therapy, identity disorders, or psychological vocational testing, evaluation or counseling.
- (BB) Expenses for sleep testing or treatment unless Medically Necessary.
- (CC) Expenses for provocative neutralization allergy testing or therapy that involves injecting a patient with varying dilutions of the substance to which the patient can be allergic.
- (DD) Services or items any school system requires or is required under public law.
- (EE) For any services, or treatment for transsexualism, gender dysphoria or sexual reassignment or change including drugs, medication or surgical, mental or Psychiatric Treatment.
- (FF) For any treatment for gender reassignment or sexual dysfunction or inadequacy, which includes implants, devices, and related hormone treatment, whether or not Medically Necessary or following surgery.
- (GG) For wigs or artificial pieces.
- (HH) For personal comfort items, and expenses for the purchase or rental of supplies of common use, including but not limited to: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows, mattresses, waterbeds, motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools, or blood pressure kits (blood pressure kits will be covered when Medically Necessary and prescribed by a Physician). Also excluded are items that promote well-being, performance enhancement, not medical in nature or are not specific for the Sickness or Injury involved, provided such items are not Medically Necessary.
- (II) For travel, whether or not recommended by a Physician.
- (JJ) Expenses:
 - (1) by a Physician or nurse who is related by blood, marriage, or by legal adoption to either a Plan Participant or Spouse (e.g., but not limited to, child, brother, sister, or parent); or
 - (2) for care or treatment provided by any person who ordinarily resides with the Plan Participant.
- (KK) Dental and vision related expenses, except as otherwise provided in this Plan.
- (LL) Expenses for non-routine tests for certification, sports, FAA requirements or insurance, unless Medically Necessary.
- (MM) Expenses for care, treatment, services, drugs or supplies received from a nurse that do not require the skill and training of a nurse, and expenses for private duty nursing care that is not Medically Necessary.
- (NN) Expenses that are not Medically Necessary.

PREFERRED PROVIDER NETWORK OVERLAY

The Plan offers a preferred provider option through the Private Healthcare System, Inc (“PHCS”) Healthy Directions network. PHCS Healthy Directions has developed the largest proprietary network of medical providers in the country. In developing this network, PHCS Healthy Directions has negotiated lower medical fees with the providers in its network and these lower costs are passed on to Plan Participants. PHCS Healthy Directions does not practice medicine, adjudicate claims or provide medical advice to plans or participants.

The PHCS Healthy Directions network is an overlay to the Plan. Plan Participants will not be required to use a PHCS Healthy Directions network provider. However, Plan Participants who use a PHCS Healthy Directions network provider will benefit through the lower negotiated rates for the services provided. To qualify for the network discount, Plan Participants must present a valid identification card to the PHCS Healthy Directions network provider at the time services are rendered. Confirmation of participating providers can be obtained by calling 866-297-9107 or through the Internet at www.phcs.com (select the Healthy Directions network). Listed below are some key points about using the PHCS Healthy Directions Network.

While the Plan uses PHCS Healthy Directions as the network of medical services providers, WebTPA will continue as the Claims Processor for all claims. PHCS Health Directions will not process or adjudicate any claim under the Plan.

Some Key Points to Remember About the PHCS Healthy Directions Network

- (A) This preferred provider option is optional and not mandatory. Benefits will not change if a Plan Participant chooses not to use a PHCS Healthy Directions medical provider.
- (B) If Plan Participant uses a PHCS Healthy Directions provider and presents a valid identification card, the cost of the medical service will be paid based on the negotiated discount agreed between the network and the provider, that will be deemed to satisfy the Plan’s Usual and Prevailing rates; however, the service will still have to satisfy other conditions for payment as contained in the Plan (for example, they must be Medically Necessary and not be contained in the Excluded Medical Benefits section of the Plan).
- (C) At times, the PHCS Healthy Directions network will change the providers in its network (for example, new providers will be added, and current providers will be dropped or decide to discontinue). If this happens to a medical provider that is used by a Plan Participant, the amount paid by the Plan will change accordingly.
- (D) Confirmation of participating providers is available at www.phcs.com (select the Healthy Directions network) or can be obtained by calling 866-297-9107.
- (E) If a Plan Participant’s Physician is in the PHCS Healthy Directions network, the Plan Participant must make sure the Physician has a copy of the Plan Participant’s identification card with the PHCS Healthy Directions logo in order to receive the PHCS Healthy Directions network benefits.
- (F) To avoid confusion, not all Plan Participants will receive an identification card. Identification cards will be issued to a Plan Participants who qualifies for reimbursement under the Plan as indicated in the WHEN BENEFITS ARE PAYABLE subsection.
- (G) Non-Network claims will be sent to the Non-Network Claims Reviewer to negotiate provider discounts using its network of providers, affiliated providers and ability to negotiate discounts.

VOLUNTARY CASE MANAGEMENT

In some cases, a patient’s medical needs can be met, as well or better, through alternative Medical Care.

Through the Voluntary Case Management program, Plan Participants whose medical claims are either catastrophic or because they have been determined to have a long-term Sickness or Injury are offered assistance in obtaining appropriate Medical Care that guarantees both continuity and quality of care. Through this program, the Claims Processor and Case Manager will identify claims that are expected to require long-term Medical Care, or claims that are expected to require an extensive course of medical treatment. When identified, the Case Manager will offer to assist the Plan Participant in obtaining appropriate Medical Care for his Sickness or Injury. This program is entirely voluntary for the Plan Participant. Each Plan Participant can accept or decline Voluntary Case Management with no penalty or delay in claim processing.

PHARMACY BENEFIT PROGRAM

Outpatient Prescription Drugs will be paid under the Pharmacy Benefit Program described in this section. The Pharmacy Benefit Program is provided through WellDyneRx (“WellDyneRx”). WellDyneRx is a pharmacy benefit manager. As a pharmacy benefit manager, WellDyneRx has established a network of participating pharmacies throughout the country. WellDyneRx uses its network of pharmacies and mail order drug facilities to fill your prescription. WellDyneRx negotiates lower drug prices and passes these lower costs to Plan Participants through both its retail and mail order drug facilities.

Under the Pharmacy Benefit Program, the Deductible will apply to Prescription Drugs. The coinsurance for Prescription Drugs will apply to the annual Out of Pocket Maximum and the cost of the Prescription Drugs, less the coinsurance of 20%, will apply to the Lifetime Maximum under the Plan. Under the Pharmacy Benefit Program, Plan Participants may obtain Prescription Drugs through either a retail pharmacy or a mail order pharmacy.

Retail Pharmacy Benefit

Under the retail pharmacy benefit, Plan Participants may use either an In-Network pharmacy or a Non-Network pharmacy to fill prescriptions

Mail Order Pharmacy Benefit

A mail order pharmacy benefit is available as primary coverage to Plan Participants who are not eligible for Medicare Part D coverage and as secondary coverage for Plan Participants who are eligible for Medicare Part D coverage. Under the mail order pharmacy benefit, Plan Participants may obtain up to a 90-day supply of Prescription Drugs. A Plan Participant can find more information about the mail order drug benefit by calling WellDyneRx Customer Care at 888-479-2000 or on the WellDyneRx website at www.myWDRX.com.

The following three subsections describe the Pharmacy Benefit Program coinsurance and procedures (When Not Eligible for Medicare, When Eligible for Medicare and Medicare Part D Elected, and When Eligible for Medicare and Medicare Part D Not Elected) for using an In-Network pharmacy and/or Non-Network pharmacy.

WHEN NOT ELIGIBLE FOR MEDICARE

Using an In-Network Pharmacy

When using an In-Network pharmacy, Plan Participants must present a Plan identification card to the pharmacist when filling a prescription. The pharmacist will charge the Plan Participant a 20% coinsurance after Deductible. There are no claim forms to file.

Using a Non-Network Pharmacy

A Plan Participant who uses a Non-Network pharmacy must pay the pharmacist the full price of the Prescription Drug. The Plan Participant must file the appropriate claim form for reimbursement from WellDyneRx and include an itemized receipt for the Prescription Drug that includes the date processed, the name of drug, NDC number, day's supply, and cost from the pharmacy utilized. WellDyneRx will reimburse the Plan Participant 80% after Deductible.

Using the Mail Order Pharmacy Benefit

Under the mail order pharmacy benefit, Plan Participants may purchase up to a 90-day supply of a Prescription Drug. The mail order pharmacy is WellDyneRx and may be reached by calling 1-888-479-2000, or through its website at www.myWDRX.com. Plan Participants will be charged a 20% coinsurance of the cost of a Prescription Drug after Deductible. For new prescriptions or to transfer an existing prescription to WellDyneRx, Plan Participants should enclose the original prescription using the appropriate mail order form. Refills may be ordered by calling WellDyneRx at 1-888-479-2000, or through its website at www.myWDRX.com. Plan Participants should allow approximately 14 days from the date that the request was mailed to receive the prescribed drug.

WHEN ELIGIBLE FOR MEDICARE AND MEDICARE PART D ELECTED

The Plan will pay as secondary using coordination of benefits with the standard Part D Plan for Prescription Drugs not covered by the Plan Participant's Medicare Part D plan, provided the drug is otherwise covered by the Plan and Medicare. Reimbursement will be coordinated with the amount that the basic Part D Medicare plan would have paid.

Using an In-Network Pharmacy

When using an In-Network pharmacy, Plan Participants must present his Medicare Part D card and his Plan identification card. The pharmacist will process the prescription as secondary to the Plan Participants Medicare Part D plan using on-line adjudication through WellDyneRx. The pharmacist will charge the applicable coinsurance after Deductible to the Plan Participant. There are no claim forms to file.

Using a Non-Network Pharmacy

A Plan Participant who uses a Non-Network pharmacy must present their Medicare Part D card and pay their applicable copay or coinsurance to the pharmacy. The Plan Participant must file the appropriate claim form for secondary reimbursement from WellDyneRx and include the summary of benefits or Explanation of Benefits from the Part D plan showing the date processed, name of drug, NDC number, day's supply, and cost from the pharmacy utilized. The applicable reimbursement will be calculated after Deductible.

Using the Mail Order Pharmacy Benefit

Plan Participants may purchase mail order prescription drugs from their Medicare Part D plan. The mail order pharmacy will process the prescription through the Medicare Part D plan in which the Plan Participant is enrolled and collect the applicable copay or coinsurance for the Part D plan in which the Plan Participant is enrolled. The Plan Participant must file for reimbursement from WellDyneRx using the appropriate claim form and include the summary of benefits or Explanation of Benefits from the Part D plan showing the date processed, name of drug, NDC number, day's supply, and cost from the mail order pharmacy utilized. WellDyneRx will determine the applicable reimbursements after Deductible.

When a Prescription Drug is NOT Covered Under the Medicare Part D Plan

In some cases, a Plan Participant's Medicare Part D plan may not cover certain Prescription Drugs (e.g., excluded from the Medicare Part D provider's formulary). In this situation, the Plan's reimbursement will be coordinated with the amount that the basic Medicare Part D plan would have paid. After satisfying the

Deductible and any coinsurance or copays, the Plan will pay as secondary by coordinating benefit payments with the standard Medicare Part D plan for Prescription Drugs not covered by the Plan Participant's Medicare Part D plan, provided the drug is otherwise covered by the Plan. The Plan Participant must file the appropriate claim form for reimbursement from WellDyneRx and include an itemized receipt that shows the date processed, name of drug, NDC number, day's supply, and cost from the pharmacy utilized. WellDyneRx will determine the applicable reimbursement after Deductible.

WHEN ELIGIBLE FOR MEDICARE AND MEDICARE PART D NOT ELECTED

The Plan will pay as secondary using coordination of benefits with the standard Part D Plan for Prescription Drugs not covered by the Plan Participant's Medicare Part D plan, provided the drug is otherwise covered by the Plan and Medicare. Reimbursement will be coordinated with the amount that the basic Part D Medicare plan would have paid.

Using an In-Network Pharmacy

When using an In-Network pharmacy, Plan Participants must present the Plan identification card. The pharmacist will process the prescription as secondary to the standard Medicare Part D plan using on-line adjudication through WellDyneRx. The pharmacist will charge the applicable coinsurance after Deductible to the Plan Participant. There are no claim forms to file.

Using a Non-Network Pharmacy

A Plan Participant who uses a Non-Network pharmacy must pay the pharmacist the full price of the Prescription Drug. The Plan Participant must file the appropriate claim form for reimbursement from WellDyneRx and include an itemized receipt that shows the date processed, name of drug, NDC number, day's supply and cost from the pharmacy utilized. WellDyneRx will determine the applicable reimbursement after Deductible.

Mail Order is not applicable for Plan Participants who do not have a Medicare Part D plan.

Key Points About the Pharmacy Benefit Program

If enrolled in a Medicare Part D plan, the Plan Participant must enclose a copy of the Medicare Part D Explanation of Benefits with the claim.

Who Administers the Pharmacy Benefit Program?

The Pharmacy Benefit Program is administered by WellDyneRx. You may contact WellDyneRx for information about a claim, location of a participating pharmacy, mail order Prescription Drug or any other question at the following:

Street Address	WellDyneRx PO Box 4517 Englewood, Colorado 80155-4517 Fax 888-830-3608 888-479-2000
Website	www.myWDRX.com :

ORTHODONTIA BENEFITS

This Supplemental Medical Coverage provides Orthodontia Benefits to Active, Furloughed or Totally Disabled Members, Active Employees, Surviving Spouses and their Eligible Dependents while they are Plan Participants. (Orthodontia Benefits are **not** available for Retired Members, Retired Employees or their Eligible Dependents.)

Under this coverage, the Plan will pay **50%** of the Eligible Expenses Incurred while a Plan Participant for the Orthodontia Treatment services described in this section that are not reimbursed or eligible for reimbursement by any OGHC. A Dependent Child of an active Employee, Active Member, Furloughed Member, or TAG Member who has OGHC will have benefits under this Plan coordinated with the greater of the benefit provider under either: (1) the Company or APA group health plan, as applicable, or (2) the benefit provided under the OGHC. A Plan Participant who has OGHC that includes orthodontia treatment **must submit** a copy of the explanation of benefits (“EOB”) received from the OGHC before this Plan pays. The Lifetime Maximum is shown in the chart on page 5.

Payment for eligible Orthodontia Treatments shall be made after the Plan Participant receives the Orthodontia Treatment. Some orthodontists, however, require a substantial advance payment before Orthodontia Treatment is provided. In this situation, the Plan will deem twenty percent (20%) of the estimated total cost of the Orthodontia Treatment as the initial payment, and the remaining balance shall be allocated in equal monthly increments over the remaining treatment period. The Plan will pay 50% of these amounts that are not reimbursed under any OGHC. Payment of these amounts is subject to the Orthodontia Treatment Lifetime Maximum shown in the chart on page 5.

If various treatments or procedures are available for a given condition, the Eligible Expenses will be limited to the least expensive procedure that will produce a professionally adequate result as determined by the Claims Processor.

Orthodontia claims must be Filed within 24 months of the date the course of treatment ended.

Eligible Orthodontia Expenses

The Plan covers the Orthodontia Treatments when performed by a Physician or licensed orthodontist as listed below:

- (A) Comprehensive full banded Orthodontia Treatment
 - (1) Preliminary study including cephalometric x-rays, diagnostic casts and treatment plan
 - (2) First month of active treatment including all active and retention appliances
 - (3) Active treatment per month after the first month
 - (4) Retention and observation treatment, per visit
- (B) Appliances for tooth guidance - Only one such appliance per Plan Participant is an Eligible Expense
 - (1) Removable
 - (2) Fixed or cemented
- (C) Orthodontic retention appliances - Only one such appliance per Plan Participant is an Eligible Expense
 - (1) Removable

- (2) Fixed or cemented
- (3) Adjunctive service
 - (a) Cephalometric X-Ray
 - (b) Examination, treatment, or adjustment of appliance, per visit
- (D) Other Orthodontic Treatment that is Medically Necessary

Excluded Orthodontia Expenses

The services or supplies listed below are not covered under this Plan:

- (A) Services that are not listed above as Orthodontia Treatments.
- (B) Services or supplies that do not meet American Dental Association standards.
- (C) Services or supplies that are included in the “Excluded Medical Expenses” subsection on page 29.

RETIREE DENTAL BENEFITS

This Supplemental Medical Coverage provides basic, diagnostic and preventive dental benefits to Retired Members, Retired Employees, pilots disabled prior to February 1, 2004, Surviving Spouses and their Eligible Dependents. (This coverage is **not** available to Active Members, Active Employees or their Eligible Dependents.)

Under this coverage, after the eligible Plan Participant satisfies a **\$50 annual Deductible**, the Plan will pay **80%** of the Eligible Expenses Incurred while a Plan Participant for the basic, diagnostic and preventive dental benefits contained in this section that are not reimbursed or eligible for reimbursement by any OGHC, up to **\$1,000** per Plan Participant per calendar year. A Plan Participant who has OGHC that includes dental coverage **must submit** a copy of the EOB received from the OGHC before this Plan pays.

This Plan coordinates coverage with other available group dental coverage, including the optional group dental plan offered by the Company. This means that the dental benefits under this section of this Plan will be reduced by the amount that could have been paid by the Company's optional group dental plan, whether or not the Plan Participant selected the Company's optional group dental plan. If a participant has obtained group dental coverage other than the Company's optional group dental plan, the Plan benefit will be reduced by the greater of the benefit that could have been provided under the Company's optional group dental plan or the benefit provided under the other group retiree dental plan.

Retiree Dental Covered Procedures

This Plan covers Eligible Expenses for the dental procedures listed below:

Diagnostic

Initial oral examination
Periodic oral examination
Emergency oral examination
Limited oral evaluation
Comprehensive oral examination
Intraoral - periapical, occlusal complete series films, including bitewings
Extraoral - film
Bitewing - films
Panoramic film
Biopsy and examination of oral tissue
Diagnostic casts

Preventive

Prophylaxis - adult or child to age 14
Topical application of fluoride, including prophylaxis sealants
Space maintainer - fixed unilateral, bilateral or stainless steel
Space maintainer - removable unilateral or bilateral
Fixed, thumb-sucking appliance
Composite restoration
Resin or composite - anterior
Pin, additional to composite
Resin or composite - posterior - primary or permanent
Pulp cap - direct or indirect, excluding final restoration
Therapeutic pulpotomy
Therapeutic pulpotomy, excluding final restoration
Root canal therapy - anterior, bicuspid or molar, excluding final restoration
Four canals endotherapy
Apexification/recalcification
Apicoectomy/periarticular surgery - anterior, bicuspid or molar

Apical surgery
Hemisection, including root removal but not root canal therapy

Basic - Periodontics

Gingivectomy or gingivoplasty
Gingival curettage, surgical, narrative report required
Gingival curettage/root planing
Gingival flap procedure, including root planing, per quadrant
Crown lengthening, hard and soft tissue
Osseous surgery, including grafts, per quadrant
Osseous graft
Apically repositioned flap procedure
Occlusal adjustment
Periodontal root planing
Guided tissue regeneration
Pedicle soft tissue graft
Free soft tissue graft
Apically repositioned flap procedure
Occlusal adjustment
Advanced periodontitis
Periodontal prophylaxis
Periodontal abscess

OPTIONAL CUSTODIAL CARE BENEFIT PROVISIONS

Effective July 1, 2001, the Optional Custodial Care Benefits coverage was closed to new enrollments and only those Plan Participants who submitted a completed enrollment form for the Optional Custodial Care Benefits prior to July 1, 2001 may continue to participate.

To be eligible for coverage, each Employee, Member, Surviving Spouse and Eligible Dependent must satisfy all of the requirements listed below:

- (A) Satisfy the eligibility requirements contained in the ELIGIBILITY AND COVERAGE section; and
- (B) Pay the appropriate contribution for this additional coverage (see the SUMMARY OF OPTIONAL CUSTODIAL CARE BENEFIT section for contribution information); and
- (C) Any Plan Participant whose Optional Custodial Care Benefits coverage terminated on or after November 1, 2012 due to termination of participation under the Supplemental Medical Coverage, shall have the option to reinstate the Optional Custodial Care Benefits coverage in accordance with the provisions of the "Reinstatement of Optional Custodial Care Benefits Coverage" subsection.

The Plan will pay Optional Custodial Care Benefits for the charges for Room and Board made by the Custodial Facility at the applicable daily rate specified in the SUMMARY OF OPTIONAL CUSTODIAL CARE BENEFITS when a Plan Participant is confined as a registered bed-patient in a Custodial Facility as a result of an Injury or Sickness (including pregnancy). The Lifetime Maximum payment period for a Confinement in a Custodial Facility is 1,095 days per Plan Participant.

CLAIMS PROCESSING PROVISIONS

This section applies to all benefits under the Plan except Vision Care Benefits.

Plan Participants are required to file a completed claim form when applying for reimbursement of Eligible Expenses. Failure to provide complete and accurate information on the claim form can unnecessarily delay claim processing. A claim is a request for a benefit determination by a Plan Participant or his authorized representative that is made in accordance with the Plan's procedures. A claim must be received by the Claims Processor on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name a specific Plan Participant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services were received, and provider name, address, phone number and tax identification number. This Plan covers Post-Service Claims only. A Post-Service Claim is a benefit claim made under a group health plan after Medical Care is received.

TIME LIMIT FOR FILING A CLAIM

Written proof of a claim must be Filed with the Claims Processor within 24 months from the date the expenses were Incurred. Orthodontia claims must be Filed within 24 months of the date the course of treatment is completed. No benefit will be payable unless this requirement is met. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided.

Failure to furnish notice or proof of a claim within the time provided shall not invalidate or reduce any claim if the Plan Participant can show that it was not within his reasonable control to furnish such notice or proof, and that such notice or proof was furnished as soon as was reasonably possible.

When a Plan Participant's coverage terminates for any reason, written proof of a claim must be given to the Claims Processor within 24 months from the date of termination of coverage, provided that the Plan remains in force. If coverage ceases due to termination of the Plan, final claims must be received within 90 days following the effective date of termination of the Plan. Claims will be paid from available Plan funds.

HOW TO FILE A CLAIM

The following summarizes the Plan's claims Filing process. Please read and follow the instructions on the claim form carefully before submitting a claim.

- (A) Obtain a Voluntary Supplemental Medical and Custodial Care Benefit Plan Claim Form or a Voluntary Supplemental Medical and Custodial Care Benefit Plan Dental Claim Form by calling the Claims Processor, WebTPA, at (800) 477-8957, or from the Benefits section of the APA website at www.alliedpilots.org.
- (B) Complete the claim form using the instructions that accompany the form.
- (C) Submit an itemized statement of expenses that includes the following:
 - (1) Name of Patient
 - (2) Date and Cause of Treatment
 - (3) Diagnosis of Injury or Sickness

- (4) A copy of the Explanation of Benefits (“EOB”) from the Company’s medical plan or OGHC for Eligible Expenses reduced due to reaching lifetime maximum payment limits under the Company’s and APA’s other medical plans.
- (D) Mail completed claim form and accompanying information directly to the Claims Processor using the address on the claim form. The date the claim is Filed is defined on page 64.

PLEASE RETAIN A COPY OF ALL SUBMITTED INFORMATION FOR YOUR RECORDS.

WHAT HAPPENS TO YOUR CLAIM

Claim information goes to a special unit at the Claims Processor that processes claims for the Plan. The Claims Processor does not insure benefits, but processes claims for APA in accordance with the terms of this Plan. The Claims Processor will send an Explanation of Benefits (“EOB”) that summarizes the benefit determination and provides backup documentation for any payment made.

The EOB explains the reason(s) why benefits are paid or not paid. Normally, the Claims Processor will send an EOB within 30 days after Filing a properly documented claim with the Claims Processor, unless further information is required. The Claims Processor will contact the claimant or the provider for such additional information. Prompt response and follow-up will expedite processing of your claim. Any problems or questions about a claim should be directed to the Claims Processor at (800) 477-8957.

The Claims Processor will use the medical information that the claimant furnishes or that is obtained from his Physician to substantiate the claim and to determine benefits. It can be forwarded to independent consultants for medical review or appropriate medical follow-up. In certain rare situations, such as a claim appeal, it can be necessary for certain employees and representatives of APA to access this medical information to fulfill APA’s duties as Plan Administrator. If this is required, this medical information will be treated as extremely confidential and disclosed only on a need-to-know basis.

After a written claim for benefits is received, the Claims Processor, acting on the authority of the Plan Fiduciary(s), may elect to have such claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. Any Non-Network facility claims will be sent to the Non-Network Claims Reviewer for review. There is no dollar limit on these type claims. This process may include, but not be limited to, identifying charges for items or services that may not be covered or may not have been delivered, duplicate charges, and charges beyond the Usual and Prevailing Expenses as determined by the Plan. This review or audit will be completed within the deadline described in the **CLAIMS PROCESSING PROVISIONS** section.

Non-Network claims will be sent to the Non-Network Claims Reviewer to reprice Non-Network inpatient and outpatient facility claims based on the following criteria:

- (A) The maximum covered expense for services provided by a non-participating facility of health care services (or supplies) will be the lesser of, the billed charge, or a reasonable compensation amount as determined by the Non-Network Claims Reviewer.
- (B) The following are the primary criteria that the Non-Network Claims Reviewer will use to determine the Usual and Prevailing Expenses:
 - (1) The complexity or severity of treatment;
 - (2) Level of skill, experience involved;
 - (3) Fees usually charged by the providers;
 - (4) Statistically credible healthcare services data that is updated annually;

- (5) Average cost to deliver care for comparable providers and similar services; and
- (6) Prevailing provider rates adjusted to the general geographical area in which the services were rendered.

Prior to treatment, the Plan Participant or his Physician may request a predetermination of the amount that the Plan would pay by contacting the Claims Processor. Following treatment, the methodology report showing how the claim payment was calculated may be accessed at www.dataisight.com.

CLAIMS PROCESS

The Claims Processor has the responsibility for completing the claims process. The Claims Processor will generally complete the claims process within 30 days from the date that the claim form and all medical records are received. If the claim is denied, in whole or in part, the Claims Processor shall provide a written notice of denial within 30 days of the date the claim is received. This 30-day period can be extended an additional 15 days if more time is needed for claim processing and the Claims Processor notifies the claimant during the initial 30-day period.

The notice of any extension beyond the initial 30 days must explain the standards on which the entitlement to a benefit is based, the unresolved issues regarding the claim and the additional information needed to resolve those issues. If such an extension is necessary due to the claimant's Physician(s)'s or medical provider(s)'s failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant's Physician(s) or medical provider(s) will be afforded at least 45 days from receipt of the notice within which to provide the specified information. The 15-day extension period will not begin until the Claims Processor receives the requested information.

If the period of time to process the claim must be extended because of the Plan Participant's failure to submit information necessary to a full and fair decision on the claim, the period for making the decision will be tolled from the date on which the notification of the extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information.

APPEAL PROCESS FOR DENIED CLAIMS

APA hopes disputes can be resolved if they arise, so that Plan Participants will obtain the benefits to which they are entitled with as little inconvenience and delay as possible. To that end, the Plan provides an appeal procedure, as well as addresses, telephone numbers and other references where additional information and assistance can be obtained.

The following describes the appeal process under this Plan:

- (A) If the Plan Participant's claim is wholly or partially denied, the notice of denial must include specific reasons for such denial, reference to Plan terms and conditions on which the denial was based, a description of the Plan's appeal procedures, and the time limits applicable to such procedures. If the claim is denied because necessary information was not available to the Claims Processor, the notice will describe the additional material or information that is required in order for the Plan Participant to perfect his claim, will provide an explanation of why such material or information is necessary, and will state that such material or information must be provided within 180 days after the Plan Participant receives notice of adverse benefit determination. The notice will also include a statement that the Plan Participant has the right to bring a civil action under Section 502(a) of ERISA to seek a judicial decision on his right to the benefit but that no such lawsuit can be filed until the appeal rights provided in this Plan have been exercised and the Plan benefits requested in such appeal have been denied in whole or in part by the BRAB.
- (B) If a Protocol was relied upon in making the adverse determination, the Plan Participant is entitled to a copy of the Protocol, or to be told that the Protocol was relied upon in making the determination,

and that the Plan Participant can receive a copy of the Protocol free of charge, upon written request to the Claims Processor.

- (C) If an adverse determination was based on a Medically Necessary or experimental treatment or a similar exclusion or limit, a written explanation or a written copy of the scientific or clinical judgment that was the basis for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, will be provided at no cost to the Plan Participant, upon a written request to the Claims Processor.
- (D) The Plan Participant can request that the BRAB review the denial of all or part of his claim by Filing an appeal. This appeal must be in writing and must be received by the BRAB no more than 180 days after the Plan Participant receives notice of the adverse benefit determination. Any appeal received by the BRAB after this 180-day period will be null and void. This appeal should be addressed to the BRAB, c/o Director of Benefits, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Fort Worth, TX 76155-2512.
- (E) As part of the appeal process, the Plan Participant can submit Appeal Materials. The BRAB's review of the appeal must take into account the Appeal Materials, regardless of whether any of the Appeal Materials were submitted or considered in the initial benefit determination; however, only Appeal Materials received by the BRAB prior to the end of the 180-day Filing period will be considered. There will be no exception to this rule. The Plan Participant must be provided, upon request and free of charge, reasonable access to and copies of the Record.
- (F) The BRAB will decide the Plan Participant's appeal based on the information submitted in accordance with paragraphs (D) and (E) above and the Record from the Claims Processor. No deference will be given to the initial adverse benefit determination, and the decision will be made by the BRAB. The BRAB will not include any individual who made the initial adverse determination or a subordinate of that individual. The BRAB shall have discretion to interpret the Plan and to make all determinations on appeal.
- (G) If the adverse claim determination was based, in whole or in part, on a medical judgment, including determinations regarding whether treatment, drugs, or other items are experimental, investigational, or not Medically Necessary or appropriate, the BRAB shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional must not have been involved in the initial adverse claim determination, nor be the subordinate of the professional involved in the initial adverse claim determination. The Plan Participant is entitled to know the identity of any medical or vocational experts whose advice the Claims Processor and/or the BRAB obtained in connection with his claim, regardless of whether his advice was relied upon in making the adverse determination.
- (H) The BRAB will advise the Plan Participant of the results of its review of the appeal within 60 days after it receives the appeal and the timely Filed Appeal Materials.
- (I) If the period of time to process the request for review must be extended because of the Plan Participant's failure to submit information necessary for a full and fair decision on the appeal, the Plan Participant will be notified within 60 days of the appeal. The notice will state the period for making the decision will be tolled from the date on which the notification is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information, but not more than 90 days.
- (J) When the review of the appeal is completed, the Plan Participant will receive a written decision that will include reference to Plan terms and conditions on which the decision was based. If his appeal has been denied, in whole or in part, the Plan Participant must be told the specific reason(s) for the denial and a reference to specific Plan provisions on which the decision is based. The Plan

Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, the Record.

- (K) If a Protocol was relied upon in making the adverse determination on appeal, the Plan Participant is entitled to a copy of the Protocol, or to be told that the Protocol was relied upon in making the determination and that he can receive a copy of the Protocol free of charge, upon request to the APA.
- (L) After exhausting the Plan's administrative claims and appeals process as contained in this section, the Plan Participant may bring a civil action under section 502(a) of ERISA for any benefit that is denied in whole or in part. A Plan Participant or his authorized representative who fails to complete the Plan's appeal process will not have the right to file suit in court. No action at law or in equity shall be brought to recover benefits under the Plan prior to the exhaustion of all internal administrative remedies in accordance with the requirements of the Plan, nor shall an action be brought at all unless brought before the later of: (1) three years after the date a benefit claim is Filed; or (2) three years after the date on the letter stating the Plan's final decision on the Plan Participant's benefit appeal.
- (M) Nothing in this section shall preclude a Plan Participant's authorized representative from acting on behalf of such Plan Participant in pursuing a benefit claim or appeal to the BRAB of an adverse benefit determination. If the Plan Participant's authorized representative is not a lawyer, the Plan Participant must provide written confirmation that the representative is authorized to act on the Plan Participant's behalf.
- (N) If the BRAB, acting through the Claims Administrator, determines, in its sole discretion, that there has been a valid assignment of benefits with respect to a claim, then the Plan Participant or provider, or both, shall have the right to appeal an adverse benefit determination under this Claims Processing Provisions section. However, the Plan will only pay benefits once with respect to a particular claim. If the Claims Administrator or the BRAB has determined that there was a valid assignment, benefits will be paid (to the extent appropriate under the Plan) only to the provider, unless the provider consents otherwise in writing.

VISION CARE BENEFITS

The Plan provides Vision Care Benefits for all Plan Participants. This benefit is provided through an insurance policy with Vision Service Plan Insurance Company (“VSP”). Plan Vision Care Benefits are limited only to those provided by that insurance policy. The Group Vision Care policy Certificate of Coverage will be provided upon request by contacting the APA Benefits Department or by accessing the APA Website at www.alliedpilots.org. The following is a summary of the benefits provided under that policy. If there is any discrepancy between the benefits described in this section and the benefits provided under the policy, the terms of the policy will govern.

VSP has an extensive nationwide network of doctors (optometrists, ophthalmologists, and doctors of osteopathy) who provide **non-medical** vision care and materials. This coverage is designed to provide regular eye examinations and benefits toward vision care expenses but not Medical Care. The following sections explain the services and costs of using both the VSP network of doctors and using other providers.

VSP BENEFITS

A Plan Participant can receive vision benefits either through the VSP Choice Network of doctors or through non-participating doctors. After paying a copay and subject to the “VSP Exclusions and Limitations” on page 48, the summary of BASIC VSP BENEFITS in the chart on page 5 summarizes the Vision Care Benefits provided to Plan Participants through either VSP Choice Network Doctors or Non-VSP Doctors.

Lenses and frames include the following professional services:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustment to frames to maintain comfort and efficiency;
- Progress or follow-up work, as necessary.

For purposes of this vision care benefit, “medically necessary contact lenses” include contact lenses that are provided under one of the following circumstances:

- Following cataract surgery;
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- Certain conditions of anisometropia;
- Keratoconus

LOW VISION BENEFIT

In addition to these basic VSP benefits, certain services and materials for low vision benefits are also covered up to a maximum benefit of **\$1,000** every two years. The copay for this low vision benefit is **25%** of the cost. The low vision benefit includes supplementary testing and supplemental care.

Supplementary testing includes a complete low vision analysis and diagnosis, a comprehensive examination of visual functions, and prescription of corrective eye wear or visual aids, where indicated. Supplemental care includes any required subsequent low vision therapy.

VSP COPAYS

Each Plan Participant will be charged a copay for vision care services and materials each time services or materials are obtained under the Plan. The copays are shown the summary of BASIC VSP BENEFITS in the chart on page 5.

VSP EXCLUSIONS AND LIMITATIONS

This coverage is designed to cover a Plan Participant's visual needs rather than services or materials that are primarily for cosmetic purposes. Thus, the Plan does not cover some services or materials. The following summarizes many of these options and exclusions that are not covered by this Plan (a complete listing of these is contained in the policy and the certificate of insurance on the APA website):

Options

- Blended lenses
- Contact lenses (except as described in this section)
- Oversize lenses
- Progressive multi-focal lenses
- Coated or laminated lenses
- A frame that exceeds the VSP allowance
- Certain limitations on low vision
- Cosmetic lenses
- Optional cosmetic processes
- Ultra-violet protected lenses

Exclusions

- Medical or surgical treatment of the eyes
- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (non-prescription)
- Two pair of glasses in lieu of bifocals
- Replacement of lenses furnished under this coverage that are lost or broken except at the normal intervals when services are otherwise provided
- Any eye examination, or corrective eye wear, required by an employer as a condition of employment
- Corrective vision services, treatments, and material of an experimental nature.

HOW TO USE VSP BENEFITS

Since the vision benefits can be obtained from either a VSP provider or a doctor outside of the VSP network, the procedures for obtaining benefits varies. Plan Participants should use the following procedures to obtain vision benefits:

Using a VSP Provider

(A) Contact a VSP member doctor. A listing of VSP doctors can be obtained from VSP by calling **(800) 877-7195** or through the Internet at www.vsp.com.

(B) Provide the following information when making an appointment:

(1) Group Name: **Allied Pilots Association**

(2) Plan Participant's Name and last four digits of the Participant's Social Security Number

The VSP doctor will verify eligibility with VSP prior to the appointment.

(C) At the appointment, the Plan Participant will pay the VSP doctor the copay and the charges for any non-covered services or materials.

Using a Non-VSP Provider

(A) Make an appointment and pay the provider in full.

- (B) Obtain an Out of-Network Reimbursement Form from the Benefits section of the APA website at www.alliedpilots.org, or send a copy of the bill that itemizes the services and materials provided to VSP and include the following information:

- (1) Group Name: **Allied Pilots Association**
- (2) Plan Participant's name, Social Security Number, mailing address and date of birth. This information can be submitted using any generic claim form available from your provider or the HCFA-1500 form.

The VSP address for claims submission is:

Vision Service Plan Insurance Company
3333 Quality Drive
Rancho Cordova, CA 95899-7105

COMPLAINTS AND GRIEVANCES

If a Plan Participant ever has a question or problem, the first step is to call VSP's customer service department. The customer service department will make every effort to answer the Plan Participant's question and/or resolve the matter informally. If the matter is not initially resolved to the satisfaction of the Plan Participant, the Plan Participant must communicate a complaint or grievance to VSP orally or in writing by using the complaint form that can be obtained upon request for the VSP customer service department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. Plan Participants also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within 30 days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than 120 days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within 30 days, a letter will be sent to the Plan Participant to indicate VSP's expected resolution date. Upon final resolution, the Plan Participant will be notified of the outcome in writing.

CLAIM PAYMENTS AND DENIALS

- (A) **Initial Determination:** VSP will pay or deny claims within 30 calendar days of the receipt of the claim from the Plan Participant or the Plan Participant's authorized representative. In the event that a claim cannot be resolved within the time indicated VSP can, if necessary, extend the time for decision by no more than 15 calendar days.
- (B) **Request for Appeals:** If a Plan Participant's claim for benefits is denied by VSP in whole or in part, VSP will notify the Plan Participant in writing of the reason or reasons for denial. Within 180 days after receipt of such notice of denial of a claim, a Plan Participant can make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Plan Participant for whom a claim for benefits was denied, including the name of the Member, identification number of the Member, the Plan Participant's name and date of birth, the name of the provider of services and the claim number. The Plan Participant can state the reasons the Plan Participant believes that the claim denial was in error. The Plan Participant can also provide any pertinent documents to be reviewed. VSP will review the claim and give the Plan Participant the opportunity to review pertinent documents, submit any statements, documents, or written arguments

in support of the claim, and appear personally to present materials or arguments. The Plan Participant or Plan Participant's authorized representative should submit all requests for appeals to:

VSP
Member Appeals
3333 Qualify Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP determination, including specific reasons for the decision, shall be provided and communicated to the Plan Participant within 30 calendar days after receipt of a request for appeal from the Plan Participant or Plan Participant's authorized representative.

If a Plan Participant disagrees with VSP's determination, he can request a second level appeal within 60 calendar days from the date of the determination. VSP shall resolve any second level appeal within 30 calendar days.

Under ERISA Section 502 (a)(1)(B), a Plan Participant has the right to bring civil (court) action when all available levels of reviews of denied claims, including the appeal process, has been completed, the claims were not approved in whole or in part, and the Plan Participant disagrees with the outcome.

IMPORTANT NOTE

This section summarizes the vision benefits provided under the Plan. The Plan's vision benefits are limited to those provided through the insurance policy with Vision Services Plan Insurance Company and if there is any discrepancy between the Plan and that policy, the terms of the policy will govern. The insurance certificate stating the terms of this policy is available on the APA Website or by requesting a copy from APA.

GENERAL PLAN PROVISIONS

ERISA RIGHTS

This section contains a statement of rights under the Employee Retirement Income Security Act of 1974, as amended from time to time (ERISA) that is required by Federal law and regulation.

As a participant in the Allied Pilots Association Voluntary Supplemental Medical and Custodial Care Benefit Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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 administrator can make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care 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 summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you can be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action 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, can fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file 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 or a medical child support 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 N.W., Washington, D.C. 20210. You can also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN INTERPRETATION

In carrying out their respective responsibilities under the Plan, the APA and certain other Plan Fiduciaries, including, as applicable, the BRAB, shall have the discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to any Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Benefits under this Plan will be paid only if a Plan Fiduciary (e.g. the BRAB regarding benefit claim appeals) decides in its discretion that the Plan Participant is entitled to them.

PLAN CONTINUANCE

APA expects to continue the Plan indefinitely, but an unqualified commitment to continue the Plan without modification is not possible. **Therefore, APA reserves the right to amend or terminate this Plan at any time through a resolution approved by the APA Board of Directors; provided, however, that any amendment required by law can be approved by the President of APA with no APA Board of Directors action required. The APA Board of Directors may delegate to the APA President and/or the BRAB, and the APA President can delegate to the BRAB, the authority to implement any resolution or action amending the Plan by preparing Plan documents (e.g., Plan amendments, Plan restatements, summaries of material modifications, etc.) and Plan-related documents (e.g. explanations, announcements, information, correspondence, etc.) consistent with such resolution or action and by taking such other actions as are reasonable and necessary to implement such resolution or action. Such amendment shall be effective as of: (A) the date of approval of the resolution by the APA Board of Directors, if no effective date is stated in the resolution, (B) the effective date expressly set forth in the resolution, or (C) for an amendment required by law, the effective date expressly set forth in writing by the APA President.**

RELATIONSHIP BETWEEN PLAN PARTICIPANTS AND THE APA

The terms of this Plan are intended solely to govern the relationship between Plan Participant and the Plan. Nothing in this Plan is intended or should be interpreted to define, qualify, limit or provide terms and conditions for the relationship between APA and the Plan Participants in non-Plan contexts. Nothing contained in the Plan shall limit or interfere with the right of APA to discharge, expel or take other action

regarding a Plan Participant in his role as a Member of the APA, where such role is applicable, regardless of the effect that such action may have upon him as a Member of the APA.

PLAN TRUST FUND AND TRUSTEE

All funds used to provide Plan benefits and pay reasonable Plan expenses are held in the Plan's Master Trust and are invested by the investment managers and the Master Trustee. The Master Trustee and investment managers are selected by APA and approved by the APA Board of Directors.

The investment policy and objectives for the Master Trust are established by APA and carried out by the Master Trustee and investment managers, as applicable, in a manner consistent with the law and the Master Trust. Such policy and objectives can be changed, from time to time, as the APA Board of Directors in its sole discretion, shall determine.

MANAGEMENT OF PLAN

The Plan must be managed fairly and in the interest of all Plan Participants. Whenever any discretionary action is required in administering the Plan, APA and the other Plan Fiduciaries shall exercise their authority in a non-discriminatory manner so that all Plan Participants similarly situated receive substantially the same treatment and so that no discretionary acts are taken that would be discriminatory under the Internal Revenue Code of 1986, as amended from time to time. No one can be discriminated against because of a disputed claim or due to the exercise of any rights under the law.

CURRENCY

All benefit payments from the Plan shall be made in the lawful currency of the United States of America.

OPTION TO PROVIDE NON-COVERED SERVICES OR SUPPLIES

The Plan can, at the sole discretion of APA, pay benefits for services and supplies not specifically covered by the Supplemental Medical Coverage. This applies if APA determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of the Plan Participant.

SUBROGATION AND REIMBURSEMENT RIGHTS

If Sickness or Injury is caused by acts or omissions for which a third party may be legally liable, including, but not limited to, coverage under auto (including uninsured and under insured motorist coverage); property and casualty, or liability insurance, the Plan shall be fully subrogated to any and all rights that the Plan Participant may have against the third party. The Plan is granted a first right of reimbursement from any third party payment (whether such payment is made as a result of litigation, settlement, insurance, or any other recovery from a third party in connection with such Sickness or Injury), without regard to the classification of such payment or its assignment by the Plan Participant.

If such third party fails or refuses to make prompt payment, the Plan may pay benefits in connection with such Sickness or Injury as interim benefits until third party payments are made, provided that the Plan Participant completes and signs the Plan's Subrogation Agreement.

If a Plan Participant is Sick or Injured through the act or omission of a third party, the benefits of the Supplemental Medical Coverage shall be provided only if the Plan Participant has agreed in writing:

- (A) (1) To immediately reimburse the Plan from such third party payments to the extent of the benefits paid, upon payment by any third party to or on behalf of the Plan Participant, whether as a result of legal action, settlement or otherwise; and
- (2) that a lien in favor of the Plan attaches to such third party payments to the extent of the benefits paid by the Plan; and

- (3) to order and direct that reimbursement of such benefits be made to the Plan, to the extent of such benefits paid by the Plan; the lien and order may be filed with the person whose act caused the Sickness or Injury, his agent or carrier, the relevant court, the Plan Participant's attorney, and any other appropriate person(s) or entity(ies); and
- (4) that the reimbursement to the Plan shall not be affected or reduced by Equitable Defenses, unless agreed to by the BRAB;
- (B) That the Plan may enforce its subrogation and reimbursement rights by requiring a Plan Participant to bring suit or other proceedings against any third party that may be legally liable, and that the Plan shall have the right to intervene in any such suit or other proceeding in order to protect the Plan's rights;
- (C) That, unless the Plan agrees otherwise, the Plan Participant shall be responsible for all fees of the attorney representing or advising the Plan Participant regarding a claim against a third party;
- (D) That the Plan, on the Plan Participant's behalf, shall have the right to negotiate a settlement with a third party, with or without the assistance of the Plan Participant's attorney and may, on the Plan Participant's behalf, agree to reasonable attorney fees, but not more than one-third of the reimbursements received by the Plan for a subrogated claim;
- (E) That if the Plan pays benefits in good faith to an organization on a Plan Participant's behalf, it is not required to pay the same benefits again; and
- (F) That if the Plan Participant receives or benefits from a third party payment in connection with Sickness or Injury for which Plan benefits were paid and the Plan Participant does not reimburse the Plan an amount equal to the lesser of such third party payment or such Plan benefits, then the benefits paid minus such reimbursements made to the Plan shall be deemed an Overpayment. (See the Recovery of Overpayment(s) subsection.)

ASSIGNMENT OF CLAIM PAYMENTS UNDER THE SUPPLEMENTAL MEDICAL COVERAGE

Payment of any Medical Care, Retiree Dental Benefits or Orthodontia Benefits claim under the Plan will be made to the Plan Participant unless he or she has previously authorized payment to a provider rendering services, treatments or supplies. If the Plan Participant dies before all benefits have been paid, the remaining benefits may be paid to any relative of the Plan Participant or to any person or entity appearing to the Plan Administrator to be entitled to payment. The Plan shall fully discharge its liability by such payments.

NON-ASSIGNMENT OF CLAIM PAYMENTS UNDER CUSTODIAL CARE BENEFITS

Payment of any Custodial Care benefits claim will be made to the Plan Participant and **cannot be assigned** to any Hospital, clinic, Physician, surgeon, or other medical or custodial care provider. If the Plan Participant dies before all benefits have been paid, the remaining benefits may be paid to any relative of the Plan Participant or to any person or entity appearing to the Plan Administrator to be entitled to payment. The Plan shall fully discharge its liability by such payments.

RECOVERY OF OVERPAYMENTS

- (A) The Plan has the right to recover any Overpayments.
- (B) By participating in the Plan, the Plan Participant consents and agrees:
 - (1) to immediately return any such Overpayment to the Plan; and
 - (2) that an equitable lien by agreement in favor of the Plan exists and attaches to an Overpayment.

- (C) The Plan may withhold or reduce future benefit payments as an offset for Overpayment, sue to recover Overpayments, or may use any other lawful remedy to recover Overpayments.
- (D) The Plan has the right to recover any Overpayment from one or more of:
 - (1) the Plan Participant to whom or on whose behalf it made the Overpayment; or
 - (2) other persons or entities.
- (E) The Plan's right to recover an Overpayment shall not be affected or reduced by Equitable Defenses.

RIGHT TO SELECT MEDICAL PROVIDER

A Plan Participant shall have the sole right to select his own Physician, surgeon, and Hospital. The Plan will not interfere with the Physician-patient relationship.

GOVERNING LAW, ETC.

The Plan shall be construed according to the laws of the State of Texas, except as otherwise provided by ERISA or other applicable Federal legislation. Headings of sections and subsections contained in this booklet are included solely for convenience of reference, and if there be any conflict between such headings and the text, the text shall control.

ADDRESS FOR NOTICES

APA can give any notice required to be given to a Plan Participant or any other person entitled to benefits under this Plan, by mailing such notice to such person at the address last furnished to APA by the Employee or Member or, if applicable, a Surviving Spouse or Eligible Dependent.

PLAN EXPENSES

All expenses of the Plan, unless paid by APA in its sole discretion, shall be paid out of the Plan account under the Master Trust.

RELIANCE ON OTHER PROFESSIONALS

APA can employ accountants, attorneys, consultants or other experts to render advice with respect to their fiduciary responsibilities. The Master Trustee can also do so at the direction of APA. APA can rely exclusively on all reports, valuations, tables, certifications, and opinions furnished by, or in accordance with the instructions of accountants, counsel, consultants, or other experts employed or engaged by APA.

OBLIGATIONS OF APA

The obligations of APA under the Plan shall be limited to those obligations specifically assumed by it under the terms of this booklet, together with such additional obligations, if any, as may be imposed upon APA by applicable law.

NOTICE OF PLAN'S EXEMPTION FROM THE AFFORDABLE CARE ACT

The Allied Pilots Association, the Plan Sponsor of the Plan, believes the Plan is exempt from the Patient Protection and Affordable Care Act ("the Affordable Care Act") as a plan that has fewer than two participants who are APA employees on the first date of each Plan year. If not exempt, the APA intends the Plan to be a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan <http://www.dol.gov/ebsa/healthreform> means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to WebTPA at 800-477-8957. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NEED HELP?

If you need further assistance, please contact:

General Information

Allied Pilots Association

14600 Trinity Blvd., Suite 500
Fort Worth, TX 76155-2412
(817) 302-2272
(800) 323-1470
www.Alliedpilots.org

Specific Claims Information

WebTPA Employer Services, LLC

P.O. Box 1987
Grapevine, TX 76099-1987
(800) 477-8957
Fax (469) 417-1979
www.WebTPA.com

Case Manager

WebTPA Employer Services, LLC

P.O. Box 1987
Grapevine, TX 76099-1987
(800) 477-8957
www.WebTPA.com

COBRA Administration

CONEXIS

6191 North State Hwy. 161, #400
Irving, TX 75038
(877) 452-6272

Vision

Vision Service Plan

P. O. Box 997100
Sacramento, CA 95899-7100
(800) 877-7195
www.vsp.com

GENERAL PLAN INFORMATION

Plan Name	Allied Pilots Association Voluntary Supplemental Medical and Custodial Care Benefit Plan
Plan Identification Number	503
Tax Identification Number	13-1982245
Type of Plan	Group health plan
Type of Administration	Contract Administration
Explanation for Contract Administration	WebTPA Employer Services, LLC performs the services described in the service agreement between WebTPA Employer Services, LLC and the Allied Pilots Association in accordance with the terms and conditions of the Plan and within the framework of policies, interpretations, rules, practices and procedures made by the Plan Sponsor or Plan Administrator, to the extent that such are consistent with the service agreement and all applicable laws and regulations.
Name and Address of the Plan Named Fiduciary (Plan Administrator and Plan Sponsor)	Allied Pilots Association 14600 Trinity Blvd., Suite 500 Fort Worth, TX 76155-2512 (817) 302-2272 or (800) 323-1470
Agent for Service of Legal Process	Allied Pilots Association 14600 Trinity Blvd., Suite 500 Fort Worth, TX 76155-2512 Service of process may also be made upon the Master Trustee
Vision Care Claims Processor	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195
Claims Processor for All Other Claims	WebTPA Employer Services, LLC P.O. Box 1987 Grapevine, TX 76099-1987 (800) 477-8957 www.WebTPA.com

Case Manager	WebTPA Employer Services, LLC P.O. Box 1987 Grapevine, TX 76099-1987 (800) 477-8957 www.WebTPA.com
COBRA Administrator	CONEXIS 6191 North State Hwy 161 Suite 400 Irving, TX 75038 (877) 452-6272 www.conexis.org
Non-Network Claims Reviewer	NCN/MultiPlan 115 Fifth Avenue 7 th Floor New York, NY 10003 (866) 750-7427 www.multiplan.com
Source of financing of the fund and identity of any organization through which benefits are provided:	Contributions are made to the Master Trust by the Plan Participants. Vision Care Benefits are provided through an insurance policy with Vision Service Plan Insurance Company; all other benefits are provided directly from the Plan assets under the Master Trust, through WebTPA.
Master Trustee	State Street Bank One Enterprise Drive Quincy, MA 02171
Plan Year	January 1st through December 31st of each year

DEFINITIONS

The following terms, wherever used in the Plan's booklet, have the following meaning:

Actively at Work

The term "Actively at Work" means the customary performance of all regular duties of employment on a full time basis and for full pay at the Plan Participant's customary place of employment or at some location to which that employment required him to travel; and solely for the purpose of determining eligibility under this Plan, "Actively at Work" shall be deemed to include absences from work because they have been determined to have a Health Status-Related Factor.

Appeal Materials

The term "Appeal Materials" means written comments, documents, records, and other information relevant to the Plan Participant's benefits claim. Note that Appeal Materials received by APA after the end of the 180-day Filing period will not be considered in the review of or decision on the appeal. There is no exception to this rule.

Business Associate

The term "Business Associate" means a person or entity that performs a function or activity regulated by HIPAA on behalf of the Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, and financial services. A Business Associate can be a covered entity.

BRAB

The term "BRAB" means the voting members of the APA Benefits Review and Appeals Board.

Case Manager

The term "Case Manager" means the firm hired to administer the Voluntary Case Management program. The Case Manager is WebTPA Employer Services, LLC ("WebTPA"), P.O. Box 1987, Grapevine, TX 76099-1987, (800) 477-8957, www.WebTPA.com.

Certificate of Creditable Coverage

The term "Certificate of Creditable Coverage" means a certificate required by HIPAA and the regulations issued thereunder at 26 CFR Part §54.9801-5 that is distributed to a Plan Participant upon termination of coverage under the Plan, at the time of a Qualifying Event or other termination of coverage, at the time COBRA coverage ceases, or upon any written request made by an individual not later than 24 months after his Plan coverage ceased.

Chemical Dependency

The term "Chemical Dependency" means the state of chronic or periodic intoxication or Drug Abuse detrimental to the individual, physically and psychologically, and to society, that results from the repeated consumption of drugs (natural or synthetic), including alcohol.

Chemical Dependency Treatment

The term "Chemical Dependency Treatment" means a program of Chemical Dependency therapy that meets **ALL** of the following requirements:

- (A) It is prescribed and supervised by a Physician; and
- (B) The Physician certifies that a follow-up program has been established that includes therapy by a Physician, or group therapy under a Physician's direction, at least once per month; and

- (C) It includes meetings of organizations devoted to the therapeutic treatment of Chemical Dependency at least twice per month. Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the after effects of a specific drinking or drug episode. Maintenance care consists of providing an environment without access to alcohol or drugs.

Chemical Dependency Treatment Center

The term “Chemical Dependency Treatment Center” means a facility that provides Chemical Dependency Treatment pursuant to a written treatment plan approved and monitored by an M.D. or D.O. and that facility is also:

- (A) Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
- (B) Accredited as such a facility by the Joint Commission on Accreditation of Health Care Organizations; or
- (C) Licensed, certified, or approved as a Chemical Dependency Treatment Program or center by any other state agency having legal authority to license, certify, or approve.

Claims Processor

The term “Claims Processor” means the firm providing or arranging for administrative and consulting services to APA in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated. The Claims Processor is WebTPA Employer Services, LLC (“WebTPA”), P. O. Box 1987, Grapevine, TX 76099-1987, (800) 477-8957, Fax (469) 417-1799, www.WebTPA.com.

COBRA

The term “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Administrator

The term “COBRA Administrator” means the firm providing or arranging for COBRA administration. The COBRA administrator is CONEXIS, 106 Decker Court, Suite 200, Irving, TX 75062, (800) 722-2667.

Company

The term “Company” means any subsidiary of AMR Corporation whose employees are represented for collective bargaining by the Allied Pilots Association.

Complications of Pregnancy

This term “Complications of Pregnancy” means:

- (A) Pregnancy-related conditions requiring Hospital Confinement (when the Pregnancy is not terminated), whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. This shall **not include** false labor, occasional spotting, Physician-prescribed rest during the period of Pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult Pregnancy but not constituting a nosologically distinct complication of Pregnancy; and
- (B) Non-elective cesarean section, termination of ectopic Pregnancy, and spontaneous termination of Pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Confinement

With respect to the Supplemental Medical Coverage, the term “Confinement” means any period for which a Hospital, Skilled Nursing or Convalescent Care Facility, Chemical Dependency Treatment Center, or Hospice Care Facility charges a Plan Participant for Room and Board.

With respect to Optional Custodial Care Benefits, the term “Confinement” means any period for which a Custodial Facility charges a Plan Participant for Room and Board as a registered bed-patient.

Continuation Coverage

The term “Continuation Coverage” means temporary extension of the Plan’s health coverage available for purchase by Qualified Beneficiaries. This is completely described in Appendix A, COBRA CONTINUATION OF COVERAGE.

Custodial Care

The term “Custodial Care” means the type of care that is primarily intended to assist an individual in meeting the requirements of his activities of daily living no matter where it is furnished or whatever name it is given. The care provided in a Custodial Facility must be recommended by a Physician in a written plan of treatment. The plan of treatment must be re-certified by the Physician every six months. Custodial Facility care includes care for those with Alzheimer’s disease or similar forms of senility.

Custodial Facility

The term “Custodial Facility” means an institution (other than a Hospital) constituted, licensed, and operated as set forth in the laws that apply, that:

- (A) mainly provides in-patient care and treatment prescribed by a Physician for Plan Participants and assists Plan Participants in the activities of daily living; and
- (B) provides care supervised by a Physician; and
- (C) provides 24 hour per day nursing care by nurses that are supervised by a full-time R.N.; and
- (D) keeps a daily clinical record of each patient; and
- (E) is not primarily for the aged, drug addicts or alcoholics; and
- (F) is not a rest or educational institution or similar place.

Deductible

The term “Deductible” means the amount of Eligible Expenses that a Plan Participant must pay in a calendar year before the Plan begins to pay. Wellness benefits (Mammogram, PSA test and Well Child Care), Orthodontia Benefits, and Vision Care Benefits are excluded from the annual Deductible. The Deductible is completely described in the DEDUCTIBLE subsection. The Medical Deductible applies to Eligible Expenses for Medical Care. The Retiree Dental Deductible applies to Eligible Expenses for Retiree Dental Benefits.

Dependent Child(ren)

The term “Dependent Child(ren)” means a child of a Member, Surviving Spouse or Employee who is under age 26, and any child required to be eligible due to a Qualified Medical Child Support Order (“QMCSO”) lawfully issued by a court of competent jurisdiction. A child is considered as placed for adoption beginning upon the assumption or retention by the Plan Participant parent of a legal obligation for the total or partial support of the child prior to the date such child attains age 26 and ending upon the date that the Eligible Member’s, Surviving Spouse’s or Employee’s legal obligation ends. A child will not be considered an Eligible Dependent for more than one Member or Employee.

The age 26 limit does not apply to an unmarried child who is an Incapacitated Child, as defined below:

Incapacitated Child

The term “Incapacitated Child” means any unmarried dependent child of a Member, Surviving Spouse or Employee and such Member’s or Employee’s Spouse who is mentally retarded or physically handicapped and is incapable of self-sustaining employment. Proof of incapacity must be furnished to the Claims Processor prior to the date the child attains age 26. After receiving proof of the dependent child’s incapacity, but not more than once a year, the Claims Processor (on behalf of APA), can require satisfactory proof of continuance of such mental or physical incapacity, inquire into changes of marital status, and examine the dependent child. This provision will not apply and the Dependent Coverage will terminate upon occurrence of:

- (A) failure to submit any required proof of incapacity; or
- (B) failure to permit such an examination; or
- (C) the Dependent Child ceases to be incapacitated; or
- (D) the Dependent Child marries.

Dependent Coverage

The term “Dependent Coverage” means coverage for the Eligible Dependents of a Member, Employee, or Surviving Spouse Plan Participant. A Member, Employee, or Surviving Spouse Plan Participant is eligible for Dependent Coverage while the Member, Employee, or Surviving Spouse, as applicable, is a Plan Participant and the dependent is an Eligible Dependent.

Drug Abuse

The term “Drug Abuse” means the chronic and uncontrolled consumption, injection or other use of any drug or other substance, singularly or in combination, not medically prescribed or administered; or the over-utilization of any drug that is medically prescribed or administered that, if continued, would irreparably harm bodily organs or functions.

Durable Medical Equipment

The term “Durable Medical Equipment” means equipment that is able to stand repeated use, and is primarily and customarily used to serve a medical purpose, and is not generally useful for a Plan Participant in the absence of Sickness or Injury.

Elective Surgery

The term “Elective Surgery” means any Surgical Procedure that is not a Medical Emergency, or that could be scheduled in advance or at the patient’s convenience.

Eligible Dependent

The term “Eligible Dependent” means a Plan Participant’s Eligible Dependent Child or the Eligible Spouse of a Member or Employee who is a Plan Participant. A Spouse or Dependent Child is not an Eligible Dependent while such individual is on active duty in the armed forces of any country.

Eligible Dependent Child(ren)

The term “Eligible Dependent Child(ren)” means a Plan Participant’s Dependent Child who satisfies the requirements under the “Dependent Child Eligibility” subsection on page 10. A Dependent Child is not an Eligible Dependent Child while such individual is on active duty in the armed forces of any country.

Eligible Employee or Eligible Member

The term “Eligible Employee” or “Eligible Member” means any Employee or Member, as applicable, who meets the requirements contained in the “Employee or Member Eligibility” subsection of this booklet (see page 9).

Eligible Expenses

The term “Eligible Expenses” applies only to the Supplemental Medical Coverage (including the Medical, Orthodontia and Dental Coverage, but excluding the Vision Care Benefits) and means expenses Incurred for Medical Care of an Injury or Sickness that are:

- (A) Medically Necessary; and
- (B) not in excess of Usual and Prevailing Expenses; and
- (C) included in the “Eligible Medical Expenses” subsection on page 23, “Eligible Orthodontia Expenses” on page 37 or “Retiree Dental Benefits” on page 39; and
- (D) not listed in the “Excluded Medical Expenses” subsection on page 29 or the “Excluded Orthodontia Expenses” subsection on page 38 of the Supplemental Medical Coverage.

Eligible Spouse

The term “Eligible Spouse” means a Spouse who satisfies the requirements for coverage under the “Spouse Eligibility” subsection on page 9.

A Spouse is not considered an Eligible Spouse while on active duty in the armed forces of any country. A Spouse who is or was a pilot for the Company and who fails to become a Member, or who resigns as a Member, is not an Eligible Spouse.

Employee

The term “Employee” means any of the following classes of individuals:

- (A) The term “Active Employee” means a person that is a full-time employee of APA who regularly works for APA at least the number of hours in APA's normal work week for that job class, but not less than 32 hours per week.
- (B) The term “Retired Employee” means an Active Employee who (a) retires at or after age 55, provided that he completes 10 years of service with APA or (b) retires after age 50, provided that he completes 20 years of service with APA.
- (C) The term “Former Employee” means an Active Employee who terminates employment following age 62, provided that he completes 5 years of service with APA.

Equitable Defense(s)

The term “Equitable Defense(s)” means a defense based on: (A) the Plan Participant not having received third party payments for the full damages or expenses in connection with the Sickness or Injury; (B) the “make whole doctrine; (C) the “fund” doctrine; (D) the “common fund” doctrine; (E) determination or agreements regarding comparative and/or contributory negligence; (F) the “collateral source” rule; (G) the “attorney’s fund” doctrine; (H) regulatory diligence; or (I) any other equitable defenses that may purport to affect the Plan’s right to subrogation or reimbursement.

Executive Non-Member

The term “Executive Non-Member” means a management pilot whose total compensation is not defined by the collective bargaining agreement and as such is not eligible for APA membership as set forth in the APA Constitution and ByLaws.

Explanation of Benefits or EOB

The terms “Explanation of Benefits” or “EOB” means the document that summarizes the benefit determination and provides backup documentation for any payments made.

Fiduciary or Fiduciaries

The term “Fiduciary” or “Fiduciaries” means person(s) responsible for the operation of the Plan. A Plan Fiduciary may serve in more than one Fiduciary capacity with respect to the Plan. In addition, Plan Fiduciaries may delegate Fiduciary responsibilities (other than trustee responsibilities to persons other than named Fiduciaries by a written instrument signed by the delegating Fiduciary and the delegate. For example the BRAB is a Plan Fiduciary.

Filed or Filing

The term “Filed” or “Filing” means the date the claim form is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date the Claims Processor receives the claim.

Furlough

The term “Furlough” means the period during which a Member or Employee is furloughed by the Company or APA, as applicable, and maintains rights of recall. For purposes of this Plan, Furlough includes any period during which a Member becomes a pilot for AMR Eagle, Inc., in lieu of furlough, pursuant to the labor agreement between APA and the Company, provided the Member maintain rights of recall. Furlough does not include any period during which a pilot defers recall by the Company.

Grandfathered Executive Member

The term “Grandfathered Executive Member” means an APA member who, on February 28, 2008, was both: (A) an executive member of APA, as defined in the APA Constitution and Bylaws, and (B) a Plan Participant.

Health Status-Related Factor

The term “Health Status-Related Factor” means information regarding: (A) health status, (B) medical condition (includes both physical and mental illness), (C) claims experience, (D) receipt of health care, (E) medical history, (F) genetic information, (G) evidence of insurability (including conditions arising out of domestic violence), or (H) disability. “Genetic information” means information about genes, gene products, and inherited characteristics that can derive from the individual or family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of gene chromosomes.

HIPAA

The term “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

HIPAA Privacy Official

The term “HIPAA Privacy Official” means a designated individual responsible for the development, implementation, and oversight of the Plan’s privacy policies and procedures. The APA HIPAA Privacy Official is the Manager, Group Medical Plans, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Arlington, TX 76155-2512, 800-323-1470.

HIPAA Security Official

The term “HIPAA Security Official” means a designated individual responsible for the development, implementation, and oversight of the Plan’s security policies and procedures. The APA HIPAA Security Official is the Benefits Manager, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Arlington, TX 76155-2512, 800-323-1470, Benefits.Manager@alliedpilots.org.

Home Health Agency

The term "Home Health Agency" means a business that provides Home Health Service and is licensed by the state's licensing laws, if any.

Home Health Care

The term "Home Health Care" means the care and treatment of an Injured or Sick Plan Participant, prescribed in writing by a Physician and administered by a Home Health Agency.

Home Health Service

The term "Home Health Service" means the provision of a Home Health Care service for payment or other consideration in a patient's residence under a plan of care established and approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician as being Medically Necessary. Home Health Service only includes:

- (A) skilled nursing by a Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse under the supervision of at least one Registered Nurse and at least one Physician; or
- (B) physical, occupational, speech, or respiratory therapy; or
- (C) the service of a home health aide under the supervision of a Registered Nurse; or
- (D) the furnishing of Durable Medical Equipment and supplies other than drugs and medicines.

Home Health Care Service does **not include**:

- (A) food or home delivered meals; or
- (B) social case work or homemaker services; or
- (C) services rendered primarily for Custodial Care; or
- (D) transportation services.

Hospice

The term "Hospice" means a facility or agency providing skilled Hospice Health Service in the home, or for short periods of stay in a home-like environment to a Terminally Ill Plan Participant. Such facility must be licensed in accordance with state laws, if any, and certified by Medicare as a provider of Hospice Care.

Hospice Care

The term "Hospice Care" means care provided by a Hospice to a Terminally Ill Plan Participant requiring skilled health care services while confined at home or in a Hospice facility.

Hospice Health Service

The term "Hospice Health Service" means the provision of a Hospice health care service for payment or other consideration in a patient's home or a Hospice facility under a plan of care established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician as being Medically Necessary.

- (A) Hospice Health Service at home is:
 - (1) part-time or intermittent nursing care by a Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse; or
 - (2) physical, speech, or respiratory therapy by a licensed therapist; or

- (3) the part-time or intermittent service of a home health aide under the supervision of a Registered Nurse; or
 - (4) homemaker and counseling services routinely provided by the Hospice agency.
- (B) Hospice Health Service at a Hospice facility is:
- (1) usual nursing care by a Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse; or
 - (2) physical, speech, or respiratory therapy by a licensed therapist; or
 - (3) Room and Board and all routine services, supplies and equipment provided by the Hospice facility.

Hospital

The term "Hospital" means an institution that fully meets **ALL** of the following requirements:

- (A) It is primarily and continuously engaged in providing medical, diagnostic and therapeutic facilities for the surgical and medical diagnosis treatment and care of Injured and Sick Plan Participants by or under the supervision of a staff of Physicians, for compensation from its patients and on an in-patient basis; and
- (B) It continuously provides 24-hour-a-day nursing service by Registered Nurses; and
- (C) It is not, other than incidentally:
 - (1) a place for convalescence, rest, or nursing services; nor
 - (2) a facility primarily affording custodial, educational, or rehabilitary care; nor
 - (3) a facility for the aged, drug addicts, or alcoholics; nor
 - (4) any military or veteran's Hospital or any Hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where the Plan Participant is legally obligated to pay; and
- (D) It is an institution operated pursuant to applicable laws and it is accredited as such a facility by the Joint Commission on Accreditation of Health Care Organizations. This requirement does not apply if the institution is not in the United States of America.

The term "Hospital" also **includes** a psychiatric hospital, Chemical Dependency Treatment Center, ambulatory surgical center, or rehabilitative hospital provided each such institution is operated primarily for the purpose of providing the specialized care and treatment for which it was duly licensed and meets **ALL** of the following requirements:

- (A) provides 24 hour nursing service under the supervision of a Physician or a Registered Nurse; and
- (B) maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and
- (C) provides appropriate methods of dispensing and administering drugs and medicines; and

- (D) has transfer arrangements with one or more Hospitals, as defined, a utilization review plan in effect, and treatment policies developed with the advice of, and reviewed by, a professional group of specialists in the care and treatment rendered by such a facility.

The term “Hospital” **does not include** any clinic, nursing home, rest home, Custodial Facility, extended care facility, Christian Scientist hospital, facility, or similar institution.

Incur or Incurred

The term “Incur” or “Incurred” means any Eligible Expenses incurred by a Plan Participant while covered under the Supplemental Medical Coverage. An expense shall be deemed incurred on the date the purchase is made, or the service is rendered.

Injury or Injuries or Injured

The term “Injury”, “Injuries”, or “Injured” means Non-Occupational accidental bodily injury that shall be definite as to how, when, and where the injury was sustained, and that shall be independent of Sickness or bodily infirmity. All injuries sustained by a Plan Participant in connection with any accident shall be considered one injury.

In-Network

The term “In-Network” means:

- (A) For Medical Care - An In-Network provider is a provider (e.g. Physician, Hospital) that has agreed to participate in the PHCS Healthy Directions network. For a list of In-Network providers, go to www.phcs.com (select the Healthy Directions network) to determine if the Physician is in the Private Healthcare Systems Healthy Directions provider network.
- (B) For Prescription Drugs - An In-Network pharmacy is a pharmacy that has agreed to participate in the WellDyneRx network of pharmacies. A Plan Participant can find an In-Network pharmacy by calling WellDyneRx Customer Care at 1-888-479-2000 or on the WellDyneRx website at www.myWDRX.com.

Lifetime Maximum or Lifetime

With respect to the Supplemental Medical Coverage, the term “Lifetime Maximum” or “Lifetime” means the maximum dollar amount of benefits payable for Eligible Expenses while a Plan Participant is covered under this or any predecessor plan of benefits sponsored by APA.

With respect to Orthodontia Benefits, the term “Lifetime Maximum” or “Lifetime” means the maximum dollar amount of benefits payable while a Plan Participant is covered under this or any predecessor plan of benefits sponsored by APA.

With respect to the Optional Custodial Care Benefit, the term “Lifetime Maximum” or “Lifetime” means the maximum dollar amount of benefits payable for Confinement in a Custodial Facility while a Plan Participant is covered under this or any predecessor plan of benefits sponsored by APA.

Master Trust

The term “Master Trust” means the Allied Pilots Association Welfare Benefits Master Trust, a trust formed to invest and account for the Plan’s assets. Plan benefits and reasonable expenses are paid from the Plan’s assets in the Master Trust in accordance with the terms of this Plan and Section 501(c)(9) of the Internal Revenue Code.

Master Trustee

The term “Master Trustee” means State Street Bank of Boston, One Enterprise Drive, Quincy, MA 02171.

Medical Care

The term “Medical Care” means any medical or dental care, treatment, services or supplies that are provided or ordered by a Physician and are necessary for diagnosing or treating an Injury or Sickness.

Medical Emergency

The term “Medical Emergency” means an Injury or Sickness of such a nature that failure to receive *immediate* Medical Care could place a Plan Participant's life in danger or cause serious harm to a Plan Participant's bodily functions. *Immediate* means that action is, or must be, taken instantly or without any considerable loss of time. The doctor who attends a Plan Participant must certify that the Sickness or Injury was a Medical Emergency.

Medically Necessary

The term “Medically Necessary” means health care services, supplies, treatments or Prescription Drugs that, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and that, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of Medical Care rendered. Health care services, supplies, treatments or Prescription Drugs are considered “Medically Necessary” if they satisfy **ALL** of the following requirements:

- (A) ordered by a Physician; and
- (B) recognized by the medical community as safe and effective; and
- (C) required for the diagnosis or treatment of the particular Sickness or Injury; and
- (D) appropriate and administered in a manner consistent with generally accepted United States medical standards; and
- (E) not in the nature of Educational, Experimental, or Investigational.

Educational means that the primary purpose of a service is to provide the patient with any training in matters other than directly medical.

Experimental or **Investigational** means the medical use of a service, supply or Prescription Drug is still under study and the service, supply or Prescription Drug is not yet recognized throughout the U.S. as safe and effective for diagnosis or treatment. This includes drugs approved by the Federal Food and Drug Administration under its temporary list as an investigative drug.

Medicare

The term “Medicare” means the programs established by Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended (Health Insurance for the Aged and Disabled of the United States Social Securities Act).

Member

The term “Member” means any of the following classes of individuals to which APA has extended membership:

- (A) The term “Active Member” means a full-time employee of the Company who is also an APA member.
- (B) The term “Retired Member” means a retired employee of the Company who:
 - (1) was also an APA member at the time of Retirement; and

- (2) retired on or after April 1, 1963; and
- (3) qualifies for Retirement as defined by this Plan.
- (C) The term “Furloughed Member” means an Active Member or an Apprentice Member, as defined in this section, who has been Furloughed by the Company and maintains rights of recall. Furloughed Member does not include any pilot who defers recall by the Company for the period during which the deferral of recall remains in effect.
- (D) The term “Apprentice Member” means a full time employee of the Company who has applied and been approved for active membership with APA.
- (E) The term “Terminated Awaiting Grievance Member” or “TAG Member” means a Member who has been terminated by the Company, has filed a grievance for reinstatement, is awaiting the final settlement of the grievance and is also an APA member.
- (F) Any other membership classification to which APA has extended coverage.

Mental or Nervous Disorder

The term “Mental or Nervous Disorder” means any condition(s) of neurosis, psychoneurosis, psychopathy, psychosis, personality disorder, transient situational disorder, or mental or emotional Sickness or disorder of any kind, as defined in the most current edition of the Diagnostic and Statistical Manual (DSM).

Minimum Necessary

The term “Minimum Necessary” means to the extent practical, individually identifiable health information should be disclosed only to the extent needed to support the purpose of disclosure.

Named Fiduciary

The term “Named Fiduciary” means the person who has the authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is APA. The BRAB is also a Fiduciary and the APA has delegated to the BRAB the authority to interpret the Plan and to decide benefit claim appeals.

Non-Network

The term “Non-Network” means:

- (A) For Medical Care- A Non-Network provider relates to care that is not received from an In-Network provider. For a list of In-Network providers, go to www.phcs.com (select the Healthy Directions network) to determine if the Physician is in the Private Healthcare Systems Healthy Directions provider network. Non-Network claims are subject to all Plan provisions, including those regarding Usual and Prevailing Expenses.
- (B) For Prescription Drugs - A Non-Network pharmacy relates to prescriptions that are not received from an In-Network pharmacy. A Plan Participant can find an In-Network pharmacy by calling WellDyneRx Customer Care at 888-479-2000 or on the WellDyneRx website at www.myWDRX.com.

Non-Network Claims Reviewer

The term “Non-Network Claims Reviewer” means the firm used to review all Non-Network inpatient and outpatient facility claims. This firm is NCN/MultiPlan, 115 Fifth Avenue, 7th Floor, New York, NY 10003, (866) 750-7427.

Non-Occupational

The term “Non-Occupational” with respect to Sickness or Injury is as follows:

- (A) The term “Non-Occupational Sickness” means a Sickness that does not arise, and that is not caused or contributed to by, or as a consequence of, any Sickness that arises out of, or in the course of, any employment or occupation for compensation or profit; however, if the Claims Processor receives written satisfactory evidence establishing that the Plan Participant concerned is covered under any Workers' Compensation law, occupational disease law, or any other legislation of similar purpose, or under the Maritime Doctrine of Maintenance, Wages, and Cure, but that the Sickness involved is one not covered under applicable laws or doctrine, then such Sickness shall, for the purpose of these Plans, be regarded as a “Non-Occupational Sickness.”
- (B) The term “Non-Occupational Injury” means an accidental bodily Injury that does not arise, and that is not caused or contributed to by, or as a consequence of, any Injury that arises out of, or in the course of, any employment or occupation for compensation or profit.

Optional Custodial Care Benefits

The term “Optional Custodial Care Benefits” means the per diem benefits contained in the OPTIONAL CUSTODIAL CARE BENEFITS PROVISIONS section of this Plan booklet that are available to certain Plan Participants for an additional contribution.

Orthodontia Benefits

The term “Orthodontia Benefits” means the Orthodontia Benefits as described on pages 37-38 of this Plan booklet.

Orthodontia Treatment

The term “Orthodontia Treatment” means a continuous single phase of treatment, involving the installation of orthodontic appliances and all orthodontic treatments concerned with the reduction or elimination of an existing malocclusion and conditions resulting from that malocclusion through correction of abnormally positioned teeth. For example a single phase of treatment would include the period beginning with the initial consultation and ending with the removal of the orthodontic appliances.

Other APA-sponsored Plan(s)

The term “Other APA-sponsored Plan(s)” means the APA Pilot Occupational Disability Plan, the APA Catastrophic Major Medical Benefit Plan, and the APA Pilot Mutual Aid Plan.

Other Group Health Coverage or OGHC

The term “Other Group Health Coverage” or “OGHC” means, excluding this Plan, any plan under which a Plan Participant is covered or is eligible to become covered that provides benefits or services for medical or dental care or treatment, that benefits or services are provided by:

- (A) Group or blanket insurance; or
- (B) Blue Cross, Blue Shield, group practice, individual practice and other prepayment coverage; or
- (C) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; or
- (D) Any coverage under governmental programs and any coverage required or provided by any statute, other than Medicaid.

Other Hospital Services and Supplies

The term “Other Hospital Services and Supplies” means any Medically Necessary service or supply furnished to a Plan Participant by a Hospital, other than: Room and Board, the professional services of any Physician; and any private duty or special nursing services that are Medically Necessary (including intensive nursing care by whatever name it's called), regardless of whether such services are rendered under the direction of the Hospital or otherwise.

Overpayment(s)

The term “Overpayment(s)” means any amount paid to or on behalf of a Plan Participant by the Plan that is greater than the benefit to which the Plan Participant is entitled. See also subsection (F) of the section entitled SUBROGATION AND REIMBURSEMENT RIGHTS.

Pharmacy Benefit Manager

The term “Pharmacy Benefit Manager” means the entity selected to administer the Pharmacy Benefit Program. The Pharmacy Benefit Manager is WellDyneRx.

Pharmacy Benefit Program

The term “Pharmacy Benefit Program” means the program used to provide outpatient Prescription Drugs that is contained in the Pharmacy Benefit Program section of the Plan.

Physician

The term “Physician” means, except as noted below, any practitioner of the healing arts who is licensed and regulated by a state or Federal agency and is acting within the scope of his license. Physician includes the following:

Certified Acupuncturist (C.A.)	Psychologist (Ph.D.)
Certified Registered Nurse	Licensed Audiologist
Anesthetist (C.R.N.A.)	Licensed Dietician (L.D.)
Certified Social Worker-Advanced Clinical Practitioner (C.S.W.-A.C.P.)	Licensed Mid-Wife while under the direction of a M.D. or D.O
Doctor of Chiropractic (D.C.)	Provisional Licensed Dietician (P.L.D.)
Doctor of Dental Surgery (D.D.S) or (D.M.D.)	Licensed Occupational Therapist
Doctor of Medicine (M.D).	Licensed Physical Therapist
Psychiatrist	Licensed Vocational Nurse or Physiotherapist (L.V.N. or L.P.T.)
Doctor of Optometry (D.O)	Licensed Professional Counselor (L.P.C.)
Doctor of Osteopathy (D.O.)	Licensed Speech Language Pathologist
Doctor of Podiatry (D.P.M.)	
Registered Nurse (R.N.)	
Licensed Practical Nurse (L.P.N.)	

For the purpose of this Plan, the term “Physician” does not include anyone who: (A) is related by blood, marriage, or by legal adoption to either the Plan Participant or Spouse; or (B) ordinarily resides with the Plan Participant. In addition, the term “Physician” does not include the following:

Christian Scientist Practitioner	Masseur or Masseuse
Doctor of Dietary Medicine (D.D.M.)	Naturopath
Doctor of Education (Ed.D.)	Physical Culturist
Licensed Marriage and Family Therapist (M.F.T.)	Physical Education Instructor
	Rolfer

Plan

The term “Plan” means the Allied Pilots Association Voluntary Supplemental Medical and Custodial Care Benefit Plan.

Plan Administrator

The term “Plan Administrator” means the Allied Pilots Association.

Plan Participant

The term “Plan Participant” means an active or retired Employee, a Member, or Surviving Spouse, or an Eligible Dependent whose Plan Participation has commenced in accordance with the “Effective Date of Participation” subsection on page 17 and whose participation has not terminated.

When both husband and wife are Employees or Members of APA, each will be covered as a single Plan Participant and not as a dependent of the other. Dependent Child(ren) can be covered as dependents of either the husband or wife, but not both.

Plan Sponsor

The term “Plan Sponsor” means the Allied Pilots Association or its successor entity.

PMA

The term “PMA” means the Allied Pilots Association Pilot Mutual Aid Plan.

Post-Service Claim

The term “Post-Service Claim” means a benefit claim made under a group health plan after medical care is received.

Pregnancy

The term “Pregnancy” means abortion, miscarriage, or child birth or any complications arising during an abortion, miscarriage or child birth.

Prescription Drug

The term “Prescription Drug” means Federally approved legend drugs that can be dispensed only by prescription, or an item specifically included herein. Prescription Drug also **includes** oral contraceptives; prescribed legend prenatal vitamins for a Plan Participant during Pregnancy; treatment or supplies (including needles or syringes) that are Medically Necessary and prescribed by a Physician: for diabetes (e.g., insulin and clinitest), pernicious anemia (e.g., B-12 injectables), allergies (e.g., vaccines), blood pressure monitoring (blood pressure kits), and growth hormones.

Prescription Drug” **does not include** any prescriptions for Worker's Compensation-related Injuries or Sickness; cosmetic use (e.g., Retin-A over age 25); IUDs; Norplants (implanted birth control device); Depo-Provera injectables; hair growth (e.g., Rogaine); over the counter drugs (even when prescribed by a Physician); vitamins and nutritional supplements (except as previously described); or smoking cessation or weight loss drugs or supplies.

Protected Health Information or (PHI)

The term “Protected Health Information” or “PHI” means individually identifiable health information created or received by a covered entity. Information is individually identifiable if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. Health information means information, whether oral or recorded in any form or medium, that (A) is created by a health care provider, plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (B) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present, or future payment for health care.

Protocol

The term “Protocol” means the internal rule, guideline, or other similar criterion relied upon in making the benefits determination.

Psychiatric Day Treatment Facility

The term "Psychiatric Day Treatment Facility" means a mental health facility that:

- (A) is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of Health Care Organizations; and
- (B) provides, in lieu of hospitalization, treatment for not more than eight (8) hours in any 24-hour period; and
- (C) provides treatment for individuals suffering from acute Mental or Nervous Disorders in a structured psychiatric program using individualized treatment plans with specific attainable goals and objectives appropriate to both the Plan Participant and the treatment modality of the program. It must also be clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Qualified Beneficiary

The term "Qualified Beneficiary" means a former Plan Participant who is eligible to continue Plan coverage under COBRA (see COBRA Continuation of Coverage section on page 77).

Qualified Medical Child Support Order (QMCSO)

The term "Qualified Medical Child Support Order" or "QMCSO" means a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Plan Participant is eligible under this Plan.

The term medical child support order means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

- (A) Provides for child support with respect to a child of a Plan Participant under this Plan or provides for health benefit coverage for such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the Plan; or
- (B) Is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act (as added by Section 13623 of OBRA-93) with respect to a group health plan.

In order for a medical child support order to be deemed qualified by the Plan, the order must satisfy criteria enumerated in ERISA Section 609(a)(3) and 609(a)(4). In order to qualify as a QMCSO, the order must, among other things, clearly specify the following:

- (A) The name and the last known mailing address (if any) of the Plan Participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof can be substituted for the mailing address of any such alternate recipient; and
- (B) A reasonable description of the type of coverage to be provide to each such alternate recipient, or the manner in which such type of coverage is to be determined; and
- (C) The period to which such order applies.

Further, the medical child support order that satisfied the criteria listed above will qualify only if such order does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of the law relating to medical child support.

Qualifying Event

The term "Qualifying Event" means events or changes in status affecting an Employee, an Eligible Spouse or an Eligible Dependent that are set out in the COBRA Continuation of Coverage section herein.

Record

The term "Record" means any materials pertaining to a Plan Participant's claim that exist at any level of the claims process.

Reimbursement Agreement

The term "Reimbursement Agreement" means (A) the written agreement between the Plan Participant and the Plan regarding the repayment of an Overpayment or (B) a similar agreement between the Plan Participant and any Other APA-sponsored Plan regarding an overpaid benefit from such plan.

Retiree Dental Benefits

The term "Retiree Dental Benefits" means the dental benefits as described on pages 39-40 of this Plan.

Retirement

For Members, the term "Retirement" means the termination of employment after satisfying the eligibility requirements for retiree benefits under the Company's group life and health plan.

For Employees, the term "Retirement" means the termination of employment after:

- (A) satisfying the eligibility requirements for retiree benefits under the APA's Retiree Health Benefit Plan, by one of the following:
 - (1) The date an Employee attains age 50 and completes 20 years of service with APA; or
 - (2) The date an Employee attains age 55 and completes 10 years of service with APA; or
- (B) the date an Employee attains age 62 and completes 5 years of service with APA.

Returning Executive Non-Member

The term "Returning Executive Non-Member" means an APA Member who ceased to be a Plan Participant due to an APA membership status change from Member to Executive Non-Member and who was a Plan Participant on the day before his change to Executive Non-Member status.

Room and Board

The term "Room and Board" means only the Hospital or other facility's charges for Room and Board in a Semi-private Room.

Semi-private Room

The term "Semi-private Room" means a Hospital bedroom with more than one bed.

Sickness or Sick

The term "Sickness" or "Sick" means Non-Occupational illness, Mental or Nervous Disorders (including Chemical Dependency Treatment), Pregnancy and Complications of Pregnancy. A recurrent Sickness shall be considered as one Sickness.

Skilled Nursing or Convalescent Care Facility

The term "Skilled Nursing" or "Convalescent Care Facility" means an institution that, in whole or in part, meets all the following criteria:

- (A) operates pursuant to law; and

- (B) is approved or qualified and capable to be approved for payment of Medicare benefits; and
- (C) in addition to Room and Board accommodations, is primarily engaged in providing, skilled nursing care under the supervision of a duly licensed M.D. or D.O.; and
- (D) provides continuous, 24-hour-a-day nursing service by or under the supervision of a Registered Nurse; and
- (E) maintains a daily medical record of each patient.

“Skilled Nursing” or “Convalescent Care Facility” **does not include** an institution that is a place of rest, a place for the aged, alcoholics, drug addicts, blind or deaf, mentally ill or retarded nor is it a facility primarily affording custodial, educational or rehabilitative care, a hotel or similar establishment.

Spouse

The term “Spouse” means a person of the opposite gender who is a husband or wife in a marriage that is a legal union between one man and one woman as husband and wife.

Subrogation Agreement

The term “Subrogation Agreement” means the written agreement between the Plan Participant and the Plan regarding the recovery of Plan payments to the extent of benefits paid, where a third party may be legally liable for the Sickness or Injury of the Plan Participant.

Supplemental Medical Coverage

The term “Supplemental Medical Coverage” means the medical, dental, orthodontic and vision care coverages provided by the Plan as contained in the BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS section of this Plan booklet.

Surgical Procedure

The term “Surgical Procedure” means any cutting operation, reduction of a fracture or dislocation, endoscopic procedure, laser, micro-surgery, lithotripsy, or any other procedure falling within the Current Procedural Terminology (C.P.T.) surgical procedure codes.

Surviving Spouse

The term “Surviving Spouse” means the unremarried Spouse of a deceased Member or Employee if the Spouse was a Plan Participant at the time of the Member’s or Employee’s death.

Terminally Ill

The term “Terminally Ill” means a condition that is generally recognized by the medical profession as having a life expectancy of six months or less.

Usual and Prevailing or Usual and Prevailing Expenses

The term “Usual and Prevailing”, “Usual and Prevailing Expenses”, or “U&P” means the maximum amount this Plan will consider as an Eligible Expense. The following are the primary factors considered when determining if a charge is within the Usual and Prevailing Expense limits:

- (A) The range and complexity of the service provided
- (B) The typical charges in the geographic area where the service or supply is rendered or provided and other geographic areas with similar medical cost experience.

The Plan Administrator, in its sole discretion, has retained the Claims Processor to determine Usual and Prevailing Expenses. These Usual and Prevailing Expenses are based on the Claims Processor’s database of prevailing health care charges.

The Usual and Prevailing Expense limits can also be impacted by the number of services or procedures the Plan Participant receives during one medical treatment. Under the Plan, when the Claims Processor reviews a claim for Usual and Prevailing Expenses, it looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (called coding fragmentation or unbundling) usually results in higher Physician charges than if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

For example, the appendix is often removed by the surgeon during a hysterectomy. The appropriate code for the hysterectomy procedure includes removal of the appendix. However, some Physicians will bill separately for a hysterectomy and an appendectomy as if these procedures had been separately performed at different times. Recognizing this, when multiple surgical procedures are performed at the same time, the Plan pays benefits up to the Usual and Prevailing Expense limit of the appropriate combined code rather than calculating and awarding benefits for each surgical procedure separately.

For Non-Network claims that are reviewed by the Non-Network Claims Reviewer, the term Usual and Prevailing will mean the standards used by the Non-Network Claims Reviewer at the time services are provided. A summary of these standards is listed in the **WHAT HAPPENS TO YOUR CLAIM** subsection.

If a Plan Participant uses a PHCS Healthy Directions provider and presents a valid identification card, the cost of the medical service will be paid based on the negotiated discount agreed between the network and the provider and will be deemed to satisfy the Plan's Usual and Prevailing requirements; however, the service will still have to satisfy other conditions for payment as contained in the Plan (for example, it must be Medically Necessary and not be contained in the Excluded Medical Benefits section of the Plan).

Vision Care Benefits

The term "Vision Care Benefits" means the vision benefit provided through the insurance policy with Vision Service Plan Insurance Company as described on pages 47-50.

Voluntary Case Management

The term "Voluntary Case Management" means a program designed to assist Plan Participants who are expected to require long-term Medical Care or an extensive course of medical treatments.

APPENDIX A COBRA CONTINUATION OF COVERAGE

(This section describes a Plan Participant's rights to continue coverage under a law called COBRA. Under this law, a Plan Participant is eligible to continue coverage as described in this section provided there is a loss of coverage due to a Qualifying Event. The law was established and written to address the typical employer-provided healthcare plans. This Plan differs from most employer-provided health plans since, in many circumstances, a Plan Participant does not lose coverage and can continue to participate following a Qualifying Event without having to purchase continuation coverage under this section (for example, a Surviving Spouse does not have to purchase continuation coverage following the death of the Employee or Member because coverage already continues under the Plan's own rules). There are some circumstances, such as child losing coverage upon attaining a limiting age, under which a former Plan Participant must purchase continuation coverage under this section in order for coverage to continue. There are some circumstances under which a Plan Participant can lose coverage and not be eligible for continuation coverage under this section because the loss of coverage is not due to a Qualifying Event, such as loss of coverage due to resigning from APA. In general, to be eligible to continue coverage under this COBRA section, a Plan Participant must lose coverage under the Plan due to a Qualifying Event. Because individual circumstances vary, this section follows the legally required language for continuation coverage under COBRA.)

Plan Participants whose Plan coverage terminates are eligible to purchase a temporary extension of the Plan's health coverage (called "Continuation Coverage" in this section) only if Continuation Coverage is purchased under the Allied Pilots Association Employee Health Plan for Employees or under the Company health plan for Members. This Continuation Coverage will be identical to the Supplemental Medical Benefit Coverage provided to all Plan Participants, including future changes. Plan Participants can individually elect Continuation Coverage. Please read this entire section very carefully so that all requirements and restrictions are completely understood. Additional information about the Plan Continuation Coverage can be obtained from WebTPA.

Qualifying Events

Certain events enable a Plan Participant whose Plan coverage terminates to purchase Continuation Coverage. Since these events vary depending on who loses Plan coverage, the following contains the provisions for each class of Plan Participant who is or can become eligible for Continuation Coverage:

- (A) **Employee or Member.** An Employee or Member whose Plan coverage terminates will be eligible to purchase Continuation Coverage if the loss of Plan coverage was for one of the following reasons:
 - (1) Reduction in work hours; or
 - (2) Termination of employment for reasons other than gross misconduct; or
 - (3) If a Retired Member or a retired APA Employee, because proceedings have commenced under Chapter 11 of the Bankruptcy Code with respect to APA; or
 - (4) Absence due to military service (applies to Employees only).

- (B) **Spouse.** The Eligible Spouse of an Employee or Member whose Plan coverage terminates will be eligible to purchase Continuation Coverage if the loss of Plan coverage was for one of the following reasons:
 - (1) Divorce or legal separation from the Employee or Member; or
 - (2) An Employee's or Member's Qualifying Event.

(C) **Dependent Child.** A Dependent Child of an Employee or Member whose Plan coverage terminates will be eligible to purchase Continuation Coverage if the loss of Plan coverage was for one of the following reasons:

- (1) The Employee's or Member's divorce or legal separation; or
- (2) The child ceases to qualify as a Dependent Child; or
- (3) An Employee's or Member's Qualifying Event.

Duration of Coverage

The maximum period for which a Qualified Beneficiary can purchase Continuation Coverage is as follows:

(A) **Employee or Member:**

- (1) 18 consecutive months from the date of the Qualifying Event.
- (2) If an Employee's loss of coverage is due to an absence from employment for military service, the maximum period of coverage shall be 24 months from the date of the Qualifying Event.

(B) **Spouse and Dependent Child(ren):**

- (1) If coverage ceases as a result of the Employee's or Member's Qualifying Event, coverage can be continued for up to 18 consecutive months from the date of the Qualifying Event.
- (2) If coverage ceases as a result of the Employee's or Member's divorce or legal separation, coverage can be continued for up to 36 consecutive months from the date of the Qualifying Event.
- (3) If a child ceases to qualify as a Dependent Child, the Dependent Child can purchase Continuation Coverage for up to 36 consecutive months from the date of the Qualifying Event.
- (4) If coverage ceases as a result of the Employee's absence from employment for military service, the maximum period of coverage shall be 24 months from the date of the Qualifying Event.

(C) A second Qualifying Event can occur within the first 18 months of Continuation Coverage (or in the case of a Qualified Beneficiary whose coverage is extended under subsection (D) below, 29 months). If this occurs, Continuation Coverage can be extended for up to 36 months from the date of the first Qualifying Event if neither the first nor second Qualifying Event was based on commencement of Federal bankruptcy proceedings with respect to APA. Except as required by law, Continuation Coverage will not exceed 36 months.

(D) Qualified Beneficiaries who lose coverage due to a reduction in hours or termination of employment and are determined by the Social Security Administration to be disabled under Title II or XVI of the Social Security Act (SSA) at some time before the 60th day of Continuation Coverage, can extend their Continuation Coverage from 18 months to the earlier of: (a) 29 months; or (b) the first day of the month following 30 days after the date of any final determination under Title II or XVI of the SSA that the individual is no longer disabled. Further, the Qualified Beneficiary must notify APA within 30 days of the date of any final determination under Title II or XVI of the SSA that the individual is no longer disabled.

Notice and Election Procedures

To elect Continuation Coverage, a Qualified Beneficiary must notify WebTPA, P. O. Box 1987, Grapevine, TX 76099, in writing, if one of the following Qualifying Events occurs:

- (A) An Employee's or Member's divorce or legal separation (provide a copy of the first and last page of divorce decree); or
- (B) When a child no longer qualifies as a Dependent Child; or
- (C) When a second qualifying event occurs after a Qualified Beneficiary has become entitled to Continuation Coverage within a maximum duration of 18 (24 or 29) months (as applicable); or
- (D) When a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration, under Title II or XVI of the SSA to be disabled at any time during the first 60 days of Continuation Coverage; or
- (E) When a Qualified Beneficiary, with respect to when a notice in paragraph (D) above has been provided, has subsequently been determined by the Social Security Administration, under Title II or XVI of the SSA to no longer be disabled.

A Plan Participant can also complete the Qualifying Event form and return it to WebTPA. Participants can obtain a Qualifying Event form and additional information about the Plan and Continuation Coverage from the Benefits Section of the APA website at www.alliedpilots.org, or by calling WebTPA at 800-477-8957.

A Qualified Beneficiary who fails to notify WebTPA within 60 days of one of these Qualifying Events; within 60 days from the date coverage ends; or within 60 days of the date on which the Qualified Beneficiary is informed through the furnishing of the Plan Summary Plan description of both the responsibility to provide the notice and the Plan's procedures for providing such notice to WebTPA (whichever is latest), shall forfeit the right to continue coverage.

Following receipt of this notification, WebTPA will notify APA and APA will notify the COBRA Administrator within 14 days, the COBRA Administrator will send a letter to the Qualified Beneficiaries within 30 days following notification from APA explaining their Continuation Coverage options. This letter will be addressed to the Qualified Beneficiary at the address maintained by APA. **It is the responsibility of all Employees, Members and Qualified Beneficiaries to keep APA informed in writing of any changes in mailing address.**

Qualified Beneficiaries have 60 days from the later of (A) the date the notification letter is sent, or (B) the date coverage terminates, to make a written election to continue coverage. The first monthly payment is due when the election form is returned to the COBRA Administrator, and will not be accepted after 45 days from that date. Subsequent payments are due on the first day of each month, and will not be accepted more than 30 days late. During this 30 day grace period claims will be conditionally paid; however, if payment is not received prior to the end of the grace period, coverage will be terminated retroactive to the last paid through date and any claims processed for dates of service after the coverage ended will be reprocessed and denied. **Failure to make timely payment will permanently terminate your right to purchase Continuation Coverage.**

If a timely election to continue coverage is made, continued coverage will commence on the first day of the month following the date of the Qualifying Event. However, Qualified Beneficiaries will not be required to make payments for months during which coverage is otherwise provided under the Plan.

The following changes will apply to anyone who is or becomes eligible for Continuation Coverage:

- (A) Continuation Coverage under this Plan will include coverage for any Dependent Child born or placed for adoption after the date Continuation Coverage begins. Such coverage will continue for as long as the former Plan Participant remains eligible for Continuation Coverage. The former Plan Participant must notify WebTPA within 90 days of the date the child became a Dependent Child.

- (B) If a Qualified Beneficiary obtains a Social Security disability award within 60 days after Continuation Coverage becomes effective, such Beneficiary must provide APA with a copy of the award prior to the end of the initial 18 month eligibility period to qualify the disabled person and all eligible family members for up to 11 additional months of Continuation Coverage. The premium for the additional 11 months of coverage will be higher than the premium for Continuation Coverage.
- (C) Continuation Coverage will end when the former Plan Participant becomes covered under another plan, unless the plan has an exclusion or limitation for pre-existing conditions that affects the former Plan Participant. If the new plan covers or begins covering the pre-existing condition affecting the former Plan Participant, Continuation Coverage under this Plan will end.

Cost of Continuation Coverage

By law, APA will charge 102% of the contribution charged to active Employees, Members and Eligible Dependents for Continuation Coverage. In addition, if coverage is being extended due to disability, APA will charge 150% of the contribution otherwise charged to active Employees, Members and Eligible Dependents for the additional 11 months. Payment amounts and due dates will be set forth on the form that is sent after the COBRA Administrator receives notice that a Qualifying Event has occurred. Employees, Members and Eligible Dependents who desire this coverage must pay the full cost of Continuation Coverage, including any additional expenses required by law, on time, in order to maintain the coverage.

Termination of COBRA Continuation Coverage

- (A) The date upon which the former Plan Participant becomes covered under any Other Group Health Coverage (including a retiree health plan) without limiting coverage for a Qualified Beneficiary's pre-existing condition; or
- (B) The first day of the month for which a timely payment is not received by the COBRA Administrator; or
- (C) The date on which the Qualified Beneficiary becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or
- (D) The date this Plan terminates; or
- (E) At the end of the Qualified Beneficiary's maximum coverage period (18, 24, 29 or 36 months); or
- (F) The date APA no longer provides any group health coverage to any Employee or member; or
- (G) If a Qualified Beneficiary was divorced from a covered Employee or Member and subsequently remarries, the date the Qualified Beneficiary becomes covered under the new Spouse's group health plan.

APPENDIX B HIPAA PRIVACY STATEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder at 45 CFR Parts §160 and §164 (the HIPAA regulations), impose privacy obligations on group health plans that restrict the use and disclosure of Protected Health Information (“PHI”).

APA and/or agents representing APA intend to receive PHI from the Plan (including its Business Associates, health insurance issuers, and their agents) from time to time.

The Plan as set forth below implements appropriate protections required under the HIPAA regulations.

Uses and Disclosures of PHI

The Plan and APA can disclose a Plan Participant’s PHI to APA (or to APA’s agent) for the following Plan administration functions under 45 CFR §164.504(a), to the extent not inconsistent with the HIPAA regulations:

- (A) **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. *For example, the Plan can share health information about a Plan Participant with Physicians who are treating the Plan Participant.*

- (B) **Payment** includes activities by this Plan, other plans, or providers to obtain contributions, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as “behind the scenes” Plan functions such as risk adjustment, collection, or reinsurance. *For example, the Plan can share information about a Plan Participant’s coverage or the expenses he has Incurred with OGHC in order to coordinate payment of benefits.*

- (C) **Health care operations** include activities by this Plan (and in limited circumstances other plans or providers) such as risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. *For example, the Plan can use information about a Plan Participant’s claim to resolve a claim dispute.*

The amount of health information used or disclosed will be limited to the “Minimum Necessary” for these purposes, as defined under the HIPAA rules. The Plan can also contact the Plan Participant to provide information about treatment alternatives or other health-related benefits and services that may be of interest to him.

Restriction on Plan Disclosure to APA

Neither the Plan nor any of its Business Associates, or health insurance issuers, will disclose PHI to APA except upon the Plan’s receipt of APA certification that the Plan has been amended to incorporate the agreements of APA as specified under Privacy Agreements of APA below, except as otherwise permitted or required by law.

Privacy Agreements of APA

As a condition for obtaining Protected Health Information (“PHI”) from the Plan, its Business Associates and insurers APA agrees it will:

- (A) Not use or further disclose such PHI other than as permitted by the Uses and Disclosures subsection above, as permitted by 45 CFR §164.508, 45 CFR §164.512, and other sections of the HIPAA regulations, or as required by law; and
- (B) Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agrees to the same restrictions and conditions that apply to APA with respect to such information; and
- (C) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of APA; and
- (D) Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which APA becomes aware; and
- (E) Make the PHI of a particular Participant available for purposes of the Participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR §164.524 and §164.526; and
- (F) Make the PHI of a particular Participant available for purposes of required accounting of disclosures by APA pursuant to the Participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528; and
- (G) Make APA's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA; and
- (H) If feasible, return or destroy all PHI received from the Plan that APA still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, APA agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- (I) Ensure that there is adequate separation between the Plan and APA by implementing the terms of (1) through (3), below:
 - (1) *Employees With Access to PHI*
The following employees or other individuals under the control of APA are the only individuals that can access PHI received from the Plan:
 - (a) The HIPAA Privacy Official
 - (b) The HIPAA Security Official
 - (c) The Benefits Department
 - (d) The Accounting Department
 - (e) The IT Department
 - (f) The Legal Department
 - (g) The Executive Administrator
 - (h) Staff designated by the Executive Administrator

- (l) The National Officers
 - (j) Staff-designated by the National Officers
 - (k) The Board of Directors
 - (l) The Benefits Review and Appeal Board
- (2) Use Limited to Plan Administration
The access to and use of PHI by the individuals described in (1) above is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by APA for the Plan.
- (3) Mechanism for Resolving Noncompliance
APA's HIPAA Privacy Official determines that if any person described in (1) above has violated any of the restrictions of this Amendment, then such individual shall be disciplined in accordance with the policies of APA established for purposes of privacy compliance, up to and including dismissal from employment. APA shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

PHI not Subject to Privacy Obligations

Notwithstanding the foregoing, the terms of this Section shall not apply to uses or disclosures of enrollment, disenrollment, and summary health information made pursuant to 45 CFR §164.504 (f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR §164.508; or in other circumstances as permitted by the HIPAA regulations.

Final HIPAA Rule

Final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the Health Information Technology for Economic and Clinical Health ("HITECH") Act are as follows:

- (A) You have the right to be notified of a data breach.
- (B) You have the right to ask for a copy of your electronic medical record in an electronic form provided the information already exists in that form.
- (C) To the extent the Plan performs any underwriting, the Plan cannot disclose any genetic information for such purposes.

APPENDIX C HIPAA PORTABILITY REGULATIONS

This Plan covers pre-existing conditions. But a former Plan Participant whose coverage has terminated under this Plan can be required to demonstrate that he has creditable coverage in order to reduce or eliminate the time period during which a pre-existing condition exclusion can be enforced by another plan. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder at 26 CFR Part §54.9801 requires group health plans to establish written procedures for requesting a Certificate of Creditable Coverage.

Therefore, the Plan Administrator or its designee will provide a written Certificate of Creditable Coverage to any individual whose coverage terminates under this Plan (A) at the time of the Qualifying Event or other termination of coverage, (B) at the time COBRA coverage ceases, and (C) upon any written request made by an individual not later than 24 months after his Plan coverage ceased.

The written certificate will include (A) the date the certificate is issued, (B) the name of the Plan, (C) the name of the Participant and/or Eligible Dependent to whom the certificate applies, (D) the name, address and telephone number of the Plan Administrator, (E) the telephone number of the person to contact for additional information, and (F) (1) the date coverage began, and (2) the date coverage ended (or indicate if it is continuing).

Procedures for Requesting a Certificate of Creditable Coverage

Contact WebTPA at 800-477-8957 and request a HIPAA Certificate of Creditable Coverage, or mail your request to WebTPA Employer Services, LLC, P.O. Box 1987, Grapevine, TX 76099-1987

Certificate of Creditable Coverage

A Certificate of Creditable Coverage will be provided free of charge from the OGHC or health insurance issuer, when coverage is lost under the plan, when entitled to COBRA Continuation Coverage, when COBRA Continuation Coverage ceases, if requested before losing coverage, or if requested up to 24 months after losing coverage. Without evidence of creditable coverage, a pre-existing condition exclusion for 12 months (or 18 months for late enrollees) after the enrollment date in the plan can apply.

For purposes of Appendix C, a "pre-existing condition" is a condition (whether physical or mental) regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within six month period ending on the Plan Participant's or Eligible Dependent's date of enrollment in the Plan. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medicines. "Creditable coverage" means, with respect to a Plan Participant, coverage of the Plan Participant under the Plan.

APPENDIX D HIPAA SECURITY REGULATIONS

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and the regulations issued thereunder at 45 CFR Parts §160 and §164 (the HIPAA regulations), requires that a group health plan implement physical, administrative and technical security safeguards to protect electronic Protected Health Information (“PHI”).

APA and/or agents representing APA receive and transmit electronic PHI from the Plan (including its Business Associates, health insurance issuers, and their agents) from time to time.

The Plan as set forth below implements appropriate protections required under the HIPAA regulations as specified in 45 CFR Part §164.314(b)(1) and (2)(i), (ii), (iii) and (iv).

The Plan implements the appropriate protections required as follows:

- (A) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- (B) Ensure that the adequate separation between the Plan and itself, which is specific to electronic PHI, will be supported by reasonable and appropriate security measures;
- (C) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- (D) Report to the HIPAA Security Official any security incident of which it becomes aware concerning electronic PHI.

For the purposes of this section, the term “electronic PHI” means PHI that is transmitted or maintained in electronic media.

APPENDIX E

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)

Federal law authorizes state courts and administrative agencies to issue Qualified Medical Child Support Orders (“QMCSO”s). A QMCSO can require you to add your child as a dependent for health and dental benefits in some situations, typically a divorce.

The following procedures have been adopted and amended with respect to medical child support orders received by group health plans maintained by the Allied Pilots Association (“APA”). 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 group health plan benefits.

These procedures are for health coverage under the Voluntary Supplemental Medical and Custodial Care Benefit Plan (the “Plan”).

Use of Terms

The term “**Plan**” as used in these procedures, refers to the plan described above.

The term “**Plan Participant**”, as used in these procedures, refers to a Plan Participant who is covered under the Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the plans described above.

The term “**Alternate Recipient**”, as used in these procedures, refers to any child of a Plan 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 Plan 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 Plan Participant under a group health plan or provides for health benefit coverage to such a child, (ii) is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under such plan, or (iii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

The term “**QMCSO**” or “**NMSN**”, as used in these procedures, refers to a medical child support order creating or recognizing the existence of an Alternate Recipient’s right to, or assigns an Alternate Recipient the right to, receive health benefits with respect to a Plan Participant under a group health plan and that meets the requirements set out in these procedures.

The term “**Plan Administrator**”, as used in these procedures, refers to APA acting in its capacity as Plan Sponsor and Administrator to the plans described above.

Procedures upon Notification of Pending Child Support Order

Notice that a Plan Participant is a party to a matter wherein an Order can be entered must provide in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at Allied Pilots Association, Benefits Department, 14600 Trinity Boulevard, Suite 500, Fort Worth, TX 76155. In addition, QMCSOs or NMSNs should be delivered to the same address.

Upon receipt by the Plan Administrator of a request for information on health coverage or a notice of Order to enroll a child, the Plan Administrator will send out a letter notifying the requesting party that Section 514(a) of ERISA contains a broad preemption provision providing that ERISA “shall supersede any and all State laws insofar as they can now or hereafter relate to any employee benefit plan[.]” Furthermore,

Section 404(a)(1) of ERISA requires a Named Fiduciary such as APA to discharge its duties solely in the interest of Plan Participants and beneficiaries. Implementing the request to enroll a dependent, or provide information concerning medical coverage for a dependent of the Plan Participant described above would require APA to act in a manner that is not solely in the interest of its Plan Participants and their beneficiaries. Accordingly, APA is not able to implement their request to add a dependent of the Plan Participant to the Plan or provide information concerning the Plan Participant's dependent's medical coverage under the Plan without breaching APA's fiduciary duty to the Plan Participant.

Recognizing that the preemptions described above could work a hardship on certain dependents of Plan Participants involved in divorce actions, ERISA was amended to provide an exception to its broad preemptive language for a court or administrative Order that meets the requirements of a QMCSO or NMSN. If the requesting party wishes to ensure the initial or continued medical coverage of a dependent of a member, APA asks that they comply with the procedures outlined in Section 609(a) of ERISA concerning the preparation and submission of QMCSOs and NMSNs.

APA does not provide interim coverage to any Member'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 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, APA cannot be held liable if a Member's dependent is either (A) not enrolled in coverage in the Plan, or (B) eliminated from coverage in the Plan. In addition, neither APA nor the Plan has an obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) a Member's dependent except upon application by the Member 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, they can contact the Plan Administrator or go to the website www.acf.hhs.gov/programs/cse/forms/ to obtain a sample National Medical Support Notice.

Procedures upon Receipt of a Medical Child Support Order

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 QMCSO. Thus, before the Plan honors the Order, the Order must meet requirements for a QMCSO or NMSN.

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. The requirements state that the Order:

- (A) 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 that: (i) <http://www.acf.hhs.gov/programs/cse/forms> 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, (ii) is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under such plan, or (iii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.
- (B) Must relate to the provision of a medical child support order that creates or recognizes 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.
- (C) Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.

(D) Must clearly specify:

- (1) The name and last known mailing address of the participant and the name and address of each Alternate Recipient covered by the Order;
- (2) 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;
- (3) The period to which the order applies (if no date of commencement of coverage is provided, or if the date if 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);
- (4) The name of each plan to which the Order applies;
- (5) 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);
- (6) The fact that all plan contributions with regard to the Alternate Recipient shall be paid by the Plan Participant;
- (7) The fact that the member, if not a Plan Participant, must be enrolled as well as the child in order to provide medical coverage for the alternate recipient.

Procedures upon Final Determination

The Plan 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 NMSN as being qualified. When 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 paid by the Plan Participant. In addition, a copy of the appropriate Summary Plan Description and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipients, at the issuing agency's address.

If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Plan Participant, the Alternate Recipient, or any designated representative in writing of such fact. The notification will state the reasons the Order is not a QMCSO or NMSN and that the Plan Administrator shall treat the Plan 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 Plan Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he or she must file an Application for Appeal. Appeals will be reviewed by the Benefits Review and Appeals Board in accordance with ERISA and the terms and provisions of the Plan. A copy of the Plan's appeal procedures, as set forth in the Plan document and Summary Plan Description shall be provided upon request.

**AMENDMENT ONE TO THE
ALLIED PILOTS ASSOCIATION (“APA”)
VOLUNTARY SUPPLEMENTAL MEDICAL AND
CUSTODIAL CARE BENEFIT PLAN (“PLAN”)**

Whereas, the “Plan Continuance” subsection of the Plan provides that the Plan can be amended, or terminated, through a resolution approved by the APA Board of Directors (“Board”) and that the Board may delegate to the President or the Benefits Review and Appeals Board (“BRAB”) the authority to implement the resolution and take actions amending the Plan that is consistent with the resolution; and

Whereas, the Board passed resolution R2014-10 Rev 1 and delegated to the BRAB the authority to implement this resolution including the drafting of the amendment to the Plan that is consistent with this resolution,

Therefore, the Plan is amended effective September 16, 2013:

1. Amend the Plan’s definition of “**Spouse**” in the “**DEFINITIONS**” section as follows:

Spouse

The term “Spouse” means any individual who is lawfully married under any state law, including an individual married to a person of the same sex who was legally married to such person in a state that recognizes such marriages, but who is domiciled in a state that does not recognize such marriages.

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed amendment to be published as Amendment One is consistent with R2014-10 Rev 1.

Approved:



First Officer Steve Conlon
BRAB Chairman

Date: Feb. 27, 2014

ADMINISTERED BY



WebTPA Employer Services, LLC

P. O. Box 1987
Grapevine, TX 76099-1987
(800) 477-8957
Fax (469) 417-1797
www.WebTPA.com