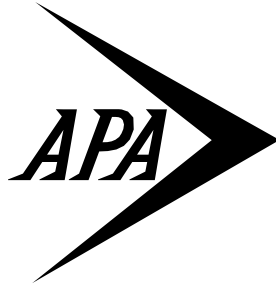




VOLUNTARY SUPPLEMENTAL MEDICAL & CUSTODIAL CARE BENEFIT PLAN

Restated April 2024



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

April 2024

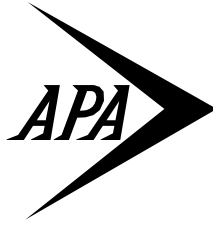
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ALLIED PILOTS ASSOCIATION VOLUNTARY SUPPLEMENTAL MEDICAL AND CUSTODIAL CARE BENEFIT PLAN

Restated April 2024

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 have access to Medical Care when it is needed. One method that has worked well for APA Members 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 pharmacy, vision care, supplemental orthodontia and retiree dental benefits.

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 for your Eligible Expenses.

The medical and custodial benefits provided by this Plan are described in this booklet. WebTPA Employer Services, LLC (“WebTPA”) has been appointed as the Claims Processor to process claims for Plan benefits, as described in the **CLAIMS PROCESSING PROVISIONS** chapter. If you have any questions about the Plan, please contact WebTPA at the following address and phone number:



WebTPA Employer Services, LLC
PO Box 1987
Grapevine, TX 76099-1987
800-477-8957

When the text references another chapter, every letter in the chapter that is referenced is capitalized, bold and in italics. When the text references another section, every letter in the section that is referenced is capitalized and bold. 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*** chapter 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. The terms of this Plan document govern all determinations made by the Plan Administrator, in accordance with its discretionary authority under the Plan, such as determinations regarding eligibility and benefits payable from the Plan. Plan terms may not be amended by verbal representations made by APA, an employee, agent, third-party administrator, or representative of APA and/or the Plan, or any other person. In the event a verbal representation conflicts with any term of the Plan, the Plan terms will control.

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. These rights are described in more detail in the PLAN CONTINUANCE section.

The next section contains a summary of the benefits under the Supplemental Medical Coverage, which includes:

- Medical Benefits
- Pharmacy Benefits
- Orthodontia Benefits
- Retiree Dental Benefits
- Vision 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** section. 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, as applicable.

SUMMARY OF COVERAGE

(Refer to SMP Coverage and Contribution Summary to determine which benefits apply to your individual situation)

<u>SUMMARY OF PROVISIONS</u>	<u>AMOUNT OF COVERAGE</u>
ANNUAL DEDUCTIBLE ⁽¹⁾⁽²⁾	\$150 per Plan Participant, up to \$400 per family
OUT-OF-POCKET MAXIMUM Per Plan Participant	\$10,000 per calendar year
MAXIMUM DAILY ALLOWANCES Hospital Room/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 LIFETIME MAXIMUM BENEFIT For each Plan Participant	\$25,000 per Plan Participant per lifetime
In-patient	80% of Eligible Expenses
Out-patient	50% of Eligible Expenses for up to 60 visits per calendar year
Psychiatric Day Treatment Facility ⁽³⁾ (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 (One Confinement maximum per Plan Participant per lifetime) For each Plan Participant	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

SUMMARY OF PROVISIONS

AMOUNT OF COVERAGE

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)

80% of Eligible Expenses

ORTHODONTIA BENEFIT ⁽⁴⁾

Benefit amount

50% of unreimbursed Eligible Expenses up to Lifetime Maximum

Lifetime Maximum for Dependent Child of Active Member, Furloughed Member, or TAG Member

\$3,000 per Dependent Child Plan Participant

Lifetime Maximum for 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 ⁽⁵⁾

Annual Deductible

\$50 per Plan Participant calendar year

Preventative Care Coverage

100% with no Deductible

Basic Care Coverage

80% of Eligible Expenses after Deductible

Major Care Coverage

50% of Eligible Expenses after Deductible

Annual Maximum Benefit

\$2,000 per Plan Participant

SUMMARY OF PROVISIONS

AMOUNT OF COVERAGE

**BASIC VSP
BENEFITS ⁽⁶⁾**

**USING VSP
NETWORK**

**USING NON-VSP
PROVIDERS**

Vision Examination
(available every calendar
year) **Lenses ⁽⁷⁾**
(available every calendar year)
Single Vision
Bifocal
Trifocal
Lenticular
Tints
Low vision benefit

\$25 copay

Up to \$45.00 after copay

\$35 copay

After copay, up to:
\$ 30.00
\$ 50.00
\$ 65.00
\$100.00
\$ 5.00
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)
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)

Elective

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)

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)

Notes:

- (1) The Plan Participant must first meet one of the conditions contained in the **WHEN BENEFITS ARE PAYABLE** section under the ***BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS*** chapter.
- (2) Wellness Benefits, Orthodontia Treatment and Vision Care Benefits are excluded from the annual Deductible.
- (3) Alternative mental health centers includes Psychiatric Day Treatment Facilities and crisis stabilization units. Treatment cannot exceed eight hours in a 24-hour period.
- (4) For Active Members, Surviving Spouses, and their Eligible Dependents who are Plan Participants.
- (5) For Retired Members, Surviving Spouses and their Eligible Dependents who are Plan Participants.
- (6) Vision Care Benefits provided through an administrative services agreement with Vision Service Plan Insurance Company.
- (7) Subject to "VSP Exclusions and Limitations".

SMP COVERAGE AND CONTRIBUTION SUMMARY

Effective April 1, 2024

The APA Board of Directors may review and adjust the contribution rates as necessary for any participant category under the Plan. Plan Participants who provide proof of unlimited medical coverage under any Other Group Health Coverage ("OGHC") that pays before the Plan pays will be charged Group A rates, the same rate that is charged for an active Plan Participant.

SMP Rate Group	Medical / Prescription	Orthodontia	Retiree Dental	Vision	Monthly Contribution
Group A: Group A: Active Rate (applied to Eligible Members, Spouses and Dependent Children based on Member's Status)	NO	YES Secondary to OGHC	NO	YES	\$30
Group B: Any Members, Spouses and Dependent Children eligible for the AA Retiree Medical Plan (\$300k Lifetime maximum)	NO	NO unless disabled prior to 2/1/2004	YES	YES	\$30
Group C: SMP Secondary to Medicare Advantage with United Healthcare provided by AA. Or SMP tertiary to Medicare and AA Retiree Medical Plan. (Eligible Members and Spouses age 65 and older)	SECONDARY to AA's UHC Medicare Advantage plan (excludes other MAPD plans). SMP provides Tertiary coverage to traditional Medicare (A, B, and D) and to AA's Retiree Medical Plan.	NO	YES	YES	\$70
Group D: SMP Primary (Eligible Members, Spouses, and Surviving Spouses)	PRIMARY until age 65	NO	YES	YES	\$650
Group E: SMP Secondary to Standard Medicare (Eligible Members and Spouses, including Surviving Spouses)	SECONDARY to Medicare	NO	YES	YES	\$200
Group F: Dependent Children of Members other than an Active Member (contribution per family not per child)	PRIMARY until dependent child reaches 26th birthday	NO	YES	YES	\$250

PLAN ELIGIBILITY, PARTICIPATION AND TERMINATION PROVISIONS

The Supplemental Medical Coverage offered under the Plan consists of supplemental medical, dental, orthodontia, and Vision Care Benefits. This section contains the provisions covering eligibility, enrollment, and termination of participation under the Plan.

PLAN ELIGIBILITY FOR MEMBERS AND THEIR DEPENDENTS

Member Eligibility

Members are initially eligible for coverage under the Plan, provided that:

- (A) the Member is Actively at Work; 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
 - (b) enrolls within the six-month period beginning on the return to Actively at Work status, if the Member 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 the Member was a Furloughed Plan Participant age 55 or older at the time of Furlough; and
- (B) the Member is not in bad standing as defined in the APA Constitution and Bylaws.

A Plan Participant shall continue to participate in the Plan until participation terminates as provided in the "Termination of Member or Retired Member Participation" subsection.

A Furloughed Member, or a Retired Member, 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, or Retired Member Participation", as applicable.

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

Spouse Eligibility

The Spouse of a Member 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 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 have been married for less than one year; or
 - (c) enrolled within the six-month period beginning on the date the Member returned to Actively at Work status, if the Member was a Furloughed Member under age 55 at Furlough; or

(d) re-enrolls within the six-month period beginning on the date the Member returned to Actively at Work status, if the Member was a Furloughed Plan Participant age 55 or older at Furlough and:

(1) the Member and Spouse were married during Furlough; or

(2) the Spouse was 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 participation terminates as provided in the "Termination of Spouse Participation" subsection.

A deceased Member's Spouse who is a Plan Participant at the time of the Member death, and otherwise meets the Plan's eligibility and participation requirements, can continue Plan participation after the death of the Member. 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 Eligibility

The Dependent Child of a Member who is a Plan Participant is initially eligible for coverage under the Plan, provided on the date of enrollment / re-enrollment the Dependent Child (see the **ORTHODONTIA BENEFITS** section for applicable restrictions):

(A) Is a Dependent Child of a Plan Participant who is under age 55; or

(B) Is a Dependent Child of a Plan Participant who is age 55 or older and has not completed six months of active service with the Company; or

(C) Has been a Dependent Child of the Plan Participant for less than 12 months; or

(D) Is enrolled within the six-month period beginning on the date the Member returned to Actively at Work status, if the Member was a Furloughed Member under age 55 at Furlough; or

(E) Is enrolled within the six-month period beginning on the date the Member returned to Actively at Work status, if the Member was a Furloughed Plan Participant age 55 or older at Furlough and:

(a) the Dependent Child became a Dependent Child during Furlough; or

(b) the Dependent Child was previously a Plan Participant.

A Dependent Child of an Active Member who is a Plan Participant must have primary OGHC to initially enroll and be eligible for coverage under the Plan.

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

A deceased Member's Dependent Child who is a Plan Participant at the time of the Member's death, and otherwise meets the Plan's eligibility and participation requirements, can continue Plan participation after the death of the Member. Such participation will continue until the date participation terminates under one of the events in the "Termination of Dependent Child Participation" subsection.

Except as otherwise provided in the “Special Enrollment” subsection, a Dependent Child of a Plan Participant must meet each applicable condition of this subsection to be initially eligible for coverage under the Plan, including with respect to a deceased Member’s Dependent Child who is not a Plan Participant at the time of the Member’s death.

Eligibility Restrictions

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

- (A) When both Spouses are pilots for the Company, the following special rules apply:
 - (1) Each Spouse is individually eligible under the Plan as a Member 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 the 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 Plan participation 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 or resigns as a Member is not eligible to participate in the Plan.
- (B) A Spouse is not initially eligible for coverage under the Plan unless the Member is a Plan Participant.
- (C) Eligible Dependent Child(ren) can only be eligible as dependents of the Member however; both parents must be Plan Participants in order for such a Dependent Child to become an Eligible Dependent Child. The Eligible Member 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, as applicable, and Spouse, if married, or Surviving Spouse are Plan Participants.
- (E) If a Member 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 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 Dependent Child(ren) terminated due to non-timely enrollment of the Member’s Spouse and the Member pays contributions for the Spouse retroactively to the first anniversary of the marriage; then:
 - (a) the Member’s Dependent Child(ren) are retroactively reinstated to the date previously terminated (provided retroactive contributions are paid for Dependent Child(ren)); or
 - (b) the Member’s 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 enrolled at the time of the Member’s death are not eligible for coverage.

- (G) Except as otherwise provided under the “Special Enrollment” subsection and with respect to a Dependent Child(ren) covered as a Dependent Child of a Surviving Spouse, Furloughed Member or a Retired Member age 65 or older, Dependent Child(ren) must have primary OGHC before they are initially eligible for coverage under the Plan. In addition, once participating in the Plan, a Dependent Child(ren), other than one covered as a Dependent Child of a Surviving Spouse, Furloughed Member or a Retired Member age 65 or older, must have primary OGHC to continue to participate in the Plan, unless the Lifetime Maximum under such OGHC has been exhausted. Once the Lifetime Maximum under all OGHC has been exhausted, a Dependent Child is no longer subject to this requirement.

No Discrimination Due to Health

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

To enroll in the Plan, please go to www2.benefitelect.com/apa. Note: For first time users please log into www.alliedpilots.org and go to the Benefits page to obtain your temporary password.

Special Enrollment

Special Enrollment may 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 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. Please note that, although the Plan recognizes such Special Enrollment events, the Plan’s enrollment rules applicable to Spouses or other Eligible Dependents may, in some cases, allow enrollment in the Plan beyond the Special Enrollment periods described in this subsection of the Plan.

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 may be permitted for 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 Member must request Special Enrollment within 60 days immediately following the occurrence of one of the events in (A) or (B) of this paragraph.

A Member or Surviving Spouse (or Eligible Dependent) will qualify for Special Enrollment if the:

- (A) Member, or Surviving Spouse (or Eligible Dependent) is otherwise eligible for initial coverage under the Plan;
- (B) Member, or Surviving Spouse (or Eligible Dependent) had OGHC at the time initially eligible under this Plan;
- (C) Member or Surviving Spouse (or Eligible Dependent) declined participation under the Plan because the Member or Surviving Spouse (or Eligible Dependent) had the OGHC;
- (D) 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) Member or Surviving Spouse (or Eligible Dependent) requests Special Enrollment in writing within 30 days after the date OGHC is lost (either due to loss of eligibility under OGHC or because the employer no longer contributes toward health coverage).

Re-Enrollment

Subject to the "Eligibility Restrictions", "Special Enrollment" and "One-Time Open Enrollment" subsections, the former Plan Participant must satisfy all of the following conditions as described in the "Effective Date of Participation" subsection:

- (A) The former Plan Participant must be an Eligible Member, 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. The five-year waiting period will not apply to:

- (1) A Plan Participant whose participation terminated while 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 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 Servicemembers Civil Relief Act ("SCRA"), 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 SCRA) after release from service; or
- (4) A Dependent Child who re-enrolls in the Plan as long as the Dependent Child 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 Eligible Dependents who re-enroll in the Plan within six months from the Furloughed Member's 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 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 will receive credit for prior participation toward the three-year requirement described in the "Orthodontia Benefits" section.

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, or Surviving Spouse attained age 55 cannot re-enroll following termination of participation.

Reinstatement

Plan Participants 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 Plan participation terminated to the effective date of 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 the Returning Executive Non-Member 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 the Member's APA membership status changed from Member to Executive Non-Member will have up to six months from the date the Member 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 the Member's 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 the Returning Executive Non-Member's APA membership status changed to Executive Non-Member status can enroll or re-enroll Eligible Dependents, provided the Returning Executive Non-Member 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 the Returning Executive Non-Member ceases to be an Executive Non-Member; or
 - (2) prior to 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 who became Eligible Dependents during the period that the Returning Executive Non-Member was an Executive Non-Member, by filing 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 the Returning Executive Non-Member 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 the Member's APA membership status changed from Member to Executive Non-Member will have up to six months from the date the Member ceases to be an Executive Non-Member to submit a completed enrollment form to the Claims Processor to enroll or re-enroll 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 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 will receive credit for their prior period(s) of Plan Participation toward the three-year requirement described in the "Orthodontia Benefits" section 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.

Effective Date of Coverage

Coverage for a Member and 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 Filed a completed enrollment or re-enrollment form to the Claims Processor, provided that the date on which such Member submitted the application to APA to return as an APA member is not later than the date the Member Filed the 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. Such contribution amounts may be amended at any time by the APA Board of Directors. Any change in contribution amounts will be communicated to Plan Participants. Unless the Plan Participant is eligible to begin participating in the Plan under the Special Enrollment subsection above, a Plan Participant who initially becomes eligible for coverage under the Plan on or after the date the Member attains age 55 must pay contributions back to the date the Member attained age 55, as follows:

- (A) Eligible Members who join the Plan at or after age 55 must pay contributions back to age 55.
- (B) An Eligible Spouse of such Member must pay contributions back to the later of:
 - (1) the Member's age 55 or;
 - (2) the date of marriage.

(C) Eligible Dependent Child(ren) of such Member must pay contributions back to the later of:

- (1) the Member's age 55 or;
- (2) the date they became Dependent Child(ren).

Effective Date of Participation

An Eligible Member 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 becomes a Plan Participant; and
- (D) For an Eligible Dependent Child, the day that both the Eligible Member and Eligible Spouse become Plan Participants; and
- (E) The effective date specified during the enrollment period.

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 participation terminates under the **TERMINATION OF PARTICIPATION** section below.

TERMINATION OF PARTICIPATION

Termination of Member or Retired Member Participation

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

- (A) The day membership with APA terminates (except for Grandfathered Executive Members) as provided in paragraph (G) below; or
- (B) The day following the Member's or Retired Member'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 received by Claim Processor. The request must be in writing via postal or email benefits.sec@alliedpilots.org to notify APA Benefits. Verbal requests to terminate coverage will not be accepted; 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 or Retired Member; 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 pilots who have been terminated from the Company and have filed a grievance seeking reinstatement coverage extends for up to 5 years or until the grievance is resolved.

- (H) For Furloughed Members, as provided in the “Termination of Furloughed Member Participation” subsection, or
- (I) 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
- (J) 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 the Plan Participant’s reasonable control.

Prohibited Rescission of Coverage

Notwithstanding the above, if required by law, the Plan will not terminate a Plan Participant’s coverage 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. When this provision applies, the Plan Administrator will provide at least 30 days advance written notice to each Plan Participant who would be affected before coverage may be rescinded. For purposes of this provision, the termination of coverage retroactively due to a Plan Participant’s failure to pay a required contributions, 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 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) Furloughed members, and their dependents, are terminated after two years of SMP coverage, subject to the Plan’s terms, if their participation in the Plan became effective prior to their Furlough.
- (D) The day that any event described in (A) - (F) or (H) - (I) under the “Termination of Member or Retired Member 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 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 the Plan Participant's 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 last day of the month in which a Dependent Child turns age 26; or
- (C) The day following the Dependent Child's death; or
- (D) 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
- (E) The day the Member's Spouse or Surviving Spouse terminates participation, except in cases involving divorce or the death of the Member or Surviving Spouse; or
- (F) 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
- (G) 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
- (H) The day OGHHC is voluntarily terminated for the Dependent Child.

BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS

This section contains the provisions of the Supplemental Medical Coverage.

WHEN BENEFITS ARE PAYABLE

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

- (A) Except for Plan Participants who are or become eligible for Medicare as their primary coverage and Plan Participants noted below, Plan Participants retiring prior to November 1, 2012, and their Eligible Dependents, must first exhaust the Lifetime Maximum benefits available under the Company's group medical plan¹, and any OGHC under which the Plan Participant is covered or has the option to obtain coverage.² Plan Participants who are or become eligible for Medicare will be subject to the applicable requirements described in the "Coordination of Benefits" subsection below, for all other coverage, including Medicare, as applicable. Note that this provision does not apply to benefits described in the **VISION CARE BENEFITS** chapter, the **ORTHODONTIA BENEFITS** chapter, or the **RETIREE DENTAL BENEFITS** chapter.
- (B) With respect to a Furloughed Member or such Member's Eligible Dependents, the Furloughed Member or Eligible Dependent must incur an Eligible Expense when no OGHC is available (such as where there is no OGHC available from either the Furloughed Member's subsequent employment or 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.
- (C) The Surviving Spouse and Eligible Dependent Child(ren) incur an Eligible Expense when no OGHC is available (such as through the Surviving Spouse's employment). Neither Surviving Spouses of pilots who die on or after November 1, 2012, nor their Eligible Dependent Child(ren), will be required to purchase the Company-provided coverage to receive benefits under the Plan.

Footnotes:

¹ Plan Participants required to exhaust coverage under the Company retiree medical plan must provide an audit from United Healthcare (UHC) stating that the lifetime maximum under the Company's retiree medical plan has been exhausted. Plan Participants can call UHC Customer Service to request this audit.

² Effective January 1, 2018, Plan Participants retiring on or after November 1, 2012, and their Eligible Dependents, are not required to purchase or exhaust Company RSMP coverage before the Plan pays benefits.

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. Wellness Benefits, Orthodontia Benefits, and Vision Care Benefits are excluded from the annual Deductible.

Medical Deductible

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

Once the Individual Deductible is met for an SMP Participant, the SMP will begin paying benefits for that Participant. Additionally, if a Participant has more than one Eligible Dependent, once the family Deductible has been met, SMP will pay benefits for all family members.

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 Other Group Health Coverage (“OGHC”) such as HMOs, PPOs, AA Retiree Medical, etc. Coordination of benefits will be required as described herein with respect to each applicable type of coverage. Plan Participants will be solely responsible for filing all required claims with other plans under which they have coverage, in accordance with applicable requirements for obtaining any benefits due under such plans. A Plan Participant’s claim for benefits under this Plan may be denied, in whole or in part, or reduced as deemed appropriate in the Claims Processor’s or Plan Administrator’s sole discretion, to the extent the Plan is unable to determine the amount of benefits owed under this Plan, if any, based on the Plan Participant’s failure to file and complete the claims process for other applicable coverage in a timely manner.

Medicare

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 the Plan Participant 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 1 contribution rates, Medicare-eligible Plan Participants’ claims will be coordinated with the payments made by:

- (1) Medicare Parts A and B; and
- (2) Either the Company’s retiree medical plan or any OGHC.

For Medical Claims paid Secondary to Medicare / OGHC:

Reduce the Eligible Expenses by any remaining SMP Deductible. The plan then pays 80% of the remainder (Eligible Expenses minus SMP Deductible). However in no case may the amount paid by the Plan exceed the amount of Eligible Expenses, less what was paid by Medicare / OGHC.

Below are examples of how these rules apply in several situations with respect to Eligible Expenses. In the following examples the term “SMP Medicare/OGHC Combined Limit” is the claim amount minus any amount paid by Medicare and/or OGHC.

*Please note that the examples below are based on Medicare’s 2018 deductible of \$183.00. The Medicare deductible for 2020 is \$198, and may change in subsequent years.

1st Example: Deductibles have been met for both OGHC and SMP: Claim total \$1000, OGHC pays 80% (\$800.00).

Claim Amount	\$1,000.00
OGHC Deductible	\$0.00
OGHC Paid	\$800.00
SMP Eligible Expense	\$1,000.00
SMP Deductible	\$0.00
SMP Eligible Expense after Deductible	\$1,000.00
SMP at 80%	\$800.00
SMP Medicare/OGHC Combined Limit	\$200.00
SMP Pays	\$200.00

2nd Example: Medicare Part B Deductible has not been met; SMP Deductible has been met. Claim amount is \$1,000 and Medicare pays 80% after the Deductible.

Claim Amount	\$1,000.00
Medicare Deductible	\$183.00
Medicare Paid	\$653.60
SMP Eligible Expense	\$1,000.00
SMP Deductible	\$0.00
SMP Eligible Expense after Deductible	\$1,000.00
SMP at 80%	\$800.00
SMP Medicare/OGHC Combined Limit	\$346.40
SMP Pays	\$346.40

3rd Example: Medicare Part B Deductible has not been met; SMP Deductible has not been met. Claim amount is \$1,000 and Medicare pays 80% after its Deductible.

Claim Amount	\$1,000.00
Medicare Deductible	\$183.00
Medicare Paid	\$653.60
SMP Eligible Expense	\$1,000.00
SMP Deductible	\$150.00
SMP Eligible Expense after Deductible	\$850.00
SMP at 80%	\$680.00
SMP Medicare/OGHC Combined Limit	\$346.40
SMP Pays	\$346.40

4th Example: Medicare Deductible has been met; SMP deductible has not been met: Claim total \$1000 Medicare pays \$800.00.

Claim Amount	\$1,000.00
Medicare Deductible	\$0.00
Medicare Paid	\$800.00
SMP Eligible Expense	\$1,000.00
SMP Deductible	\$150.00
SMP Eligible Expense after Deductible	\$850.00
SMP at 80%	\$680.00
SMP Medicare/OGHC Combined Limit	\$200.00
SMP Pays	\$200.00

TRICARE

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

HMO

Since HMOs have no Lifetime Maximum benefit provisions 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, 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) Prescription Drugs as provided under the Pharmacy Benefit Program and as defined in the **DEFINITIONS** chapter.
- (F) Diagnostic X-Ray and laboratory examinations, excluding dental X-Rays, provided, however, that preventative routine screenings are subject to the limits set forth in paragraph (M) below.
- (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** chapter:
 - (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 or Spouse. Maternity expenses Incurred for Complications of Pregnancy by a Dependent Child who is a Plan Participant are covered. Under Federal law, the Plan 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 delivery by 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. Also, under Federal law, coverage you receive under the Plan, if any, may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. However, the Plan may pay for a shorter stay if your Physician or other attending provider (such as a nurse, midwife, or Physician's assistant) discharges the mother or newborn earlier, after a medical consultation.

(M) The following routine screenings, subject to the indicated limit for each such routine screening: Prostate Specific Antigen (PSA) tests (limited to one per calendar year), pap smears (one per calendar year), colonoscopy (once every five years), and mammograms according to the following schedule:

<u>Age</u>	<u>Schedule</u>
Up to age 35	One baseline mammogram
Age 36 and older	Once per year

(N) Expenses for an abortion for a Plan Participant who is a Member, 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 the **EXCLUDED MEDICAL EXPENSES** section 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 due to 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, 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 due to 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 the Plan Participant 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** section 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** section 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.
- (DD) Except as provided in this paragraph (DD), (1) 100 percent of any Medically Necessary screening and testing for COVID-19 or any similar strains of coronavirus that may develop in the future (collectively referred to herein as "Coronavirus") that is completed In-Network and (2) with respect to each Plan Participant who is diagnosed with Coronavirus, all direct related treatment costs, including without limitation hospital, transportation, and pharmacy services, subject to otherwise applicable limitations and requirements under the Plan. Notwithstanding anything in the Plan to the contrary, eligible screening and testing described in clause (1) above will be covered with no pre-approval necessary, including the costs of the visit to the applicable Plan Participant's medical care provider, associated lab testing and radiology services, and emergency or urgent care setting treatment costs. **All otherwise Eligible Medical Expenses described in this paragraph (DD) will be subject to the limits established by APA's Board of Directors under R2020-21, as they may be amended from time to time in accordance with R2020-21.** In no event will the Plan pay benefits exceeding the actual amount of a Plan Participant's otherwise eligible screening, testing, or treatment expenses, less the amount paid by Medicare or OGHC with respect to such screening, testing, or treatment expenses, as applicable.

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 (TMJ) are covered. Except as otherwise provided, crowns, splints, dental services, dentures, orthodontics or appliances are not covered. See the RETIREE DENTAL BENEFITS section for other covered TMJ services.

WELL CHILD CARE

A Member, 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 Plan Participant 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.

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, as applicable, or an amount over and above the benefit limits shown in the **SUMMARY OF SUPPLEMENTAL MEDICAL COVERAGE** chapter.
- (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 subchapter, 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** section.
- (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** section or if included in that subsection, any amounts exceeding or outside of the relevant limitations.
- (L) Expenses for the following care to the extent in excess of, or not as described previously, in this **BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS** chapter:
 - (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** section), 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** section or as described under the **VISION CARE BENEFITS** chapter).
- (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** section.
- (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** section.
- (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** section. 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) Medical expenses incurred outside the United States of America or its possessions (collectively referred to as "USA") will be excluded, unless required for emergency medical care. This exclusion includes medical expenses incurred while living outside the USA or when traveling outside the USA for specific services, supplies, or treatments.
- (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.
- (OO) Expenses for routine / preventive services or screenings unless specifically included under the **ELIGIBLE MEDICAL EXPENSES** section.

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** section.
- (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 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 BeneCard PBF. BeneCard has established a network of participating pharmacies throughout the country. BeneCard uses its network of pharmacies and mail order drug facilities to fill prescriptions. BeneCard negotiates lower drug prices and passes on these lower costs to Plan Participants through both its retail and mail order drug facilities. Claims for pharmacy benefits otherwise payable under the Plan must be filed and completed in accordance with the procedures described in this section of the booklet, before a Plan Participant may become eligible to appeal a denial of any such claim under the procedures provided for in the "Claims Processing Provisions" section of the Plan.

Plan Participants may contact BeneCard for information about a claim, location of a participating pharmacy, mail order Prescription Drug or any other question at the following:

Street Address	BeneCard PBF 5040 Ritter Road Mechanicsburg, PA 17055 888-907-0070
Website	www.benecardpbf.com

Under the Pharmacy Benefit Program, the Medical Deductible applies to Prescription Drugs. The coinsurance for Prescription Drugs will apply to the annual Out of Pocket Maximum. Refer to the **BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS** chapter of this Plan booklet for more details.

Under the Pharmacy Benefit Program, Plan Participants may obtain Prescription Drugs through either a retail pharmacy or a mail order pharmacy. The claim processing procedures depend on whether the claim is a Primary Claim, Secondary Claim or Tertiary Claim.

PHARMACY CLAIMS PROCEDURES:

Prescription drug claims must be filed not later than one year from the prescription fill/refill date.

PRIMARY CLAIMS

A claim is a Primary Claim if the Plan pays before any other group medical plan or insurance. In general, the Plan will pay 80% of the cost of covered prescription drugs after deductible.

Retail Pharmacy Benefit (Network Pharmacy)

Plan Participants have the option to obtain a 90-day supply through the retail network.

- Present the Plan ID card to the pharmacists at the time of payment.
- The pharmacist will charge the Plan Participant the Deductible, if applicable, and the co-insurance amount.
- There are no claim forms to file.

Retail Pharmacy Benefit (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 with BeneCard PBF 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. The BeneCard claim form is available in the Benefits section of www.alliedpilots.org/benefits. Click Voluntary Supplemental Medical & Custodial Care, then click Claim Kit, and then click BeneCard PBF, BeneCard PBF – Primary Reimbursement Form. You can also obtain a copy of the form by calling APA at 817-302-2140. Print, complete, and return to the address listed on the form.

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 BeneCard Central and may be reached by calling 888-907-0070 or through its website at www.benecardpbf.com For new prescriptions or to transfer an existing prescription to BeneCard Central

Fill, Plan Participants should enclose the original prescription using the appropriate mail order form. Refills may be ordered by calling BeneCard Central at 888-907-0070, or through its website at www.benecardpbf.com. Plan Participants should allow approximately 14 days from the date that the request was mailed to receive the prescribed drug.

Maintenance medications can be submitted to BeneCard Central Fill, the mail order facility. The Plan allows for up to a 90-day supply with 3 refills, according to the physician's instructions.

- For the first order, Plan Participants have two options:
 - Mail a completed Mail Service Order Form along with the original prescription to BeneCard Central Fill; or
 - Plan Participants can have their physician fax the prescription to **1-888-907-0040**. Be sure that the physician includes the cardholder name, ID number, shipping address and patient's date of birth. Only prescriptions faxed from a doctor's office will be accepted via fax.
- To order refills, there are three options:
 - **Internet:** Visit **www.benecardpbf.com**. If the Plan Participant has not yet registered, click on Register. If the Plan Participant is a registered user, log in and select Mail Order.
 - **Phone:** Call Member Services toll-free, **1-888-907-0070** 24 hours a day, 7 days a week and use the prompts to order refills. Have the identification number and credit card information ready.
 - **Mail:** Send the Refill Request Order Form provided with the last shipment back to BeneCard Central Fill mail service in the pre-addressed envelope.

BeneCard Central Fill does NOT automatically refill prescriptions. It is each Plan Participant's responsibility to ensure that any necessary refills are ordered in a timely manner, to meet the Plan Participant's medical needs.

SECONDARY CLAIMS

(Plan Participant is Covered under Medicare Part D or is Medicare Eligible and has no Other Group Health Coverage)

Unless they have other group health coverage, this would include claims filed by the following Plan Participants:

- Participants who are listed on the **SMP Coverage and Contribution Summary** as having medical/Rx coverage "Secondary to Medicare".
- Participants who are listed on the **SMP Coverage and Contribution Summary** as having medical/Rx coverage "Tertiary to Medicare and AA Retiree Medical", and have exhausted the Lifetime Maximum benefit under the American Airlines Retiree Medical Plan.

The Plan will pay as secondary to Medicare Part D. The Plan will reimburse the amount of claim remaining after Medicare Part D Plan has paid, if the Plan Participant has met the Plan Deductible. If the Prescription Drug is not covered under by Medicare Part D or if Plan Participant is not enrolled in Medicare Part D, the Plan will reimburse 40% of the allowable cost as determined by BeneCard.

Mail Order Pharmacy

Plan Participants who have Medicare Part D are not eligible to use Mail Order through BeneCard Central Fill.

Retail Pharmacy Benefit (Network Pharmacy)

When using an In-Network pharmacy, Plan Participants covered under Medicare Part D must present their Medicare Part D card and their Plan identification card. The pharmacist will process the prescription as secondary to the Plan Participant's Medicare Part D plan using on-line adjudication through BeneCard PBF. The pharmacist will charge the applicable coinsurance after Deductible to the Plan Participant. Normally, there are no claim forms to file.

When using an In-Network pharmacy, Plan Participants not covered under Medicare Part D must present their plan identification card. The pharmacist will process the prescription as primary using on-line adjudication through BeneCard PBF. Normally, there are no claim forms to file.

Retail Pharmacy Benefit (Non-Network Pharmacy)

A Plan Participant who uses a Non-Network pharmacy must present their Medicare Part D card if enrolled in part D. The claim filing process for secondary coverage depends on whether the Plan Participant has a Medicare Part D plan and if Medicare Part D Plan covers all of the Prescription Drugs on the claim.

If the Plan Participant has a Medicare Part D Plan that covers the Prescription Drug, then submit the following:

- Include a copy of the Medicare Part D Explanation of Benefits (“EOB”). If the Medicare Part D plan paid the full price of the prescription drug and the Plan Participant paid no copay, coinsurance or deductible, then do not file a claim since there would be no payment from the Plan.
- Mail the completed BeneCard Prescription Reimbursement Claim form and the copy of the Medicare Part D EOB to:

**BeneCard PBF
5040 Ritter Road
Mechanicsburg, PA 17055**

Or Email to: APAclaims@benecardpbf.com

- The BeneCard Prescription Reimbursement Claim form is in the Benefits section of www.alliedpilots.org. Click Voluntary Supplemental Medical & Custodial Care, then click Claim Kit, click BeneCard PBF, and then click BeneCard PBF – Secondary/Tertiary Reimbursement Form.

If the Plan Participant does NOT have a Medicare Part D Plan or the prescription drug is not covered by Medicare Part D, then the following must be submitted:

- The BeneCard Prescription Reimbursement Claim Form
- Copies of pharmacy receipts

Mail the completed form and receipts to:

**BeneCard PBF
5040 Ritter Road
Mechanicsburg, PA 17055**

Or Email to: APAclaims@benecardpbf.com

- The BeneCard Prescription Reimbursement Claim form is in the Benefits section of www.alliedpilots.org. Click Voluntary Supplemental Medical & Custodial Care, then click Claim Kit, click BeneCard PBF, and then click BeneCard PBF – Secondary/Tertiary Reimbursement Form.

TERTIARY CLAIMS

(Plan Participant is Eligible for Medicare Part D and Covered under the American Airlines Retiree Medical Plan)

Plan Participants have TERTIARY coverage if the Plan pays after the American Airlines Retiree Medical Plan and Medicare Part D. This would include the following individuals:

- Medicare-eligible pilots who retired prior to November 1, 2012 and their Medicare-eligible spouses who have not used up the lifetime maximum benefit under the American Airlines Retiree Medical Plan

How Do Plan Participants File a Tertiary Claim?

The claim filing process for a Plan Participant who has tertiary coverage depends on whether the American Airlines Retiree Medical Plan covers all of the prescription drugs on the claim.

If the American Airlines Retiree Medical Plan covers the prescription drug:

- If the Plan Participant has Medicare Part D, the Plan will reimburse the amount of the claim remaining after the American Airlines Retiree Medical Plan has paid, less any applicable SMP Deductible.
- If the Plan Participant does not have Medicare Part D, the Plan will pay 40% of the difference between the UHC allowed cost for the prescription drug and the maximum calculated UHC benefit less any applicable SMP Deductible.

Submit the following:

- American Airlines Retiree Medical Plan Explanation of Benefits (“EOB”) from United HealthCare (“UHC”), and
- The completed UHC Claim Form, and
- The completed BeneCard Prescription Reimbursement Claim form

Mail all three forms to:

**BeneCard PBF
5040 Ritter Road
Mechanicsburg, PA 17055**

Or Email to: APAclaims@benecardpbf.com

- The BeneCard Prescription Reimbursement Claim form is in the Benefits section of www.alliedpilots.org. Click Voluntary Supplemental Medical & Custodial Care, then click Claim Kit, click BeneCard PBF, and then click BeneCard PBF – Secondary/Tertiary Reimbursement Form.

If the American Airlines Retiree Medical Plan does NOT cover the prescription drug:

- The Plan will reimburse 40% of the allowable cost as determined by BeneCard.

Plan Participants must submit the following:

- The BeneCard Prescription Reimbursement Claim Form
- Copy of the UHC Explanation of Benefits (“EOB”)
- Copies of the pharmacy receipts

Mail the completed form and the copies of the UHC EOB and receipts to:

**BeneCard PBF
5040 Ritter Road
Mechanicsburg, PA 17055**

Or Email to: APAclaims@benecardpbf.com

ORTHODONTIA BENEFITS

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

Notwithstanding anything in the Plan to the contrary, a Dependent Child will not qualify for Orthodontia Benefits until the Dependent Child has been a Plan Participant for 3 consecutive years (referred to in this booklet as the “three-year requirement”). Please note that this 3 year waiting period will not apply to a Dependent Child(ren) in the following situations:

- (a) Where the applicable Member is (i) under age 55 and (ii) has not completed 24 months of active service with the Company on the date of the Dependent Child’s enrollment in the Plan; or
- (b) Where the applicable Member is (i) age 55 or older and (ii) has not completed 6 months of active service with the Company on the date of the Dependent Child’s enrollment in the Plan.

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 up to the Orthodontia Lifetime Maximum in the **SUMMARY OF SUPPLEMENTAL MEDICAL COVERAGE** chapter. A Dependent Child of an 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.

Payment for eligible Orthodontia Treatments will be made in one lump sum up to the Lifetime Maximum upon commencement of treatment and receipt of a complete claim. The claim must include the treatment plan, the duration of treatment, the total case fee and the date the treatment began.

The Orthodontist should submit one billing that reflects the total cost of the patient’s orthodontic treatment – even if the duration of treatment moves across calendar years.

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 12 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:

Comprehensive full banded Orthodontia Treatment

Preliminary study including cephalometric x-rays, diagnostic casts and treatment plan

First month of active treatment including all active and retention appliances

Active treatment per month after the first month

Retention and observation treatment, per visit

Appliances for tooth guidance - Only one such appliance per Plan Participant is an Eligible Expense

Removable

Fixed or cemented

Orthodontic retention appliances - Only one such appliance per Plan Participant is an Eligible Expense
Removable

Fixed or cemented

Adjunctive service - Cephalometric X-Ray or examination, treatment, or adjustment of appliance, per visit

Other Orthodontic Treatment that is Medically Necessary

Excluded Orthodontia Expenses

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

Services that are not listed above as Orthodontia Treatments.

Services or supplies that do not meet American Dental Association standards.

Services or supplies that are included in the **EXCLUDED MEDICAL EXPENSES** section.

RETIREE DENTAL BENEFITS

For Plan Participants eligible to receive this coverage, the Plan will pay:

- **Preventive Dental Care - 100%** of Eligible Expenses Incurred for preventive dental care, with no Deductible.

After each Plan Participant satisfies a **\$50 annual Deductible**, the Plan will pay:

- **Basic Dental Care - 80%** of the Eligible Expenses Incurred for the basic dental benefits contained in this section that are not reimbursed by any OGHC.
- **Major Dental Care - 50%** of the Eligible Expenses Incurred for the major dental benefits contained in this section that are not reimbursed by any OGHC.

Any otherwise eligible dental care expenses described above must also be Incurred while the eligible individual is a Plan Participant.

The Plan will pay a maximum benefit up to **\$2,000** 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 group dental coverage, including the optional group dental plan offered by the Company. This means that the eligible dental expense to be considered by the Plan will be reduced by the amount paid by the OGHC plan.

ELIGIBLE RETIREE DENTAL EXPENSES

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

Preventive Care

The Plan pays 100% of the Usual and Prevailing charge for the following preventive and diagnostic services. The annual Deductible does not apply to these services, but benefits for these services count toward the annual maximum benefit.

- (A) Clinical oral evaluation, periodic or comprehensive, but not more than two in a calendar year
- (B) Routine cleaning (prophylaxis), but not more than two in a calendar year
- (C) Fluoride applied on teeth of dependent children under age 19, but not more than twice in a calendar year
- (D) Space maintainers (initial appliance only) for dependent children under age 19
- (E) Dental X-rays (refer to Note at end of list):
 - (1) Full mouth (complete series including up to 4 bitewings and 12 individual X-rays [periapical]), but not more than once every 36 months
 - (2) Intraoral (up to 12 periapical); benefits not to exceed a full mouth series
 - (3) Bitewings, but not more than four films twice per calendar year
 - (4) Panoramic film, including bitewings and periapicals if necessary, considered a complete series, but not more than once every 36 months
- (F) Emergency treatment to relieve pain, but not on the same day as any other service except X-rays
- (G) Sealants for dependent children under age 19, on occlusal surfaces of permanent molars only, and not more than once every 24 months

NOTE: X-ray limits apply even if X-rays are taken by different dentists. You are encouraged to transfer your X-rays if you visit another dentist.

Basic Care

The Plan pays 80% of Usual and Prevailing charges for the following basic services to restore teeth and gums. Each Plan participant must satisfy the annual Deductible before receiving benefits for basic services. These benefits are included in the annual maximum benefit.

- (A) Extraction (removal) of erupted teeth (refer to Note at end of list)
- (B) Surgical services, including usual postoperative services
- (C) Filling of decayed or fractured teeth, except as listed under Major Care
- (D) Anesthetics (general and intravenous) when medically necessary and in connection with a covered dental procedure; local and regional block anesthesia only with surgical procedures
- (E) Periodontal treatment or periodontal surgery to remove diseased gum tissue or bone (including gingivectomy and osseous surgery) and localized delivery of chemotherapeutic agents
- (F) Gingivectomy, gingival curettage (surgical), gingival flap procedures, mucogingival surgery and osseous surgery (including flap entry and closure), limited to four quadrants per treatment program
- (G) Periodontal maintenance procedures following active therapy, but not more than once every three consecutive months; periodontal scaling and root planning, limited to four quadrants per treatment program
- (H) Full mouth debridement for evaluation and diagnosis
- (I) Occlusal guard, but not more than one every three years
- (J) Occlusal adjustment in conjunction with periodontal surgery, limited to four quadrants per treatment program
- (K) Occlusal adjustment (complete) in conjunction with periodontal surgery, limited to four quadrants per treatment program, but not more than once every 24 consecutive months
- (L) Endodontic treatment (root canal therapy)
- (M) Pulpal therapy on primary teeth
- (N) Apexification/recalcification, including initial visit, interim medication replacement and final visit (limited to patients under age 12)
- (O) Add teeth to an existing fixed bridge, partial or full denture, but only to replace teeth that are extracted after you or your family members are covered under this Plan
- (P) Antibiotic injections when given by the dentist
- (Q) Repairs to and re-cementing of crowns, inlays, bridgework or dentures
- (R) Relining and rebasing of dentures or partials, after six months following installation, but not more than once every 36 consecutive months

NOTE: Procedures for the surgical extraction of impacted wisdom teeth, removal of tumors (benign and malignant) and for accidental injury to sound natural teeth are not covered dental benefits for purposes of this Plan, but may be covered as medical benefits in accordance with applicable provisions.

Major Care

The Plan pays 50% of Usual and Prevailing charges for the following major services. Each Plan Participant must satisfy the annual Deductible before receiving benefits for major services. These benefits are included in the annual maximum benefit.

- (A) Major restorative dentistry (laboratory-fabricated restorations and crowns) only when necessitated by decay or traumatic injury and when crowns and prosthodontics cannot be restored with a routine filling material

- (B) The initial installation of fixed bridgework, partial or full dentures or implants, but only to replace teeth (excluding third molars) that are extracted after you or your family members are covered under the Plan – includes the cost of temporary prosthodontics within 12 months of installation. However, benefits for implant(s) and all related expenses, including all preparatory, adjunctive and restorative/ prosthetic procedures are limited to the alternate benefit of a bridge or denture benefit that would otherwise be payable under this Plan for replacement of the tooth or teeth replaced by the implant(s).
- (C) Separate benefits are not allowed for adjustments or relines within six months after installation
- (D) Specialized techniques and characterizations are not covered
- (E) Replacement of an existing fixed bridge, partial or full denture subject to the conditions below:
 - (1) The existing denture or fixed bridge cannot be made serviceable and was installed at least five years prior to the time of replacement; or
 - (2) The existing denture is certified by the dentist or physician to be a temporary full denture that cannot be made permanent and is replaced with a permanent denture within 12 months of the date it was installed.
- (F) Crowns, inlays, onlays or gold fillings to restore teeth, but only when:
 - (1) The tooth is fractured or has major decay; and
 - (2) The tooth cannot be restored with fillings such as amalgam, plastic or composite resin.

Temporomandibular Joint (TMJ) Services

The Plan pays 50% of Usual and Prevailing charges for TMJ services, up to a \$1,500 per-person lifetime maximum benefit for the following expenses:

- (A) An initial examination including a history, physical examination, muscle testing, range of motion measurements and psychological evaluation, as necessary
- (B) Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of service
- (C) Appliance therapy using an appliance that does not permanently alter tooth position or bite relationship (Benefits for this appliance therapy will be based on the allowance for a single appliance, regardless of the number of appliances used in treatment. The benefit for appliance therapy will include an allowance for all jaw relation and position diagnostic services, office visits, adjustments, training, repair and replacement of the appliance within three years.).

TMJ expenses not covered by the Retiree Dental Plan include:

- (A) CT scans or magnetic resonance imaging
- (B) Therapeutic injections
- (C) Electronic diagnostic modalities
- (D) Occlusal analysis
- (E) Any irreversible procedure, including but not limited to orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures or full dentures
- (F) Surgery and related services
- (G) Any procedure not specifically listed as a covered expense

NOTE: Expenses Incurred by a Plan Participant for diagnostic or surgical treatment for TMJ Dysfunction are not covered dental benefits for purposes of this Plan, but may be covered as medical benefits in accordance with applicable provisions.

EXCLUDED RETIREE DENTAL EXPENSES

Certain dental expenses are not covered retiree dental benefits for purposes of the Plan, including expenses for the following:

- (A) Dental care that is not customarily performed
- (B) Services, supplies, facilities or equipment determined to be experimental or investigational
- (C) Implant(s) and all related expenses, including all preparatory, adjunctive and restorative/ prosthetic procedures except as provided under **Major Care** in paragraph (B).
- (D) An injury or illness from any employment or occupation covered by Workers' Compensation
- (E) A military-related injury caused by any act or incident of declared or undeclared war, riots, insurrection or acts of terrorism
- (F) Dental care received during a stay in a hospital owned or operated by a federal, state, provincial or political unit, unless required by statute or regulations
- (G) Charges (or the portion thereof) that are in excess of the Usual and Prevailing charge
- (H) Dental care for cosmetic purposes, unless the care is needed because of an accidental dental injury received while covered (facings on crowns or pontics behind the second bicuspid will always be considered cosmetic.)
- (I) Injury while committing or attempting to commit a felony, or while engaging in an illegal occupation
- (J) Impacted wisdom teeth (his service may be covered under the Plan's medical benefits.)
- (K) Services performed by a close relative or by someone who ordinarily lives in the covered person's home
- (L) Any treatment that is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation
- (M) An appointment the covered person did not attend
- (N) Telemedicine
- (O) Services the covered person would not be obligated to pay in the absence of this dental coverage or that are provided to the covered person at no cost
- (P) Care that is excluded elsewhere in this Plan
- (Q) Services that are not on the list of covered dental services
- (R) Procedures that are not necessary and do not meet professionally recognized standards of care, as determined by the claims administrator
- (S) Any service deemed to have a poor prognosis
- (T) Replacement of lost, missing or stolen appliances, regardless of any other Plan provision
- (U) A service not furnished by a licensed dentist, dental hygienist who works under the supervision and direction of a licensed dentist, or physician who furnishes any dental services that the physician is licensed to perform, unless it is for an X-ray ordered by a dentist
- (V) Dental care for the purpose of altering vertical dimension, restoring occlusion, splinting or replacing tooth structure lost as a result of abrasion, attrition or erosion
- (W) Athletic mouth guards, denture duplication, treatment of fractures, myofunctional therapy or orthognathic surgery
- (X) Multiple surgical and periodontal procedures in the same area (Benefits will be limited to the most extensive and inclusive procedure.)
- (Y) Replacement of an appliance or prosthetic device or a fixed bridge, within five years of the date it was last placed (A temporary denture is considered a permanent prosthetic device after 12 months.

This exclusion will not apply if replacement is needed due to an accidental dental injury received while covered and within 12 months of such accident.)

- (Z) A fixed bridge replacing a partial denture, unless medically necessary
- (AA) General anesthesia and intravenous sedation, unless medically necessary
- (BB) The initial installation of a complete or partial denture or for fixed bridgework if it involves replacing one or more natural teeth missing or lost prior to the date the covered person became covered (This exclusion will not apply if the denture or bridgework includes replacing a natural tooth extracted while covered under this Plan. This exclusion also shall not apply to covered persons who were covered under a previous dental plan of the company, provided that such natural teeth were extracted while covered under the previous plan.)
- (CC) Dental expenses incurred outside the United States of America or its possessions (collectively referred to as "USA") will be excluded, unless required for emergency dental care.
- (DD) Dental care of a congenital or developmental malformation (including congenitally missing teeth)
- (EE) Payment of flat rate charges when procedures, time and/or fees involved are not itemized

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.

Eligibility

To remain eligible for coverage, each Member and Eligible Dependent who was timely enrolled in the Optional Custodial Care Benefit must pay any required monthly contributions.

Eligible Dependents will cease to be eligible for Optional Custodial Care Benefits coverage when they no longer meet the definition of "Eligible Dependent" set forth below.

Benefit Payments

The Plan will pay Optional Custodial Care Benefits of \$50 a day, up to \$54,750 per Plan Participant for any combination of:

- (A) The charges for Room and Board made by Custodial Care Facility when a Plan Participant is confined as a registered bed patient in a Custodial Care Facility as a result of an Injury or Sickness (including pregnancy); or
- (B) The charges for Room and Board made by an Assisted Living Facility when a Plan Participant is confined as a registered bed patient and the patient is unable to perform at least two of the six Activities of Daily Living or the needs for substantial supervision to protect from harm due to a Severe Cognitive Impairment; or
- (C) The charges for Home Care when a Plan Participant is unable to perform at least two of the six Activities of Daily Living or needs substantial supervision to protect from harm due to a Severe Cognitive Impairment.

Optional Custodial Care Benefits begin the first day of covered care up to a combined Lifetime Maximum Payment period of 1,095 days for all types of covered Custodial Care.

Only Custodial Care provided in the United States is covered.

Reinstatement of Optional Custodial Care Benefits Coverage

Plan Participants 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 the 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.

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 the enrollment form is Filed so within such six-month period.

Except as provided above, no individual can enroll or re-enroll in the Optional Custodial Care Benefits portion of the Plan, except for a Furloughed Member and Eligible Dependents who re-enroll in the Plan within six months from return to Actively at Work status. After meeting the requirement for payment under

this section, the Plan will pay the dollar amount in the “Benefit Payments” subsection to the Plan Participant for each day of Confinement while covered under the Plan, up to the Lifetime Maximum.

Definitions

Activities of Daily Living

The term “Activities of Daily Living” means any of the following:

- (A) Bathing: Washing oneself by sponge bath; either in a tub or shower, including the task of getting into or out of the tub or shower.
- (B) Dressing: Putting on or taking off all items of clothing and necessary braces, fasteners or artificial limbs.
- (C) Transferring: Move into or out of a bed, chair or wheelchair.
- (D) Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- (E) Continence: Ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- (F) Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table by a feeding tube or intravenously).

Assisted Living Facility

The term “Assisted Living Facility” means a facility that satisfies all of the following:

- (A) Maintains all appropriate licensing required under the laws of the state or jurisdiction in which it is located to provide Maintenance or Personal Care; and
- (B) Provides 24-hour a day care and services sufficient to assist residents with needs that result from the inability to perform Activities of Daily Living or Severe Cognitive Impairment; and
- (C) Whose residents are not related to the owner or manager of the facility or anyone related to the owner or manager, or any contractor(s) providing services to the facility or their relatives; and
- (D) Has a minimum of six residents; and
- (E) Uses aides trained or certified to provide Maintenance or Personal Care in accordance with any laws applicable to the provision of such care; and
- (F) Provides 24-hour supervision of residents by a trained staff; and
- (G) Has formal arrangements for emergency medical care; and
- (H) Maintains written or electronic records of services provided to each resident; and
- (I) Provides residents with three meals a day or the equivalent; and
- (J) Has appropriate methods and procedures to assist in administering prescribed drugs where allowed by law; and

- (K) Is not used primarily as a hotel, motel, a place for rest, a place for treatment of drug addiction or alcoholism, retirement home, congregate living, senior housing, other facility primarily intended to provide residential services but not Maintenance or Personal Care.

Assisted Living Facility includes any such facility that specializes in the care of persons with Alzheimer's disease and other dementias. If a facility has multiple licenses or purposes, only that section of the facility specifically meeting the definition of Assisted Living Facility will qualify as such.

Confinement

The term "Confinement" means any period for which a Custodial Facility or Assisted Living Facility charges the Plan Participant for Room and Board as a registered bed-patient. Home Care may also qualify for Optional Custodial Care Benefits if the Plan Participant is unable to perform at least two of the six Activities of Daily Living or requires substantial supervision to protect from harm due to a Severe Cognitive Impairment.

Dependent Child(ren)

The term "Dependent Child(ren)" shall mean a Member's unmarried child who is under age 19 years. "Dependent Child(ren)" includes any natural child, adopted child, or stepchild of a Member. An adopted child or stepchild must be principally dependent upon the Member (or Surviving Spouse if Member is deceased) for support and maintenance, and live and reside in the home of the Member (or Surviving Spouse if Member is deceased) in a regular parent-child relationship. There are two exceptions for children who reach the limiting age. The age 19 limit does not apply to an unmarried Dependent Child who is either an Incapacitated Child or a Full-Time Student, as defined below:

(A) Incapacitated Child

Any unmarried Dependent Child of a Member who is mentally or physically disabled and is incapable of self-sustaining employment will be deemed an "Incapacitated Child" and will not be subject to the age 19 limit. Proof of incapacity must be furnished to the Claims Processor within 31 days prior to the date the Dependent Child reaches age 19. After receiving proof of the Dependent Child's incapacity, but not more than once a year, the Claims Processor (on behalf of APA), may require satisfactory proof of continuance of such incapacity due to mental or physical disability, inquire into changes of marital status, and examine the Dependent Child.

This provision will not apply and coverage will terminate upon occurrence of:

- (1) Failure to submit any required proof of incapacity; or
- (2) Failure to permit such an examination; or
- (3). The child ceases to be incapacitated; or
- (4) The child marries.

(B) Full-Time Student

A "Full-Time Student" means a Dependent Child of a Member who satisfies both (1) and (2) below:

- (1) Is enrolled in and regularly attends as a full-time student in an educational institution as defined below:
 - a. A university, or
 - b. A college (including a junior college), or
 - c. A licensed secondary school, or
 - d. An institution for the training of nurses which is accredited by the state where it is located.

and

- (2) Is principally dependent upon the Member (or Surviving Spouse if the Member is deceased) for support and maintenance and has his or her legal residence with the Member (or Surviving Spouse if the Member is deceased).

In such cases, the Full-Time Student Dependent Child's coverage may be continued up to his or her 23rd birthday. Proof of Full-Time Student status will be required at the time a claim is made.

A Dependent Child will not be considered an Eligible Dependent for more than one Member or Employee.

Eligible Dependent

The term “Eligible Dependent” means the Dependent Child or Eligible Spouse of a Member who is a Plan Participant that was properly enrolled in the Optional Custodial Care Benefits coverage prior to July 1, 2001, who still meets the definition of Dependent Child or Eligible Spouse, and for whom the required contributions have been made. A Dependent Child or Eligible Spouse is not an Eligible Dependent while such individual is on active duty in the armed forces of any country.

Eligible Spouse

The term “Eligible Spouse” means any individual who is lawfully married under any state law to a Member who is a Plan Participant or is the Surviving Spouse of a Member who was a Plan Participant immediately prior to his/her death.

Home Care

The term “Home Care” means care given in the residence of the Plan Participant or a relative of the Plan Participant, or an adult day care center by a home health aide, a care management organization, a licensed health care practitioner, a home health care agency or hospice.

Severe Cognitive Impairment

The term “Severe Cognitive Impairment” means the deterioration or loss in intellectual capacity that places a person in jeopardy of harming him or herself or others and, therefore, the person requires substantial supervision by another individual. Deterioration or loss must be measured by clinical evidence and standardized tests that reliably measure impairment in short or long term memory; orientation to people, places or time; and deductive or abstract reasoning,

Custodial Care Benefit Plan Participant Monthly Contributions

	Member Under Age 60	Member Age 60 or Older
Member	\$10.42	\$20.84
Eligible Spouse	\$10.42	\$20.84
Dependent Children	\$ 5.00	\$ 5.00

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

The optional Custodial Care Benefits requires monthly contributions from each Plan Participant. The monthly contributions shall be reviewed each year by the APA Board of Directors. The Board may suspend or change the monthly contributions otherwise set forth above.

CLAIMS PROCESSING PROVISIONS

This section applies to all benefits under the Plan except Prescription Drug Benefits and Vision Care Benefits. A Plan Participant with a claim for Prescription Drug Benefits or Vision Care Benefits must refer to the "Pharmacy Benefit Program" or "Vision Care Benefits" section of the Plan, as applicable, for more information on the required steps for filing a claim for such benefits. Plan Participants are required to complete and comply with all applicable claims filing procedures for Prescription Drug Benefits before they will be eligible to appeal any denial of such benefits in accordance with the "Appeal Process for Denied Claims" described in this section. With respect to Vision Care Benefits, all claims and appeals will be handled under the procedures outlined in the "Vision Care Benefits" section, and no Plan Participant will be eligible to file an appeal under the "Appeal Process for Denied Claims" described in this section.

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 the Plan Participant's 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. 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 12 months from the date the expenses were incurred. Orthodontia claims must be Filed within 12 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 the Plan Participant's 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 12 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.

Attention: Participants in the AA Retiree Medical Plan

You will not be eligible for benefit payments under the SMP until you have exhausted your Lifetime Maximum under the AA Retiree Medical Plan. To determine if you have met your UHC Lifetime Maximum, you will need to request a copy of the UHC audit letter. If you have met your UHC Lifetime Maximum, you must submit a copy of the UHC audit letter to WebTPA.

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) There are separate claims forms for:

- Primary/Secondary Medical Claims
- Tertiary Medical Claims
- Dental/Orthodontia Claims
- Custodial Care Claims

(B) Obtain the appropriate claim forms from the Benefits section of the APA website at www.alliedpilots.org or by calling the Claims Processor, WebTPA, at 800-477-8957.

- (C) Using the instructions located on the top of the claim form, fill out the applicable claim form in its entirety, every section must be completed for payment consideration. All supporting documents requested on the claim form must be submitted along with the claim form.

PLEASE RETAIN A COPY OF ALL SUBMITTED DOCUMENTATION 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 the claimant’s 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.

APA’s intent is for any disputes to be resolved in a manner that allows Plan Participants to obtain the benefits to which they are entitled with as little inconvenience and delay as possible. The Plan provides a claim and appeal procedure, as well as addresses, telephone numbers and other references where additional information and assistance may be obtained.

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 this **CLAIMS PROCESSING PROVISIONS** chapter.

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 the Plan Participant's 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

WebTPA has been appointed the Claims Processor with respect to review of initial claims for benefits and, as such, has the responsibility for completing the claims process and making initial benefit claim determinations, as described below. 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.

WRITTEN NOTICE OF ADVERSE BENEFIT DETERMINATION WITH RESPECT TO INITIAL CLAIM

If a Plan Participant's claim is wholly or partially denied by the Claims Processor, the Plan Participant will be provided with written or electronic notification of the adverse benefit determination, in accordance with applicable Department of Labor regulations. The notice of denial must include:

- (A) The specific reason(s) for such denial.
- (B) Reference to Plan terms and conditions on which the denial was based.
- (C) A description of the Plan's appeal procedures, and the time limits applicable to such procedures.
- (D) If the claim is denied because necessary information was not available to the Claims Processor, the additional material or information that is required in order for the Plan Participant to perfect the Plan Participant's claim, an explanation of why such material or information is necessary, and a statement that such material or information must be provided within 180 days after the Plan Participant receives notice of the adverse benefit determination.
- (E) 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 the Plan Participant's right to the benefit following an adverse benefit determination by the BRAB on appeal.
- (F) If the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of

the Plan to the Plan Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- (G) Either the specific Protocol(s) that the Claims Processor relief upon in making the adverse benefit determination or, alternatively, a statement that such a Protocol does not exist.
- (H) A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Records with respect to the claim.

APPEAL PROCESS FOR DENIED CLAIMS

The following describes the appeal process under this Plan:

- (A) A Plan Participant who has been sent notice of an adverse benefit determination described above will be provided a reasonable opportunity to appeal that determination to the BRAB. The appeal request must be in writing, explain the basis of the Plan Participant's appeal, and be received by the BRAB no more than 180 days after the Plan Participant receives notice of the Claims Processor's adverse benefit determination. Any notice of appeal received by the BRAB after this 180-day period will be null and void. Appeals must be addressed to the BRAB, c/o Director of Benefits, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Fort Worth, TX 76155-2512. Upon receipt of a timely appeal, the BRAB will provide a full and fair review of the Plan Participant's initial claim and adverse benefit determination.
- (B) All Appeal Materials that a Plan Participant wants to have considered by the BRAB as part of the appeal process must also be submitted to the BRAB prior to the end of the 180 day Filing period described above. The BRAB's review of the appeal will take all such Appeal Materials into account, regardless of whether any of the Appeal Materials were submitted or considered in the initial benefit determination. Appeal Materials that are not received by the BRAB prior to the end of the 180-day Filing period will not be considered.
- (C) The BRAB will decide the Plan Participant's appeal based on the information submitted in accordance with paragraphs (A) and (B) above and the Record provided by 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.
- (D) 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 the Plan Participant's claim, regardless of whether the health care professional's advice was relied upon in making the adverse determination.
- (E) The BRAB will advise the Plan Participant of the results of its review, in accordance with paragraph (F) below, within 60 days after it receives the appeal and the timely Filed Appeal Materials, unless it determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the request for review. In order for the time to be extended, the Plan Participant must be provided with notice of the extension within the initial 60 day period. The notice must tell the Plan Participant the nature of the special circumstances and the date by which the BRAB expects to render the decision on review. If the period of time to process the request for review must be extended because of the failure of the Plan Participant or his Physician or medical provider to submit information necessary to provide a full and fair decision on the appeal, the notice will also state that the period for

the BRAB to render the decision will be tolled for up to 90 days 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. Upon exhaustion of this tolling period, the appeal will be reviewed by the BRAB and a determination made on the Appeal Materials submitted.

- (F) When the review of the appeal is completed, the Plan Participant will receive a written decision in accordance with this paragraph (F). If the Plan Participant's appeal has been denied, in whole or in part, the Plan Participant will be provided with a written or electronic notification of the adverse benefit determination, in accordance with applicable Department of Labor regulations. The notice of denial will include:
1. The specific reason(s) for such denial.
 2. Reference to the specific Plan terms and conditions on which the denial was based.
 3. A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Records with respect to the claim and appeal.
 4. A statement that the Plan Participant has the right to bring a civil action under Section 502(a) of ERISA, including a description of the limitations period on bringing such action described below, with the date on which such limitations period will expire for the particular claim involved.
 5. If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
 6. Either the specific Protocol(s) that the Plan relied upon in making the adverse benefit determination on appeal or, alternatively, a statement that such a Protocol does not exist.

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 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 any 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 BRAB's final decision on the Plan Participant's benefit appeal.**

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. References to the Plan Participant in the claim and appeal procedures above are intended to also refer to a Plan Participant's authorized representative, as applicable.

If the Claims Processor or the BRAB determines that there has been a valid assignment of benefits to a medical provider with respect to a claim, benefits that are otherwise payable by the Plan will be paid to the applicable provider, unless the provider consents otherwise in writing. The Plan will only pay benefits once with respect to a particular claim.

VISION CARE BENEFITS

The Plan provides Vision Care Benefits for all Plan Participants. This benefit is provided through an administrative services agreement with Vision Service Plan Insurance Company (“VSP”). Plan Vision Care Benefits are limited only to those provided by that administrative services agreement. The following is a summary of the benefits provided under that agreement. If there is any discrepancy between the benefits described in this section and the benefits provided under the agreement, the terms of the Plan 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”, the summary of **BASIC VSP BENEFITS** section 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** section.

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:

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 procedures outlined below to obtain vision benefits. Claims for vision benefits otherwise payable under the Plan must be filed and completed in accordance with the claim and appeal procedures described in this section of the booklet.

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 Quality 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, the Plan Participant 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.

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.

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 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 Chapter 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, 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, in whole or in part, including without limitation amendments to required contribution levels and adjustments to benefits and termination of the Plan with respect to all or to any group or class of Participants, 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 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, 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 the Plan Participant's role as a Member of APA, regardless of the effect that such action may have upon the individual as a Member of 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, the Plan Participant's 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)** section.)

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 the Plan Participant has previously authorized payment to a provider rendering services, treatments or supplies, or as otherwise provided in the **CLAIMS PROCESSING PROVISIONS** chapter above. 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. If a Plan Participant or other individual entitled to receive benefits under the Plan is determined by the Plan Administrator (or its delegate) to be incompetent, or is adjudged by a court of competent jurisdiction to be legally incapable of giving valid receipt and discharge for benefits provided under the Plan, the Plan may pay such benefits to the duly-appointed guardian or conservator of such person or to any third party who is authorized (as determined by the Plan Administrator or its delegate) to receive any benefit under the Plan for the Plan Participant or such other person entitled to receive Plan benefits. Such payment shall fully discharge all liabilities and obligations of the Plan with respect to payment of Plan benefits.

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. If a Plan Participant or other individual entitled to receive benefits under the Plan is determined by the Plan Administrator (or its delegate) to be incompetent, or is adjudged by a court of competent jurisdiction to be legally incapable of giving valid receipt and discharge for benefits provided under the Plan, the Plan may pay such benefits to the duly-appointed guardian or conservator of such person or to any third party who is authorized (as determined by the Plan Administrator or its delegate) to receive any benefit under the Plan for the Plan Participant or such other person entitled to receive Plan benefits. Such payment shall fully discharge all liabilities and obligations of the Plan with respect to payment of Plan benefits.

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 a Physician, surgeon, and Hospital. The Plan will not interfere with the Physician-patient relationship. Each Plan Participant should independently evaluate the quality of care received by the Plan Participant's medical provider(s) and act accordingly.

COMPLIANCE WITH HIPAA PRIVACY REQUIREMENTS

HIPAA requires, among other things, that group health plans protect the confidentiality and privacy of certain protected health information that personally identifies or reveals the identity of a Plan Participant. A current copy of the Plan's HIPAA Notice of Privacy Practices, which describes how the Plan will comply with these HIPAA requirements, can be obtained at any time by visiting the Benefits section of the APA website at www.alliedpilots.org, emailing hipaa-privacy@alliedpilots.org, or by calling WebTPA at 800-477-8957. The Notice may be updated from time to time.

COMPLIANCE WITH OTHER LAWS

The Plan will comply with all other laws applicable to the Plan or certain benefits offered under the Plan, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and any applicable state laws, as such laws may be amended from time to time.

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 chapters, 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 Member or, if applicable, a Surviving Spouse or Eligible Dependent. Each Plan Participant is responsible for providing APA with current contact information. If a Plan Participant fails to do so, neither APA nor the Plan shall be responsible for any late payment or loss of benefits, or for failure of any notice to be provided or provided timely under the terms of the Plan to a Plan Participant or any other person entitled to receive benefits or notices from the Plan with respect to a deceased Plan Participant.

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. As a result, the Plan may not include certain consumer protections of the Affordable Care Act that apply to many other 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

Diversified Benefits Services (DBS)
PO Box 260 Hartland, WI 53029
800-234-1229
www.dbsbenefits.com

Vision

Vision Service Plan
P. O. Box 997100
Sacramento, CA 95899-7100
800-877-7195
www.vsp.com

Pharmacy Benefit Manager

BeneCard PBF
5040 Ritter Road
Mechanicsburg, PA 17055
888-907-0070
www.benecardpbf.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	ERISA Welfare plan providing group health benefits
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 Medical Claims	WebTPA Employer Services, LLC P.O. Box 1987 Grapevine, TX 76099-1987 800-477-8957 <u>www.WebTPA.com</u>
Pharmacy Benefit Manager for Prescription Drugs	BeneCard PBF 5040 Ritter Road Mechanicsburg, PA 17055 888-907-0070 <u>www.benecardpbf.com</u>

Case Manager	WebTPA Employer Services, LLC P.O. Box 1987 Grapevine, TX 76099-1987 800-477-8957 www.WebTPA.com
COBRA Administrator	Diversified Benefits Services (DBS) PO Box 260 Hartland, WI 53029 800-234-1229 www.dbsbenefits.com
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. 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 Member's customary place of employment or at some location to which that employment required the individual 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.

APA

The term "APA" means the Allied Pilots Association.

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.

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 469-417-1979, 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 Diversified Benefits Services (DBS), PO Box 260, Hartland, WI 53029, 800-234-1229.

Company

The term “Company” means any subsidiary of American Airlines Group, Inc. 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.

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 the individual's 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, Orthodontia Benefits, and Vision Care Benefits are excluded from the annual Deductible. The Deductible is completely described in the **DEDUCTIBLE** section. 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 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 legal obligation ends. A child will not be considered an Eligible Dependent for more than one Member.

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

Any unmarried dependent child of a Member, Surviving Spouse and such Member'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 or Surviving Spouse Plan Participant. A Member or Surviving Spouse is eligible for Dependent Coverage while the Member 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 Participants Eligible Dependent Child or the Eligible Spouse of a Member who is a Plan Participant or Prefunding Participant's. 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. A Dependent Child is not an Eligible Dependent Child while such individual is on active duty in the armed forces of any country.

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** section, "Eligible Orthodontia Expenses" or **RETIREE DENTAL BENEFITS**; and

- (D) not listed in the **EXCLUDED MEDICAL EXPENSES** section or the “Excluded Orthodontia Expenses” subsection of the Supplemental Medical Coverage.

Eligible Member

The term “Eligible Member” means a Member who meets the requirements contained in the “Member Eligibility” subsection.

Eligible Spouse

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

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.

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 or enrollment form is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date the Claims Processor receives the claim or enrollment.

Furlough

The term “Furlough” means the period during which a Member is laid off 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 Envoy Air, 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-privacy@alliedpilots.org.

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 Network Manager, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Fort Worth, TX 76155-2512, 800-323-1470, hipaa-security@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 received 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 BeneCard PBF network of pharmacies. A Plan Participant can find an In-Network pharmacy by calling BeneCard Customer Care at 888-907-0070 or on the BeneCard PBF website at www.benecardpbf.com

Lifetime Maximum or Lifetime

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. The Lifetime Maximum includes the total amount of benefits paid for Orthodontia Treatment by the Plan. Orthodontia Treatment between January 1, 2011 and December 31, 2014 shall not be subject to the \$3,000 Lifetime Maximum until January 1, 2015.

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, are 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. A health care service, supply, treatment or Prescription Drug is considered “Medically Necessary” if it is ordered by a Physician and satisfies one of the tests in paragraph (A) or (B) below:

- (A) Such service, supply, treatment or Prescription Drug is:
 - (1) Recognized by the medical community as safe and effective; and
 - (2) Required for the diagnosis or treatment of the particular Sickness or Injury; and
 - (3) Appropriate and administered in a manner consistent with generally accepted United States medical standards; and
 - (4) Not in the nature of Educational, Experimental, or Investigational; or

- (B) Such service, supply, treatment or Prescription Drug is intended to address a life-threatening or seriously debilitating condition and is provided in a clinically controlled research setting using a Clinical Protocol. The service, supply or treatment must be considered safe and at least as likely to produce equivalent therapeutic results as a service, supply, treatment or Prescription Drug that would be covered under paragraph (A) above, as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications. However, the Plan will not cover the following:
- (1) Non-routine services, supplies, and treatments such as the investigational items, devices, services or drugs being studied as part of the research;
 - (2) Services, supplies and treatments that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or
 - (3) Services, supplies and treatments inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

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 that 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.

A Clinical Protocol means a specific and detailed treatment plan that meets standards equivalent to those defined by the National Institutes of Health for a life-threatening or seriously debilitating condition, to be determined by the Claims Processor in accordance with its standard procedures for making such determinations, as they may be amended from time to time.

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.

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 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 BeneCard PBF Customer Care at 888-907-0070 or on the BeneCard PBF website at www.benecardpbf.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** chapter 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 in the **ORTHODONTIA BENEFITS** chapter.

Orthodontia Treatment

The term “Orthodontia Treatment” means 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.

Other APA-sponsored Plan(s)

The term “Other APA-sponsored Plan(s)” means the APA Pilot Occupational Disability Plan, the APA Survivor Benefit Plan, and/or 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 including without limitation benefits erroneously paid by the Plan based on a mistake of fact or administrative error or as a result of fraud, misrepresentation, or concealment of any relevant fact (as determined by the Plan Administrator in its sole discretion). 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 BeneCard PBF.

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 the Physician's license. Physician includes the following:

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

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
- Doctor of Dietary Medicine (D.D.M.)
- Doctor of Education (Ed.D.)
- Licensed Marriage and Family Therapist (M.F.T.)
- Masseur or Masseuse
- Naturopath
- Physical Culturist
- 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 a Member, or Surviving Spouse, or an Eligible Dependent whose Plan Participation has commenced in accordance with the "Effective Date of Participation" subsection and whose participation has not terminated.

When both husband and wife are Members, 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.

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, standard, 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** chapter).

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 subchapter 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 a Plan Participant that are set out in the **COBRA CONTINUATION OF COVERAGE** chapter herein.

Record

The term “Record” means all documents, records, and other information relevant to a Plan Participant’s claim for benefits.

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 in the **RETIREE DENTAL BENEFITS** chapter.

Retirement

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, or termination of employment at age 65.

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 the 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 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.

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 Benefits provided by the Plan as contained in the **BASIC SUPPLEMENTAL MEDICAL COVERAGE PROVISIONS** chapter 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 if the Spouse was a Plan Participant at the time of the Member’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.

Totally Disabled

The term Totally Disabled means:

- (A) the complete inability of a Plan Participant to perform any and every duty pertaining to any occupation or employment; or
- (B) the complete inability of a Plan Participant’s dependent to perform the normal activities of a person of like age and gender in good health.

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** section.

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 benefit under the Plan that is administered by Vision Service Plan Insurance Company as described in the *VISION CARE BENEFITS* chapter.

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.

Wellness Benefits

The term "Wellness Benefits" refers to Well Child Care, and routine Prostate Specific Antigen (PSA) tests, pap smears, colonoscopy, and mammograms.

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 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 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) **Member.** A Retired Member whose Plan coverage terminates will be eligible to purchase Continuation Coverage if the loss of Plan coverage results from the commencement of proceedings under Chapter 11 of the Bankruptcy Code with respect to APA.
- (B) **Spouse.** The Eligible Spouse of a 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 Member; or
 - (2) A Member's Qualifying Event.
- (C) **Dependent Child.** A Dependent Child of a 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 Member's divorce or legal separation; or
 - (2) The child ceases to qualify as a Dependent Child; or
 - (3) A Member's Qualifying Event.

Duration of Coverage

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

(A) **Member:**

- (1) 18 consecutive months from the date of the Qualifying Event.

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

- (1) If coverage ceases as a result of the 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 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.

- (C) A second Qualifying Event can occur within the first 18 months of Continuation. 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.

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) A 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 or 24 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

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 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.

Cost of Continuation Coverage

APA will charge 102% of the cost of Plan coverage, as calculated by the Plan's actuaries to Members and Eligible Dependents for Continuation Coverage, in accordance with applicable law. In addition, if coverage is being extended due to disability, APA will charge 150% of the cost of Plan coverage, as calculated by the Plan's actuaries otherwise charged to Members and Eligible Dependents for the additional 11 months, also in accordance with applicable law. 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. 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); 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, or 36 months); or
- (F) The date APA no longer provides any group health coverage to any member; or
- (G) If a Qualified Beneficiary was divorced from a covered 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 the Plan Participant 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.

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
- (i) 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)(l)(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 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 D 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 COBRA '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 of commencement of coverage has passed when the order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the order);
- (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

The Plan Participant or Alternate Recipient who wishes to dispute the terms of the QMCSO or NMSN 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.