ALLIED PILOTS ASSOCIATION
PILOT OCCUPATIONAL DISABILITY PLAN

Amended and Restated Effective July 1, 2008

INTRODUCTION

The Allied Pilots Association ("APA") has developed a voluntary plan for its Members that is specifically designed to provide temporary financial assistance to mitigate the hardships experienced during medical disability while enabling a member to recover and return to flying or to transition to another career.

Financial protection during a disability can take many forms. For example, some pilots have another profession to support them that does not require the rigorous physical standards of commercial piloting. Others may have additional financial resources. But for most of us, the loss of our pilot income would be a serious financial blow requiring major changes to our lifestyle and retirement planning.

The Allied Pilots Association Pilot Occupational Disability Plan ("Plan") (formerly known as the Allied Pilots Association Disability Income Plan (Loss of License) was designed to help our pilots through such a period of Disability. This Plan provides monthly benefit payments to Plan Participants who have satisfied all of the conditions for payment under the Plan.

This is your Plan. You must follow the procedures and meet the requirements of the Plan, as contained in this booklet, to obtain Disability payments. You should file a claim immediately for any Disability you incur, regardless of the expected duration of your absence.

The Plan has two major service providers.

HEALTHFIRST
Third Party Administrators

HealthFirst TPA, Inc. ("HealthFirst") is the Plan Processor and administers all aspects of the Plan except claims (i.e., enrollments, monthly contributions, benefit payments, etc.). If you have any questions about these aspects of the administration of the Plan, please contact HealthFirst at the following address and phone number:

HealthFirst TPA, Inc.
821 E.S.E. Loop 323, Suite 200
P.O. Box 130217
Tyler, Texas 75713-0217
(903) 581-2600
(800) 477-8957

Harvey Watt & Co.

Harvey W. Watt & Company ("Harvey Watt") is the Claims Processor and administers Plan claims. If you have questions about filing a claim or about a claim determination, contact Harvey Watt at the following address and phone number:

Harvey W. Watt & Company
Claims Department
P.O. Box 20787
Atlanta Airport
Atlanta, GA 30320
(404) 767-7501
(800) 241-6103

Throughout this booklet any reference to the terms "he" or "him" shall also mean "she" and "her." When the text references another section, every letter in the section that is referenced will be capitalized. When the

text references another subsection, the first letter of each word in the subsection that is referenced will be capitalized and the entire heading will be in quotations. At the end of this booklet you will find a DEFINITIONS section defining terms that have a specific meaning for this Plan. These terms are capitalized throughout this booklet for your information. Please review the DEFINITIONS section to fully understand these terms.

This booklet constitutes the complete and official Plan document and summary Plan description, effective July 1, 2008. It is intended to give you a description of the benefits provided by the Plan, how to file a claim for benefits and your rights under the Plan. **APA reserves the right to amend or terminate this Plan at any time through a resolution approved by the APA Board of Directors; provided, however, that any amendment required by law may 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 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: (i) the date of approval of the resolution by the Board, if no effective date is stated in the resolution, or (ii) the effective date expressly set forth in the resolution, or (iii) for an amendment required by law, the effective date expressly set forth in writing by the APA President.**

SUMMARY OF THE PILOT OCCUPATIONAL DISABILITY PLAN

DISABILITY BENEFITS FOR PLAN PARTICIPANTS	AMOUNT OF COVERAGE[1]
Monthly Benefit Choices	$200 increments from $1,000 to $6,000.
Maximum Benefit	40% of Average Crew Pay, not to exceed 90% of Average Crew Pay when combined with the benefit under the American Airlines, Inc. Pilot Long Term Disability Plan (see page 42).
Duration of Benefits	For Any One Period of Disability, the duration is the period during which the Basic Benefit and the Extended Benefit are paid.
(1) Basic Benefit	The Basic Benefit is paid after completion of the Elimination Period and ends on the earliest of the following events: (a) The Plan Participant has received 60 Monthly Payments; (b) The Plan Participant has received a total of 24 Monthly Payments for a Mental or Nervous Disorder(s) and/or a Limited-Term[2] Disability(ies) (c) The Plan Participant has received a total of 18 Monthly Payments for Chemical Dependency, (d) The Plan Participant is no longer Disabled, retires, returns to Active Flight Status,

[1] The Plan Participant must meet all of the conditions contained under the BENEFIT PAYMENT PROVISIONS section.

[2] Formerly known as “Self-Reported Disability”.

dies or is otherwise disqualified for payment (see the "Termination of Disability Benefit Payments" subsection on pages 17-18 for a complete list), or

(e) The Plan Participant reaches age 60,

(f) The Plan Participant has received the Lifetime Maximum Benefit (see page 47).

(2) Extended Benefit:

The Extended Benefit is payable only if the Plan Participant qualifies for Social Security Disability Benefits prior to the last payment of Basic Benefits and meets the other requirements listed in "Extended Benefit" on page 14. The Extended Benefit begins immediately following the Basic Benefit in 1(a) or 1(b) above and ends upon the earliest of the:

(a) exhaustion of the Lifetime Maximum Benefit (see page 47); or

(b) date the Plan Participant loses qualification or can no longer provide evidence that he continues to qualify for Social Security Disability Benefits; or

(c) the earlier of the dates described in (d) and (e) under Basic Benefit above.

Lifetime Maximum Benefit:

The equivalent of 96 Monthly Payments. All Disability payments made on or after July 1, 2008 are applied to this limit.

Elimination Period

The Elimination Period for benefits other than for Recurrent Disability[3] ends on the latest of:

(a) The date of exhaustion of paid sick and vacation time from the Company, or

(b) For claims Filed within six months of the Onset of Disability, the first day of the month coincident with or next following 14 months from the Onset of Disability, or

(c) For claims Filed more than six months following the Onset of Disability, one year from date Filed.

[3] See the definition of Recurrent Disability and Recurrent Disability Filing Deadline.

MONTHLY PLAN PARTICIPANT CONTRIBUTIONS

Contributions are based on the Plan Participant's attained age and selected benefit amount. The age category is determined by the Plan Participant's attained age on January 1 of each year. The chart below shows the contribution rates per $100 of monthly benefit.

Attained Age	POD Monthly Rate per $100 of Benefit	Attained Age	POD Monthly Rate per $100 of Benefit
35 & Under	$0.82	48	$3.36
36	0.94	49	3.75
37	1.06	50	4.15
38	1.13	51	4.55
39	1.21	52	4.82
40	1.28	53	5.17
41	1.37	54	5.37
42	1.45	55	4.97
43	1.73	56	4.30
44	2.02	57	3.29
45	2.33	58	2.77
46	2.65	59	2.25
47	2.98		

The Plan Participant's monthly contribution is determined by dividing his monthly benefit amount by 100 and multiplying the result by the rate from the chart. The following example shows how to calculate the monthly contribution, assuming that the Plan Participant is age 48 and has selected the $5,000 monthly benefit amount.

Amount of Monthly Benefit selected divided by 100	50 ($5,000 ÷ 100)
Monthly Rate per $100 of Benefit:	$3.36
Monthly contribution	$168.00 ($3.36 x 50)

ELIGIBILITY AND COVERAGE PROVISIONS

Eligibility

A Member is eligible to join and participate in the Plan if the Member meets the following conditions on the date that HealthFirst receives his completed application and on his Effective Date of coverage:

(A) He is a Member in good standing as defined in the APA Constitution and Bylaws; and

(B) He is on Active Flight Status with the Company; and

(C) He holds a 1st or 2nd class FAA medical certificate, and

(D) His coverage in any APA-sponsored plan has not been terminated due to an overpayment.

Enrollment or Re-enrollment

An Eligible Member may begin the Plan's enrollment process at any time by completing an Enrollment/Change Form, including Evidence of Good Health, if required, and forwarding it to HealthFirst. An Eligible Member whose coverage terminated for any reason under the "Termination Of Coverage" subsection, except those in paragraphs G through I, may begin the Plan's re-enrollment process at any time by completing an Enrollment/Change Form, including Evidence of Good Health, if required, and forwarding it to HealthFirst.

Evidence of Good Health Requirement

An Eligible Member who enrolls or re-enrolls in the Plan must provide Evidence of Good Health if the Eligible Member has completed more than five years of Active Service as of the date HealthFirst receives his application for enrollment or re-enrollment. No Evidence of Good Health is required for changing benefit amounts.

Effective Date Of Coverage

An Eligible Member who enrolls or re-enrolls becomes a Plan Participant on the first day of a month. If HealthFirst receives his completed application, including Evidence of Good Health, if required, on the first day of a month, coverage is in effect on that day; if HealthFirst receives his completed application, including Evidence of Good Health, if required, on any other day of the month, coverage is effective on the first day of the next month.

If a Plan Participant changes his monthly benefit amount, such change will become effective on the first day of a month. If HealthFirst receives his completed application to change his benefit amount on the first day

of a month, the new benefit amount is effective on that day; however, if HealthFirst receives his completed application to change his benefit amount on any other day of the month, the new benefit amount is effective on the first day of the next month.

Please note that neither coverage under the Plan nor coverage for a new benefit amount, as applicable, will become effective unless:

1. the Plan Participant is an Eligible Member on the date that the benefit amount is to become effective, and
2. required contributions are made, and
3. the Eligible Member has provided satisfactory Evidence of Good Health, if required.

Termination Of Coverage

The coverage of any Plan Participant, including a Plan Participant who is receiving benefit payments, shall automatically cease at midnight on the earliest of the following:

(A) The date the Member's membership with APA is terminated (except for Grandfathered Executive Members); or

(B) The date the Member's employment as a pilot with the Company ceases, unless the pilot is on an unpaid sick leave or receiving disability benefits from the Company; or

(C) The first day of the month in which a Member is Furloughed from the Company; or

(D) 90 days after the Member takes a voluntary leave of absence from the Company; or

(E) The date the Member's pilot certification is suspended or revoked for non-medical reasons (for example, loss of ATP license); or

(F) The last day for which a required contribution has been paid; or

(G) 30 days following the date on the certified letter that APA sends a Plan Participant notifying him of an overpaid PMA or Plan benefit, if the Plan Participant has failed, within 30 days of the date on such certified letter, to repay the overpayment or enter into a Reimbursement Agreement; or

(H) The end of the month following the month a reimbursement payment is not paid within 30 days of the date due to either PMA or the Plan under a Reimbursement Agreement, unless the Plan Participant can show, to the satisfaction of, and in the sole discretion of, the BRAB, that failure to submit such reimbursement payment was not within his reasonable control; or

(I) The last day before the Member's 60th birthday, unless the Member is Disabled; or

(J) The date the Plan is terminated.

CONTRIBUTIONS

Plan coverage is voluntary and, except as provided under the "Waiver of Required Contribution" subsection below, requires contributions from each Plan Participant. Contribution amounts are shown in the SUMMARY OF THE PILOT OCCUPATIONAL DISABIILTY PLAN section on page 4 and are based on the Plan Participant's attained age as of January 1 of each calendar year and on the monthly benefit amount selected. Contributions must be made monthly.

Contributions During Elimination Period

A Plan Participant is required to continue contributions during the Elimination Period, except when waived as stated below in the "Waiver of Required Contributions" subsection.

Waiver Of Required Contribution

No Contributions are required during the following periods:

(A) Any period for which a Disabled Plan Participant is entitled to receive a Disability benefit payment; or

(B) Any period for which a contribution holiday is approved by the APA Board of Directors, or

(C) The period of time between the final payment of Basic Benefit and the approval for Social Security Disability Benefits, provided that the Plan Participant qualifies for Extended Benefits for that period. A Disabled Plan Participant who is not approved for Social Security Disability Benefits who wishes to remain in the Plan shall have the option to do so if he pays contributions back to the date that his Basic Benefit ended.

BENEFIT AMOUNT

Selecting A Benefit Amount

The Plan provides monthly benefit amounts in $200 increments from $1,000 to $6,000. Each Plan Participant must select a monthly benefit amount that is within this range by filing a completed Enrollment/Change Form with HealthFirst. The monthly benefit amount cannot exceed 40% of a pilot's current monthly Crew Pay. When selecting a benefit amount, please note the additional restrictions in the "Basic Benefit" subsection below.

Changing Benefit Amounts

A Plan Participant who is on Active Flight Status may select a higher monthly benefit amount once every 12 months, provided such higher benefit amount does not exceed 40% of current monthly Crew Pay. Such higher amount will be subject to all Plan provisions, including the Pre-Existing Condition exclusion for the increased amount. Any Disability for which the Onset of Disability is within six months following the Effective Date of an increase in the monthly benefit amount will be paid the amount in effect six months prior to the Onset of Disability, unless the Disability is due to either an Injury that occurs after the Effective Date of the increase or a Pre-Existing Condition. **A Plan Participant may not increase his monthly benefit amount by more than $1,000 in any 12-month period**. Each Plan Participant must select a monthly benefit amount that is within this limit by filing a completed Enrollment/Change Form with HealthFirst.

For example: John increases his monthly benefit amount from $3,000 to $4,000 effective March 1, 2009. On July 15, 2009 John calls in sick due to chest pains. Medical tests indicate that he must have bypass surgery. He files a claim for Disability. Because John's Onset of Disability (July 15, 2009) is within six months of March 1, 2009 (the Effective Date of his increase to $4,000) and his Disability is not due to an Injury, he will receive a monthly benefit of $3,000, which was the amount in effect immediately prior to his increase to $4,000. If John's Disability had been due to an Injury, then he would have received a monthly benefit of $4,000.

A Plan Participant may select a lower monthly benefit amount at any time prior to the Onset of Disability and the lower amount will be effective on the first day of a month. If HealthFirst receives his Enrollment/Change Form on the first day of a month, the lower amount is effective on that

day. However, if HealthFirst receives his Enrollment/Change Form on any other day of the month, the lower amount is effective on the first day of the next month.

Under this Plan, a Plan Participant may qualify for a Basic Benefit. That Plan Participant may also qualify for an Extended Benefit if he fulfills the requirements for the Extended Benefit.

Basic Benefit

The Basic Benefit is the first benefit that is payable for Any One Period of Disability. The Basic Benefit can be paid for up to 60 Monthly Payments (24 months for Limited-Term Disability or Mental and Nervous Disorders or 18 months for Chemical Dependency, as applicable). The amount of the Basic Benefit is the monthly benefit amount selected by the Plan Participant, up to the Maximum Benefit, which was in effect on the date of the Plan Participant's Onset of Disability. If the Plan Participant has selected a monthly benefit amount that is higher than the Maximum Benefit, the Disabled Plan Participant will receive the Maximum Benefit.

To show how the Maximum Benefit is determined, let's look at two pilots. For the first pilot, let's assume that First Officer Ana's Average Crew Pay is $8,000 and that she selected the $3,000 monthly benefit amount. For the second pilot, let's assume that Captain Bill's Average Crew Pay for the 12-month period immediately prior to his Onset of Disability is $15,000 and that he selected the $5,000 monthly benefit amount.

	FO ANA	CA Bill
Average Crew Pay	**$8,000**	**$15,000**
Step I – Determine 40% and 90% of Average Crew Pay		
1. 40% of Average Crew Pay	$3,200	$ 6,000
2. 90% of Average Crew Pay	$7,200	$13,500
Step II – Determine the Maximum Benefit		
3. Company disability benefit (55% of average monthly compensation up to $6,000)	$4,400	$ 6,000
4. Maximum Benefit (2) - (3), up to $6,000	$2,800	$ 6,000
Average Crew Pay	**$8,000**	**$15,000**
Step III – Determine the benefit payable: (lesser of Maximum Benefit or monthly benefit amount selected)		
5. Maximum Benefit	$2,800	$6,000
6. Monthly benefit amount selected	$3,000	$5,000
Monthly Benefit payable	**$2,800**	**$5,000**

Extended Benefit

The Extended Benefit is the benefit that is payable following the final payment of the Basic Benefit, except that Disabilities due to Chemical Dependency are not eligible for the Extended Benefit.

To be eligible for the Extended Benefit, a Disabled Plan Participant must apply for Social Security Disability Benefits and provide to Harvey Watt a copy of the Social Security Disability Benefits application prior to the end of the period for which the Basic Benefit is payable. Upon approval for Social Security Disability Benefits, the Disabled Plan Participant must provide the following to Harvey Watt:

(A) Proof that Social Security Disability Benefits are effective on or before the end of the period for which the:

1. Basic Benefit is payable, or
2. 24-month lifetime payment maximum for Mental or Nervous Disorders or Limited-Term Disabilities is payable; and

(B) A copy of the award showing the amount of the monthly Social Security Disability Benefit.

Otherwise, Extended Benefits will not be paid, even if the Plan Participant later qualifies for Social Security Disability Benefits, and even if that later qualification is retroactive to the period for which the Basic Benefit was payable.

To continue to receive Extended Benefits, the Plan Participant must meet the Plan's requirements for payment of Disability benefits that include continued Proof of Disability, as well as continued proof that the Disabled Plan Participant qualifies for Social Security Disability Benefits.

The monthly amount of the Extended Benefit is the greater of:

(A) The Basic Benefit minus 50% of the Plan Participant's Social Security Disability Benefit at the time the Extended Benefit payments begin; or

(B) 50% of the Disabled Plan Participant's Basic Benefit.

The following shows the calculation of the Extended Benefit assuming Captain Claudette has a Basic Benefit of $3,800 per month and has received notification from the Social Security Administration that she has been approved for Social Security Disability Benefit payments of $3,500 per month commencing prior to the exhaustion of her Basic Benefits. After exhausting her Basic Benefit from the Plan, Captain Claudette still qualifies for Social Security Disability Benefit payments of $3,500 per month:

Step I – Determine Basic Benefit minus 50% of Social Security Disability Benefit	**CA Claudette**
1. Basic Benefit (including limitation for Maximum Benefit)	$ 3,800
2. 50% of monthly Social Security Disability Benefit ($3,500 ÷ 2)	$ 1,750
3. Basic Benefit less 50% of monthly Social Security Disability Benefit ($3,800 -$1,750)	$ 2,050
Step II – Determine 50% of Basic Benefit	
4. 50% of Basic Benefit ($3,800 ÷ 2)	$ 1,900
Extended Benefit (Greater of 3 or 4)	**$ 2,050**

BENEFIT PAYMENT PROVISIONS

When Benefits Are Payable

After completing the Elimination Period, a Plan Participant who is Disabled will receive a Basic Benefit and, if eligible, an Extended Benefit, provided that he meets all of the following conditions for payment:

(A) The Plan Participant becomes Disabled while his coverage is in force; and

(B) The Plan Participant's coverage is in force on the date that he is removed from Active Flight Status; and

(C) The Plan Participant completes the Elimination Period (for a Recurrent Disability, this includes any portion of the Elimination Period that was not satisfied prior to the date the Plan Participant returned to Active Flight Status, plus any additional paid sick or vacation time from the Company that was credited from the date the Plan Participant returned to Active Flight Status to the date that the Plan Participant was Disabled due to the Recurrent Disability); and

(D) Except as provided under the "Contributions During Elimination Period" subsection on page 11, the Plan Participant continues to make the required contributions until the monthly benefit is payable; and

(E) The Plan Participant places himself under the care of a Physician appropriate for the Disability as soon as possible and follows a Recommended Therapeutic Program, if one has been established; and

(F) The Plan Participant makes every reasonable effort to return to Active Flight Status (including presenting his case, if necessary, to the principal medical officer or other appropriate medical official of the FAA or its legal successor, when appropriate, after he has complied with any Recommended Therapeutic Program); and

(G) The Plan Participant provides Proof of Disability (see page 50) to Harvey Watt, any necessary forms for the release of medical information, and the names and addresses of any Physicians or medical facilities providing treatment or diagnosis, within a reasonable time of the request but in no event more than 45 days after the date on Harvey Watt's request for such information; and

(H) The Disability is not excluded from coverage (see the "General Exclusions" subsection on pages 18 and 19) or subject to the Limitations and Restrictions on pages 19-22.

Payment Period
Disability benefits during Any One Period of Disability shall be payable from the day following the completion of the Elimination Period. Benefit payments for Recurrent Disability claims Filed after the Recurrent Disability Filing Deadline will be made only for the period that begins on the date the claim was received by Harvey Watt. Payments shall be made on the last business day of each calendar month. The first and last payments may be prorated and, if so, will be based on a 30-day month for the portion of the month that the Disabled Plan Participant is eligible for payment. In determining the maximum period of payment for Basic Benefits, Extended Benefits, and Lifetime Maximum Benefit, pro-rated months shall be cumulative.

For example, First Officer Danny completes his Elimination Period on July 6 and qualifies for a monthly Disability benefit of $4,000. His first payment would be made on the last business day in July in the amount of $3,333.33 ($4,000 x 25/30). Assuming that he continued to be Disabled for the full 60-month period, his last payment would be $666.67.

Termination of Disability Benefit Payments
Disability benefit payments shall cease on the date that is the earliest of the following occurrences:

(A) The date the Plan Participant:
1. returns to Active Flight Status, or
2. retires as a pilot from the Company, or
3. terminates employment with the Company (except for TAG; see Paragraph (J) in the "Limitations and Restrictions" subsection on page 21), or
4. attains age 60, or
5. is Furloughed, or
6. disappears, or
7. dies; or

(B) The date the Plan Participant recovers from Disability or the date the Disability can no longer be verified. Lack of verification includes:
1. failure to provide Proof of Disability, or
2. failure to undergo independent medical examinations, if requested by Harvey Watt, or
3. failure to follow Recommended Therapeutic Programs, if established, or
4. failure to submit to any tests required by the FAA to obtain a first or second class FAA medical certificate; or

(C) date the Disabled Plan Participant receives 60 Basic Benefit Monthly Payments for Any One Period of Disability, unless the Disabled Plan Participant qualifies for Extended Benefit payments; or

(D) The date the Disabled Plan Participant receives 96 Monthly Payments; or

(E) The date the Plan Participant's coverage terminates (see "Termination of Coverage" subsection on pages 9 and 10); or

(F) The date the Disabled Plan Participant has received the maximum number of Monthly Payments provided in Paragraph (A) of the "Limitations and Restrictions" subsection on page 19; or

(G) The date the Disabled Plan Participant has received the maximum number of Monthly Payments provided in paragraph (B) of the "Limitations and Restrictions" subsection on page 19, unless the Plan Participant qualifies for Extended Benefits; or

(H) The date the Plan Participant fails to meet any of the conditions for payment contained in the "When Benefits Are Payable" subsection on page 16.

Disability payments for a Plan Participant whose Disability recurs during Any One Period of Disability shall resume on the day after the date of exhaustion of paid time from the Company.

General Exclusions
The Plan does <u>not</u> provide benefits for:

(A) any Disability due to or arising out of the Plan Participant's intentionally self-inflicted sickness or injury. A self-inflicted sickness includes any sickness caused by or related to an overdose of drugs, taking of poisons, inhaling of noxious fumes or gases or similar activity, if intentional; or

(B) any Disability due to or arising out of the Plan Participant's commission of a violent crime; or

(C) any Disability where the Plan Participant has made a material omission or misstatement of information directly concerning a Disability; or

(D) any Disability where the Plan Participant has made a misstatement or material omission in order to obtain a first or second class medical certificate from the FAA; or

(E) any Disability due to or arising out of a Pre-Existing Condition occurring within the first 12 or 24 months, as applicable, of the

Effective Date of coverage (see Enrollment or Re-enrollment on page 8). This Pre-Existing Condition exclusion will not apply to a Plan Participant who has remained on Active Flight Status during the entire period of time in subparagraphs 1 or 2 below:

1. A period of 12 consecutive months from the Effective Date of coverage, if the Plan Participant has remained treatment-free for the Pre-Existing Condition, or
2. A period of 24 consecutive months from the Effective Date of coverage, regardless of treatment for the Pre-Existing Condition; or

(F) any Disability due to or arising out of a Disability incurred while the Plan Participant is not on Active Flight Status, unless the Plan Participant is on paid or unpaid sick leave from the Company or Disabled under the Plan; or

(G) any Disability for which the Onset of Disability is within six months following the Effective Date of coverage, unless the Disability is due to an Injury that occurs after the Effective Date of coverage; or

(H) any Disability for which the Plan Participant fails to satisfy any of the conditions for payment in the "When Benefits Are Payable" subsection on page 16.

Limitations And Restrictions

The following are the limitations and restrictions on Plan benefits:

(A) Benefits for any or all Disabilities caused by or related to Chemical Dependency will be limited to the lesser of 18 Monthly Payments per lifetime or the Lifetime Maximum Benefit. The 18 Monthly Payments may be either consecutive or non-consecutive.

(B) Benefits for any or all Disabilities caused by a Mental or Nervous Disorder or that are determined to be a Limited-Term Disability will be limited to the lesser of a combined lifetime maximum of 24 Monthly Payments or the Lifetime Maximum Benefit. The 24 Monthly Payments may be either consecutive or non-consecutive.

(C) The lifetime maximum of 24 Monthly Payments described in paragraph (B) does not apply, and the Disabled Plan Participant will be eligible to receive continued Monthly Payments up to the Lifetime Maximum, if the Plan Participant is Confined to a Hospital for a Mental or Nervous Disorder or for a Limited-Term Disability on the last day for which the 24th Monthly Payment is made. Monthly payments will continue for the duration of the Confinement, up to the Lifetime Maximum Benefit.

(D) The lifetime maximum of 24 Monthly Payments described in paragraph (B) does not apply and the Disabled Plan Participant will be eligible to receive continued benefit payments if the Disabled Plan Participant qualifies for Extended Benefits. If the Disabled Plan Participant otherwise remains eligible for Extended Benefits, Monthly Payments will continue for the lesser of:

1. Up to 96 Monthly Payments for the Disability; or
2. The remaining number of Monthly Payments, up to the Lifetime Maximum Benefit.

(E) If a Disability is deemed to be a Limited-Term Disability and such Disability is later determined **NOT** to be a Limited-Term Disability, the Disabled Plan Participant will be eligible, provided he otherwise remains eligible for Disability benefit payments, for benefit payments to continue for the lesser of:

1. Up to 60 Monthly Payments of the Basic Benefit and, if qualified, up to 36 Monthly Payments of the Extended Benefit; or
2. The remaining number of Monthly Payments, up to the Lifetime Maximum Benefit.

For example, Captain Erika files for Disability due to chronic, severe fatigue for which her doctors are unable to find a cause. Although Captain Erika continues to follow her doctor's orders, her condition continues to worsen. During a routine follow-up, Captain Erika's doctor determines that she has Parkinson's disease and that her chronic fatigue was a symptom of this disease. At this point, and based on the medical verification of Parkinson's disease, Captain Erika would be eligible to receive the balance of the 60 Basic Benefit Monthly Payments up to the Lifetime Maximum Benefit, provided she otherwise meets the requirements for payment of benefits.

(F) Disability benefits may be terminated or suspended if a Disabled Plan Participant fails to provide satisfactory Proof of Disability or any other information requested by Harvey Watt which is reasonably necessary to determine the Disabled Plan Participant's eligibility for Disability benefits under the Plan.

(G) A Plan Participant may not choose a monthly benefit amount that exceeds the Maximum Benefit (see page 48).

(H) Plan benefit payments are limited to the Plan's assets under the Master Trust.

(I) The monthly benefit amount for a Plan Participant who increases his amount and subsequently becomes Disabled as the result of a non-Injury Disability shall be limited to the monthly benefit amount in effect six months prior to the Onset of Disability; provided, however, that the benefit may also be excluded from coverage as a result of a Pre-Existing Condition.

For example, First Officer (FO) Fred enrolls in the Plan on January 1, 2009 at a monthly benefit amount of $3,600. On January 1, 2010, FO Fred increases his coverage to $4,400. On May 15, 2010, FO Fred has sinus surgery and subsequently files a Disability claim for his sinus condition. Because his increase to the $4,400 monthly benefit amount had not been in effect for six months, his monthly benefit amount would be based on $3,600 (assuming that his sinus condition was not already a Pre-Existing Condition). (Note also that if medical records reveal that FO Fred had treatment for his sinus condition during the 12 months immediate prior to his Effective Date of coverage for $3,600, then the condition would be a Pre-Existing Condition and his Disability would not be covered unless he had met the requirements waiving the application of the Pre-Existing Condition (see Paragraph (E) under the "General Exclusions" subsection on pages 18-19).

(J) Notwithstanding any other provision, a Plan Participant who qualifies for Disability benefits not due to a Mental or Nervous Disorder or a Limited-Term Disability, but whose employment has been terminated by the Company and is the subject of a pending grievance for that termination (sometimes referred to as TAG status), shall continue to participate, including qualifying for continued Monthly Payments, as long as he otherwise remains eligible, pending a final decision on that grievance. If the termination is subsequently upheld, then all Plan benefits shall cease at that time and no repayment shall be required. If that termination is overturned, Monthly Payments shall continue for as long as such Plan Participant remains otherwise eligible to receive benefits.

(K) A Plan Participant who goes on military leave of absence ("MLOA") shall have the option to remain in the Plan for the duration of his leave, provided that he continues to make monthly contributions. Any Disability incurred during the military leave will not be eligible for benefits unless he returns to Active Flight Status or completes Company training. A Plan Participant who is unable to return to Active Flight Status due to a Sickness or Injury will receive a refund of all contributions paid during such MLOA. A Plan Participant who decides not to return to Active Flight Status or decides not to complete Company training will not be eligible for a refund of contributions.

(L) A Disabled Plan Participant who is Disabled due to a Chemical Dependency, a Mental or Nervous Disorder, or a Limited-Term Disability and is or becomes Disabled due to another condition that occurs during Any One Period of Disability shall continue to have the Monthly Payments count toward the Chemical Dependency, Mental or Nervous Disorder, or Limited-Term Disability maximum number of Monthly Payments until the month in which the Disabled Plan Participant provides Proof showing that his Disability is no longer due to a Chemical Dependency, Mental or Nervous Disorder, or Limited-Term Disability.

Grandfather Provisions

The following provisions shall apply to Plan Participants who were receiving Disability benefits or had Filed a claim for benefits, prior to July 1, 2008:

(A) Plan payments shall be limited to the lesser of:

1. 60 Monthly Payments on or after July 1, 2008, unless the Plan Participant qualifies for Social Security Disability Benefits; or
2. The balance of the lifetime maximum of 24 Monthly Payments for Limited-Term Disabilities and/or Mental or Nervous Disabilities, unless the Plan Participant qualifies for Social Security Disability benefits; or
3. The balance of the 18 Monthly Payments for Chemical Dependency; or
4. The balance of the 96 Monthly Payments for the Disability.

(B) Plan payments shall be reduced for the Social Security Disability Benefit as follows:

1. For Disabled Plan Participants to whom paragraph (A)(1) applies, any payments made after 60 Monthly Payments shall be in an amount equal to the greater of the following:

(a) The amount the Disabled Plan Participant was receiving immediately prior to the exhaustion of 60 Monthly Payments minus 50% of such Participant's Social Security Disability Benefit that was in effect immediately prior to the exhaustion of 60 Monthly Payments; or

(b) Fifty percent (50%) of the amount the Disabled Plan Participant was receiving under the Plan immediately prior to the exhaustion of 60 Monthly Payments.

2. For Disabled Plan Participants to whom paragraph (A)(2) applies, any payments made on or after the later of either July 1, 2010 or the exhaustion of the 24 month payment period, shall be in an amount equal to the greater of the following:

(a) The amount of the Disabled Plan Participant's last full Monthly Payment from the Plan minus 50% of such Participant's Social Security Disability Benefit that was in effect when such last full Monthly Payment was made; or

(b) Fifty percent (50%) of the amount the Disabled Plan Participant received from the Plan as his last full Monthly Payment from the Plan immediately prior to the exhaustion of 24 Monthly Payments.

(C) All payments made on or after July 1, 2008 shall be applied to the Lifetime Maximum Benefit.

The following charts provide examples of claims that fall under the Grandfather Provision. Each of these examples assumes the Disabled Plan Participant continues to otherwise remain eligible for payment under the Plan.

Nature & Duration of Disability	Number of Monthly Payments Received Prior to July 1, 2008	Number of Monthly Payments Available as of July 1, 2008 Under Paragraph (A)	If Social Security Disabled, Number of Monthly Payments NOT OFFSET under Paragraph (B) above	If Social Security Disabled, Number of Monthly Payments OFFSET under Paragraph (B) above
Example 1: Mental or Nervous Disorder and/or Limited-Term Disability	22 of 24	2	22	50
Example 2: Mental or Nervous Disorder and/or Limited-Term Disability - Social Security Disabled	32 of 24	0	24	40

Example 1 shows a Plan Participant who has not yet received the lifetime maximum of 24 Mental or Nervous Disorder and/or Limited-Term Disability payments as of July 1, 2008, and is therefore eligible for 2 additional Monthly Payments before reaching the lifetime maximum of 24 Monthly Payments. If the Plan Participant qualifies for Social Security Disability Benefits, the Plan Participant will receive up to 72 more Monthly Payments; 22 months of these Monthly Payments will not be offset under paragraph (B) above, and the remaining 50 Monthly Payments will be offset under paragraph (B) above, for a potential lifetime total of 96 Monthly Payments (22 pre-July 1, 2008, plus 24 non-offset post-July 1, 2008, plus 50 offset post-July 1, 2010 payments = 96 Monthly Payments).

Example 2 shows a Plan Participant who is receiving Social Security Disability Benefits as of July 1, 2008 and has received 32 Monthly Payments of Plan benefits prior to July 1, 2008. Under the Grandfather

Provisions, this Plan Participant will also receive up to 24 more Monthly Payments after July 1, 2008 with no offset under paragraph (B) above and 40 Monthly Payments that are offset under paragraph (B) above. In this case, the Disabled Plan Participant will receive 96 Monthly Payments of which 56 Monthly Payments are not offset and 40 Monthly Payments are offset as provided under paragraph (B).

Nature & Duration of Disability	**Number of Monthly Payments Received Prior to July 1, 2008**	**Number of Monthly Payments Available as of July 1, 2008 Under Paragraph (A)**	**If Social Security Disabled, Number of Monthly Payments NOT OFFSET under Paragraph (B) above**	**If Social Security Disabled, Number of Monthly Payments OFFSET under Paragraph (B) above**
Example 3: Mental or Nervous Disorder and/or Limited-Term Disability – Pending	0	24	0	72

In **Example 3**, the claim was Filed before July 1, 2008 but no benefit payments were made before July 1, 2008. The Plan Participant may therefore receive up to 24 Monthly Payments after July 1, 2008 which are not offset under paragraph (B) above and up to 72 Monthly Payments that are offset under paragraph (B) above, for a total of up to 96 Monthly Payments.

Nature & Duration of Disability	**Number of Monthly Payments Received Prior to July 1, 2008**	**Number of Monthly Payments Available as of July 1, 2008 Under Paragraph (A)**	**If Social Security Disabled, Number of Monthly Payments NOT OFFSET under Paragraph (B) above**	**If Social Security Disabled, Number of Monthly Payments OFFSET under Paragraph (B) above**
Example 4: Non Mental or Nervous and/or Limited-Term	28 of 96	60	0	8
Example 5: Non Mental or Nervous and/or Limited-Term	54 of 96	42	0	0

In **Examples 4,** the Plan Participant has already received, prior to July 1, 2008, 28 of a possible lifetime maximum 96 Monthly Payments. That Plan Participant is entitled to a possible 60 additional Monthly Payments (the maximum period of non-offset benefits allowed under paragraph (B) above) and 8 additional Monthly Payments that are offset under paragraph (B) above, for a lifetime maximum of 96 Monthly Payments.

In **Example 5**, the Plan Participant has already received 54 Monthly Payments before July 1, 2008 leaving 42 possible Monthly Payments before he reaches the maximum of 96 Monthly Payments for that Disability. Because this Plan Participant will not receive more than 60 Monthly Payments under paragraph A after July 1, 2008, none of the payments made after July 1, 2008 are subject to the offset in paragraph (B) above.

Nature & Duration of Disability	Number of Monthly Payments Received Prior to July 1, 2008	Number of Monthly Payments Available as of July 1, 2008 Under Paragraph (A)	If Social Security Disabled, Number of Monthly Payments NOT OFFSET under Paragraph (B) above	If Social Security Disabled, Number of Monthly Payments OFFSET under Paragraph (B) above
Example 6: Non Mental or Nervous Disorder and/or Limited Term Disability - Pending	0	60	0	36

In **Example 6**, the Plan Participant's claim was filed before July 1, 2008 but no payments were made before July 1, 2008. Therefore, the Plan Participant can receive up to 60 Monthly Payments under paragraph A above with no offset under paragraph (B) above, plus up to 36 Monthly Payments that are offset under paragraph (B) above, for lifetime maximum of up to 96 Monthly Payments.

CLAIMS PROCESSING PROVISIONS

Claims Filing

Plan Participants are required to file a completed claim form when applying for benefits. Failure to provide complete and accurate information on the claim form may unnecessarily delay claim processing.

Time Limit For Filing A Claim

A Plan Participant must file written proof of a claim with Harvey Watt. A Plan Participant should file a claim as soon as possible because delayed filing can lead to a delay in the start of benefit payments or a denial of benefit payments. The following time limits apply to all claims unless the Plan Participant can show that it was not within his reasonable control to file the claim and that he Filed the claim as soon as was reasonably possible.

(A) Claims Filed within six months of the Onset of Disability will be payable on the later of: (1) the first day of the month coincident with or next following the day that is 14 months after the Onset of Disability; or (2) the day following the exhaustion of paid sick and vacation time from the Company.

Example 1: Onset of Disability is February 15, 2009 and the Plan Participant has no paid sick and vacation time from the Company. The Plan Participant Files his claim on April 15, 2009. Since May 1, 2010 is the first day of the month that is 14 months after his Onset of Disability, if eligible for benefits, he will receive a payment on the last business day of May 2010 for the month of May 2010.

Example 2: Onset of Disability is February 15, 2009 and the Plan Participant has 800 hours of paid sick and vacation time from the Company. The Plan Participant Files his claim on April 15, 2009. Assuming that the Plan Participant exhausts his sick and vacation time on August 20, 2010 he will receive his first payment from the Plan on the last business day of August 2010 for the period August 21 - 31, 2010 because the date he exhausted his sick and vacation time was later than 14 months after his Onset of Disability.

(B) Claims Filed more than six months after the Onset of Disability will be payable on the day after the later of: (1) 12 months from the date Filed; or (2) the exhaustion of paid sick and vacation time from the Company.

Example 3: Onset of Disability is February 15, 2009 and the Plan Participant has no paid sick and vacation time from the Company. The Plan Participant Files his claim on January 15, 2010, more than six months after the Onset of Disability. If eligible for benefits, he will receive a payment on the last business day of January 2011, 12 months after the date he Filed his claim and the payment will be for the period January 16-31, 2011.

Example 4: Onset of Disability is February 15, 2009 and the Plan Participant has 1,000 hours of paid sick and vacation time from the Company. The Plan Participant Files his claim on January 15, 2010, more than six months after the Onset of Disability. Assume that the Plan Participant exhausts his paid sick and vacation time on April 30, 2011, 24 months after his Onset of Disability. The Plan Participant would receive his first benefit payment on the last business day of May 2011 (i.e., after the later of: (a) January 15, 2011, 12 months after he Filed his claim; or (b) May 1, 2011, the day after he exhausts his paid sick and vacation time.)

(C) Claims will not be eligible for payment if Filed after the later of: (1) more than 24 months after the Onset of Disability; or (2) the exhaustion of paid sick and vacation time from the Company.

Example 5: Onset of Disability is May 1, 2009 and the Plan Participant has no paid sick and vacation time from the Company. The Plan Participant Files his claim on June 1, 2011, more than 24 months after the Onset of Disability. He will not be eligible for any benefit payments for that Disability.

Example 6: Onset of Disability is May 1, 2009 and the Plan Participant has 28 months of paid sick and vacation time from the Company which he exhausts on September 18, 2011. The Plan Participant Files his claim on June 1, 2011, which is more than 24 months after the Onset of Disability, but prior to the exhaustion of his paid sick and vacation time from the Company. If eligible for benefits, he will receive a payment on the last business day of June 2012, which is one year after the date he Filed his claim and the payment will be for the month of June 2012.

A Plan Participant who has a Recurrent Disability must file a claim for benefits by the Recurrent Disability Filing Deadline to avoid a delay in the payment (see the "Payment Period" subsection on page 17 for more information.).

If coverage ceases due to termination of the Plan, final claims must, without exception, be received within 90 days following the effective date of termination of the Plan. Claims will be paid from available Plan assets upon the Plan Participant's qualification for Disability benefits.

How To File A Claim

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

1. Obtain a Disability Income Plan Claim Form by calling Harvey W. Watt & Co., at (404) 767-7501 or (800) 241-6103 or from the Benefits section on the APA Website (www.alliedpilots.org).
2. Complete the claim form using the instructions that accompany the form.
3. Send the completed claim form and accompanying information directly to the Harvey Watt using the address on the claim form. The date the claim is treated as Filed is defined on page 45.

The Plan Participant must provide Proof of Disability to Harvey Watt, including the provision of the Plan Participant's Physician(s) or medical provider(s) information used to process the claim. The Plan Participant is responsible for assisting Harvey Watt if permission or instructions to Physician(s) or medical provider(s) are needed. A Physician(s)'s or medical provider(s)'s failure to provide requested information may lead to denial of the claim.

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

What Happens To A Claim

Claim information goes to a special unit at Harvey Watt that processes claims for the Plan. Harvey Watt does not insure benefits, but processes claims for APA in accordance with the terms of this Plan. The Plan Participant will receive an *Explanation of Benefits* ("EOB") which summarizes the benefit calculation and provides backup documentation for any payment made.

The EOB explains the reason(s) why benefits are paid or not paid. Normally, the Plan Participant will receive an EOB within 45 days after filing a properly documented claim with Harvey Watt, unless further information is required. Harvey Watt will contact the Plan Participant or the provider for such additional information. Prompt response and follow-up will expedite processing of the claim. Any problems or questions about the claim should be directed to the Harvey Watt at (404) 767-7501 or (800) 241-6103.

Harvey Watt will use the medical information the Plan Participant furnishes or which is obtained from his Physician or medical provider to

substantiate the claim and to determine benefits. It may be forwarded to independent consultants for medical review or appropriate medical follow-up. In certain rare situations, such as a claim appeal, it may 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.

Claims Process

Harvey Watt has the responsibility for completing the claim process. Harvey Watt will generally complete the claims process within 45 days from the date that the claim form is Filed. If the claim is denied, in whole or in part, Harvey Watt shall provide a written notice of denial within 45 days of the date the claim was Filed. This 45-day period may be extended an additional 30 days if more time is needed for claim processing and if Harvey Watt notifies the Plan Participant during the initial 45-day period.

Notice of any extension beyond the initial 45-day period 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 Plan Participant'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 Plan Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information or ensure that the Plan Participant's Physician(s) or medical provider(s) provide it. The 30-day extension period for claim processing will not begin until the Plan Participant has provided all of the requested information.

If, prior to the end of the first 30-day extension period, Harvey Watt determines that a decision cannot be rendered due to matters beyond its control, the period for making the determination may be extended up to an additional 30 days. In this case, Harvey Watt will notify the Plan Participant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the additional extension and the date when Harvey Watt expects to render a decision. 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 notice will also state that the period for making the decision will be tolled from the date on which the notification of the extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information.

Appeal Process For Denied Claims

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

The following describes the appeal process under this Plan:

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

(B) If a Protocol was relied upon in making the adverse determination, the Plan Participant is entitled to a copy of the Protocol, or be told that the Protocol was relied upon in making the determination, and that the Plan Participant can receive a copy of the Protocol free of charge, upon written request to APA..

(C) The Plan Participant may request that the BRAB review the denial of all or part of his claim. This request must be in writing and must be received by the BRAB no more than 180 days after the Plan Participant receives notice of Harvey Watt's adverse benefit determination. Any appeal received by the BRAB after this 180-day period will be null and void. The appeal should be addressed to the Benefits Review and Appeals Board, c/o Director of Benefits, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Fort Worth, TX 76155-2512

(D) As part of the appeal process, the Plan Participant may submit Appeal Materials. The BRAB's review of the appeal must take into account the Appeal Materials, regardless of whether any of the

Appeal Materials was submitted or considered in the initial benefit determination; however, only Appeal Materials received by the BRAB prior to the end of the 180-day filing period will be considered. There will be no exception to this rule.

(E) The BRAB will decide the Plan Participant's appeal based on the information provided in accordance with paragraphs (C) and (D) above and the Record from Harvey Watt and/or HealthFirst. 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 make all determinations on appeals.

(F) 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 Harvey Watt and/or the BRAB obtained in connection with his claim, regardless of whether his advice was relied upon in making the adverse determination.

(G) The BRAB will advise the Plan Participant of the results of its review within 45 days after it receives the appeal and the timely filed Appeals 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 receive notice of the extension within the initial 45-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 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.

(H) When the review of the appeal is completed, the Plan Participant will receive a written decision that will include reference to Plan terms and conditions on which the decision was based. If his appeal has been denied, in whole or in part, the Plan Participant must be told the specific reason(s) for the denial and a reference to specific Plan provision(s) on which the decision is based.

(I) The Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, the Record.

(J) If a Protocol was relied upon in making the adverse determination on appeal, the Plan Participant is entitled to a copy of the Protocol, or to be told that the Protocol was relied upon in making the determination and that he can receive a copy of the Protocol free of charge, upon request to the APA.

After exhausting the Plan's administrative claims and appeals process as contained in this section, the Plan Participant may bring a civil action under section 502(a) of ERISA for any benefit that is denied in whole or in part. A Plan Participant (or his authorized representative) who fails to complete the Plan's appeal process will not have the right to file suit in court. **NO ACTION IN 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 THIS 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.

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 Pilot Occupational Disability 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 may 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.

Prudent Action by Plan Fiduciaries
In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions
If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Actions by Plan Fiduciaries
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 Plan Fiduciaries by a written instrument signed by the delegating Fiduciary and the delegatee. In any case in which a signature is required by an entity rather than an individual, the signature may be made by the president or other senior officer of the entity.

Plan Interpretation
In carrying out their respective responsibilities under the Plan, APA and certain other Plan Fiduciaries, including, as applicable, the BRAB, shall have 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. In deciding an appeal, the BRAB shall have the discretion to interpret the Plan and make all benefit determinations. 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 decides in its discretion that the Plan Participant is entitled to them.

Plan Continuance
APA expects to continue the Plan indefinitely, but an unqualified commitment to continue the Plan without modification is not possible. **Therefore, APA reserves the right to amend or terminate this Plan at any time through a resolution approved by the APA Board of Directors; provided, however, that any amendment required by law may 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: (i) the date of approval of the resolution by the Board, if no effective date is stated in the resolution, (ii) the effective date expressly set forth in the resolution, or (iii) for an amendment required by law, the effective date expressly set forth in writing by the APA President**

Plan Not A Contract
The Plan shall not be deemed to constitute a contract between APA and any Plan Participant or to be consideration or an inducement for the membership of any Plan Participant. Nothing contained in the Plan shall be deemed to give any Plan Participant the right to be retained in the service or membership of APA, or to interfere with the right of APA to discharge or expel a Plan Participant at any time, regardless of the effect which such discharge or expulsion shall have upon him as a Plan Participant.

Plan Trust Fund And Trustee
All funds used to provide Plan benefits and pay reasonable Plan expenses are held in the Plan's account in the Master Trust and are invested by 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 may 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, 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 may 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.

Physical Examination
The Plan shall have the right (at its own expense) to require a Disabled Plan Participant to undergo a physical examination by an independent medical examiner, when and as often as may be reasonable but in no event more than once during any 90-day period.

To Whom Plan Benefits Are Payable
All Disability benefits are payable to the Plan Participant. Any benefit payable under the Plan after a Plan Participant's death will be made to the Plan Participant's spouse or if the Plan Participant is single, to his estate.

Right Of Recovery
If the amount of the payments made by the Plan is more than it should have paid, the Plan may recover the excess or reduce unpaid benefits by the excess. The Plan may get such recovery or payment from one or more of: (a) the Plan Participant it has paid or for whom it has paid; (b) insurance companies; or (c) other persons or organizations.

Right To Select Medical Provider
A Plan Participant shall have the sole right to select his own Physician, surgeon, and hospital. The Plan will not interfere with the Physician-patient relationship.

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

Address For Notices
APA may give any notice required to be given to a Plan Participant or any other person entitled to benefits under the Plan, by mailing or otherwise delivering such notice to such person at the address last furnished to APA.

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

Reliance On Other Professionals
APA may employ accountants, attorneys, consultants or other experts to render advice with respect to their fiduciary responsibilities. The Master Trustee may also do so at the direction of APA. APA may 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.

Need Help ?
If you need further assistance, please contact:

General Information
Benefits Department
Allied Pilots Association
14600 Trinity Boulevard, Ste 500
Fort Worth, Texas 76155-2512
(817) 302-2140
(800) 323-1470 Ext. 2140

Specific Plan Information or Billing Questions
HealthFirst TPA, Inc.
P.O. Box 130217
Tyler, Texas 75713-0217
(903) 581-2600
(800) 477-8957

Claims Information
Harvey W. Watt & Company
Claims Department
P. O. Box 20787
Atlanta Airport
Atlanta, GA 30320
(800) 241-6103

GENERAL PLAN INFORMATION

Plan Name	Allied Pilots Association Pilot Occupational Disability Plan
Plan Identification Number	504
Tax Identification Number	13-1982245
Type of Administration	Contract Administration
Name and address of the Plan Named Fiduciary (Plan Administrator and Plan Sponsor)	Allied Pilots Association O'Connell Building 14600 Trinity Boulevard, Suite 500 Fort Worth, TX 76155-2512 (800) 323-1470 Ext 2140
Agent for Service of Legal Process	Allied Pilots Association O'Connell Building 14600 Trinity Boulevard, Suite 500 Fort Worth, TX 76155-2512
Plan Processor	HealthFirst TPA, Inc. 821 E.S.E. Loop 323, Suite 200 P.O. Box 130217 Tyler, Texas 75713-0217 (903) 581-2600 (800) 477-8957
Claims Processor	Harvey W. Watt & Company Claims Department P. O. Box 20787 Atlanta Airport Atlanta, GA 30320 (404) 767-7501 (800) 241-6103
Source of financing of the Plan and identity of any organization through which benefits are provided:	Contributions are made to the Plan's account in the Master Trust by Plan Participants. Benefits are provided directly from the Plan through Harvey Watt and HealthFirst
Master Trustee	State Street Bank One Enterprise Drive Boston, MA 02171
Plan Year	Calendar year

DEFINITIONS

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

Active Flight Status
The term "Active Flight Status" means performing, in the usual manner, all of the regular duties of a commercial pilot for the Company on a scheduled work day. A Member will be deemed to be on Active Flight Status on a day that is not a scheduled work day only if he would otherwise be able to perform in the usual manner all of the regular duties of his employment if it were a scheduled work day.

Active Service
The term "Active Service" means the period of time during which the Member is on Active Flight Status.

Any One Period of Disability
The term "Any One Period of Disability" means a period or periods of Disability separated by less than 12 months where the Plan Participant returns to Active Flight Status and the subsequent Disability is due to the same cause or causes for which the Plan Participant was previously Disabled. If the Plan Participant returns to Active Flight Status for more than 12 months or the Disability is due to a cause other than the one(s) for which the Disabled Plan Participant was previously Disabled, the Disability will be considered a new claim and subject to a new Elimination Period (see the SUMMARY OF PILOT OCCUPATIONAL DISABILITY PLAN section on page 4).

Appeal Materials
The term "Appeal Materials" means written comments, documents, records, and other information relevant to the Plan Participant's benefits claim.

Average Crew Pay
The term "Average Crew Pay" means the average of the Plan Participant's monthly Crew Pay for the highest 8 contractual months out of the last 12 months immediately prior to his Onset of Disability. If the Plan Participant has less than 8 contractual months of Crew Pay prior to his Onset of Disability, Average Crew Pay shall be the monthly average of Crew Pay during such shorter period.

Basic Benefit
The term "Basic Benefit" means the Disability benefit amount selected by the Plan Participant, not to exceed the maximum monthly benefit amount payable for the first 60 Monthly Payments (24 Monthly Payments for Limited-Term Disability and/or Mental and Nervous Disorders or 18 Monthly Payments for Chemical Dependency, as applicable) for Any One Period of Disability as shown on page 4.

Board
The term "Board" means the Allied Pilots Association Board of Directors.

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

Chemical Dependency
The term "Chemical Dependency" means (1) Drug Abuse, or (2) the state of chronic or periodic intoxication detrimental to the individual, physically or psychologically, or to society, produced by the repeated consumption of a drug, natural or synthetic (e.g., alcohol).

Claims Processor
The term "Claims Processor" means the firm that determines a Plan Participant's initial and continued eligibility for a Disability benefit under the Plan. Harvey W. Watt & Company, Inc. is the Claims Processor.

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

Confined or Confinement
The terms "Confined" or "Confinement" means any period for which a Hospital charges a Plan Participant for room and board.

Crew Pay
The term "Crew Pay" means crew pay, as noted on a Plan Participant's monthly earnings statement from the Company.

Disabled or Disability
The terms "Disabled" or "Disability" mean the inability of a Plan Participant to perform the material occupational duties of a Company pilot as the result of an Injury or Sickness and such Injury or Sickness is not excluded under the "General Exclusions" subsection on pages 18 and 19. The Plan Participant must be under the Regular Care and Attendance of a Physician and must be unable to maintain either a 1st or 2nd class FAA medical certificate.

Drug Abuse
The term "Drug Abuse" shall mean the chronic and uncontrolled consumption, injection or other utilization of any drug or other substance, singularly or in combination, not medically prescribed or administered or the over-utilization of any drug which is medically prescribed or administered which, if continued, would irreparably harm bodily organs or functions.

Effective Date
The term "Effective Date" shall mean the date on which the coverage becomes effective either for the Plan or a Plan Participant (upon enrollment, re-enrollment or increase in the monthly benefit amount), given the context of its use. If a Plan Participant changes to a new benefit amount, the term "Effective Date" shall mean the date on which the new benefit amount becomes effective (see page 8).

Elimination Period
The term "Elimination Period" means the period(s) during Any One Period of Disability for which no benefit is payable and during which the Eligible Member is Disabled. For a Recurrent Disability, this includes any paid sick or vacation time credited by the Company from the date the Plan Participant returned to Active Flight Status to the date the Plan Participant was Disabled due to the Recurrent Disability. This period is shown in the SUMMARY OF PILOT OCCUPATIONAL DISABILITY PLAN section (see page 6).

Eligible Member
The term "Eligible Member" means a Member who satisfies the requirements contained in the "Eligibility" subsection under the ELIGIBILITY AND COVERAGE PROVISIONS section.

Evidence of Good Health
The term "Evidence of Good Health" means the medical information provided by the Eligible Member verifying that such Member meets the medical underwriting standards as determined by Harvey Watt for participation in the Plan. A Member will have satisfied the Evidence of Good Health by providing both a copy of: (1) the latest FAA Form 8500-8 (Application for Airman Medical Certificate or Airman Medical & Student Pilot Certificate) and (2) the completed Plan medical questionnaire.

Extended Benefit
The term "Extended Benefit" means the Disability benefit paid immediately following the exhaustion of the Basic Benefit. The Extended Benefit is only payable if the Disabled Plan Participant qualifies for Social Security Disability Benefits and is otherwise eligible for Disability benefit payments under the Plan. The monthly amount of the Extended Benefit is the greater of: (A) the Basic Benefit minus 50% of the Plan Participant's Social Security Disability Benefits at the time the Extended Benefit payments begin; or (B) 50% of the Disabled Plan Participant's Basic Benefit. Disabilities due to a Chemical Dependency do not qualify for Extended Benefits.

FAA
The term "FAA" means the Federal Aviation Administration, its predecessors and its successors.

Fiduciary
The term "Fiduciary" or "Fiduciaries" means person(s) responsible for the operation of the Plan.

Filed
The term "Filed" means the date the claim form is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date Harvey Watt receives the form.

Furlough
The term "Furlough" means the period during which a Member is furloughed by the Company and maintains rights of recall. For purposes of this Plan, "Furlough" includes any period during which a Member becomes a pilot for AMR Eagle, Inc., in lieu of furlough, pursuant to the labor agreement between APA and the Company, provided the Member maintains rights of recall.

Grandfathered Executive Member
The term "Grandfathered Executive Member" means an APA member who, on February 28, 2008, was both: (1) an executive member of APA, as defined in the APA Constitution and Bylaws, and (2) was a Plan Participant.

Harvey Watt
See "Claims Processor".

HealthFirst
See "Plan Processor".

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

(A) It is primarily and continuously engaged in providing, for compensation from its patients and on an in-patient basis, 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; and

(B) It continuously provides twenty-four hour a day nursing service by registered nurses; and

(C) It is not, other than incidentally

1. a place of convalescence, rest, or nursing services,
2. a facility primarily affording custodial, educational, or rehabilitory care,
3. facility for the aged, drug addicts, or alcoholics,
4. any military or veteran's hospital or any hospital contracted 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 law and 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 Chemical Dependency treatment center, psychiatric hospital, ambulatory surgical center, or rehabilitative hospital, provided such institution is operated primarily for the purposes

of providing the specialized care and treatment for which was duly licensed and meets ALL of the following tests:

(A) Provides twenty-four hour a day nursing service under the supervisions of a Physician or registered nurse; and

(B) Maintains daily clinical records on each patient and has available the services of 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 facility.

The term “Hospital” does not include any clinic, nursing home, rest home, custodial facility, extended care facility, Christian Scientist hospitals or facilities, or similar institutions.

Injury
The term "Injury" means accidental bodily injury that causes Disability.

Lifetime Maximum Benefit
The term “Lifetime Maximum Benefit” means the maximum number of Monthly Payments that a Plan Participant can receive from the Plan after July 1, 2008. The Lifetime Maximum Benefit is 96 Monthly Payments, which may be either consecutive or non-consecutive and may arise out of one or multiple Disabilities.

Limited-Term Disability
The term “Limited-Term Disability” means:

(A) a Disability due to one or more of the following: chronic fatigue conditions; any allergy or sensitivity to chemicals or the environment; chronic pain conditions; obstructive sleep apnea; vertigo; unexplained loss of consciousness; headache; migraine; ocular migraine; pain; fatigue; loss of energy; stiffness; soreness; ringing in the ears; dizziness; numbness; and itching; and/or

(B) in addition to those conditions listed in (A) above, a Disability with symptoms where the manifestation(s) of the Disability are not verifiable using tests or procedures accepted as standard medical practice regarding such Disability.

Limited-Term Disabilities do not include neoplastic diseases, neurological diseases, endocrine diseases, hematological diseases, chronic pulmonary diseases, cardiovascular diseases, or connective tissue diseases, unless listed in subsection (A) above or described in subsection (B) above.

Master Trust
The term "Master Trust" means the Allied Pilots Association Welfare Benefits Master Trust, a trust formed for the purpose of investing the assets of the Plan. Plan benefits and reasonable Plan expenses are paid from the Plan’s account 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.

Maximum Benefit
The term "Maximum Benefit" means the maximum monthly benefit amount that a Plan Participant is eligible to receive under the Plan. The Maximum Benefit is the monthly benefit amount that is equal to 40% of the Plan Participant’s Average Crew Pay, not to exceed 90% of the Plan Participant’s Average Crew Pay, when combined with the benefit under the American Airlines Inc. Pilot Long Term Disability Plan, of the Plan Participant's Average Crew Pay. (See pages 13 and 14 for an example.) The Maximum Benefit may be less than the monthly benefit amount that the Plan Participant has selected, due to limitations imposed by the Plan, including offsets for the Social Security Disability Benefit.

Member
The term "Member" means a full-time pilot of the Company who is also an active, dues-paying APA member, or a full-time pilot of the Company who has applied for membership with APA and whose application has not been denied.

Mental or Nervous Disorder
The term “Mental or Nervous Disorder” means any mental disorder, disturbance, dysfunction or syndrome, regardless of cause (including any biological or biochemical disorder or imbalance of the brain) or the presence of physical symptoms. Mental or Nervous Disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic-depressive illness, depression and depressive disorders, anxiety and anxiety disorders. It does not include dementia caused by stroke, trauma, viral infection, or Alzheimer’s disease.

Monthly Payment
The term “Monthly Payment” means a benefit payment for a complete calendar month. Partial calendar months shall be prorated based on a 30-day month. Thirty prorated days shall equal a Monthly Payment.

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

Onset of Disability
The term "Onset of Disability" means the date a Plan Participant can no longer perform all of the regular duties of a commercial pilot for the Company due to a Disability.

Physician
The term "Physician" means a medical practitioner of a healing art which is recognized by applicable state or federal law, who:

(A) Is practicing within the scope of his or her license;

(B) Is certified or credentialed by the appropriate medical or professional board that provides certification or credentialing for practitioners who perform the type of treatment or service such practitioner is providing for the Plan Participant’s Sickness or Injury; and

(C) Possesses the necessary training and qualifications, according to generally accepted medical standards, to evaluate and treat the Plan Participant’s condition.

Physician shall not include the Member or a person in the Member's immediate family, currently or previously related by blood or marriage or a current or former domestic partner.

Plan
The term “Plan” means the Allied Pilots Association Pilot Occupational Disability Plan.

Plan Administrator
The term "Plan Administrator" means the Allied Pilots Association.

Plan Participant
The term "Plan Participant" means an Eligible Member who has enrolled in the Plan, paid the required contribution and whose coverage has not terminated.

Plan Processor
The term “Plan Processor” means the firm providing or arranging for administrative services to APA in connection with the operation of the Plan and performing such other functions as may be delegated to it. HealthFirst TPA, Inc. is the Plan Processor.

Plan Sponsor
The term "Plan Sponsor" means the Allied Pilots Association.

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

Pre-Existing Condition
The term "Pre-Existing Condition" means a Sickness or Injury for which the Plan Participant:

(A) Received medical treatment or consultation;

(B) Had medical care or service(s); or

(C) Took prescribed drug(s) or medicine(s)

within the 12-month period immediately prior to the Plan Participant's Effective Date of coverage.

Proof or Proof of Disability
The terms “Proof” and “Proof of Disability” shall mean evidence as reasonably required by Harvey Watt to confirm that the Plan Participant has incurred a Disability or continues to be Disabled. Such proof may include evidence of a surrendered FAA medical license, the results of any medical, physical or other examinations, or reasonable medical treatment which may enable the Plan Participant to avoid, rehabilitate, correct or cure the Participant’s Disability, among other items.

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

Recommended Therapeutic Program
The term "Recommended Therapeutic Program" means a treatment program for the condition causing the Disability which is recommended by the Plan Participant's Physician; the Physician must be appropriate for the Disability.

Record
The term "Record" means any materials relevant to a Plan Participant's claim that exist at any level of the claims process. Materials include documents, records and other information.

Recurrent Disability
The term "Recurrent Disability" means a Disability that occurs after the Plan Participant has returned to Active Flight Status that is due to the same cause or causes as the previous Disability and such Disability begins less than 12 months after the date the Plan Participant returned to Active Flight Status from the previous Disability.

Recurrent Disability Filing Deadline
The term "Recurrent Disability Filing Deadline" means the claim filing deadline for a Disabled Plan Participant who has a Recurrent Disability. The Recurrent Disability Filing Deadline is the date that is the later of:

(A) The date the Plan Participant exhausts Company paid sick and vacation time, or

(B) 90 days after the date of the Onset of Disability for the Recurrent Disability, or

(C) 90 days after the date the Disabled Plan Participant was removed from Active Flight Status because of the Recurrent Disability.

Regular Care and Attendance of a Physician
The term "Regular Care and Attendance of a Physician" means a planned program of observation and treatment which is carried out by a Physician, in accordance with current standards and customs of medical practice, and necessary for the treatment of the Sickness or Injury causing the Disability.

Reimbursement Agreement
The term "Reimbursement Agreement" means the written agreement between the Plan Participant and the Plan or PMA regarding repayment of an overpaid benefit.

Sickness or Sick
The term "Sickness" means illness, disease or pregnancy that causes the Plan Participant to be Disabled and the term "Sick" means having an illness, disease or pregnancy that causes the Plan Participant to be Disabled.

Social Security Disability Benefit(s)
The term "Social Security Disability Benefit(s)" means disability benefit(s) payable by the United States Social Security Administration.

Amendment One to the Allied Pilots Association ("APA") Pilot Occupational Disability Plan (POD) ("Plan")

Effective Date: July 1, 2008

Amend paragraph 4 on page 12 of the Plan, which is paragraph 3 under "Changing Benefit Amounts", by deleting it in its entirety and restating it as follows:

A Plan Participant may select a lower monthly benefit amount at any time and the lower amount will be effective on the first day of a month. If HealthFirst receives his Enrollment/Change form on the first day of a month, the lower amount is effective on that day. However, if HealthFirst receives his Enrollment/Change Form on any other day of the month, the lower amount is effective on the first day of the next month. If the change is made after the Onset of Disability, such lower monthly benefit will be no greater than 40% of the Plan Participant's current monthly Crew Pay. During Any One Period of Disability, the monthly Disability benefit paid to a Plan Participant who selects a lower monthly benefit amount after the Onset of Disability shall not exceed the lower monthly benefit amount selected. Upon return to Active Flight Status, the Plan Participant may change his monthly benefit amount in accordance with Plan provisions.

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed APA Pilot Occupational Disability Plan (POD) amendment to be published as Amendment One is consistent with R2008-69.

Approved:

/signed/

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Captain Keith Wilson
BRAB Chairman

Date 12/17/2008

AMENDMENT TWO TO THE ALLIED PILOTS ASSOCIATION ("APA") PILOT OCCUPATIONAL DISABILITY PLAN ("PLAN")

Effective Date: July 1, 2008

1. Add two new paragraphs prior to the last paragraph of the section entitled "Time Limit for Filing A Claim" on page 29 as follows:

> A Plan Participant who has a subsequent Disability during a Period of Disability must file a claim for the subsequent Disability with the Claims Processor. Eligibility for Monthly Payments will begin no earlier than the date the claim is Filed for the subsequent Disability.
>
> A Disabled Plan Participant to whom the Grandfather Provisions on page 22 of the Plan apply and who has incurred a subsequent Disability prior to May 20, 2009, but has not Filed a claim form for the subsequent Disability as of May 20, 2009, shall have until December 1, 2009 to File the claim form to be eligible for retroactive Monthly Payments. Monthly Payments for any such Disabled Participant shall be retroactive to July 1, 2008 or retroactive to the Onset of Disability for the subsequent Disability, if later.

2. Add the following text to the end of paragraph (B) of the "Limitations And Restrictions" subsection on page 19 of the Plan booklet as follows:

> If a subsequent Disability that is either a Mental or Nervous Disorder or a Limited-Term Disability occurs during a Period of Disability, the lifetime maximum of 24 Monthly Payments shall apply beginning on the earlier of:
>
> (1) the Onset of Disability of such subsequent Disability, or
>
> (2) the date the claim is Filed for such subsequent Disability.

However, no payment(s) shall be made for such subsequent Disability for the period before a claim is Filed for such subsequent Disability or no earlier than the end of the Elimination Period applicable to the initial Period of Disability, if later.

Example: Captain Mike is Disabled and begins receiving Monthly Payments on January 1, 2010. Six months later, on July 1, 2010, Captain Mike becomes Disabled due to a Mental or Nervous Disorder but does not file a claim for his Mental or Nervous Disorder until January 1, 2011. On February 1, 2011, Captain Mike fully recovers from his initial Disability but remains Disabled due to his Mental or Nervous Disorder. As of February 1, 2011, Captain Mike is eligible to receive up to 17 additional Monthly Payments for his Mental or Nervous Disorder.

3. Add subparagraph (M) to the subsection entitled "Limitations and Restrictions" beginning on page 19 of the Plan booklet as follows:

(M) Regardless the number of conditions for which a Plan Participant is Disabled during a month, a Disabled Plan Participant shall be entitled to receive only one Monthly Payment for such month.

4. Replace the current text in paragraph (B)(2) of "Grandfather Provisions" on page 23 of the Plan booklet with the following:

(2) For Disabled Plan Participants to whom paragraph (A)(2) above applies, any payment made on or after the later of either July 1, 2010 or the exhaustion of the lifetime maximum of 24 Monthly Payments shall be in an amount equal to the greater of the following:

5. Insert a new penultimate paragraph (D) under "Grandfather Provisions" section on page 23 of the Plan booklet as follows:

(D) To be eligible for benefits specified in paragraphs (B)(1) and (B)(2) above, a Disabled Plan Participant must apply for Social Security Disability Benefits and provide to Harvey Watt a copy of the Social Security Disability Benefits application prior to the

end of the period for which the benefit is payable in (A)(1) or (A)(2) above. Upon approval for Social Security Disability Benefits, the Disabled Plan Participant must provide the following to Harvey Watt:

(1) Proof that Social Security Disability Benefits are effective on or before the end of the period for which the Disabled Plan Participant receives the number of payments specified in (A)(1) or (A)(2) above; and

(2) A copy of the award showing the amount of the monthly Social Security Disability Benefit.

Otherwise Disability benefits will not be continued even if the Plan Participant later qualifies for Social Security Disability Benefits, and even if that later qualification is retroactive to the periods for which his benefit was payable under (A)(1) or (A)(2) above.

6. Delete the definition of "Any One Period of Disability" on page 42 of the Plan in its entirety and add the following new definition "Period of Disability" in alphabetic order as follows:

Period of Disability
The term "Period of Disability" means a period of Disability during which:

(A) the Plan Participant is continuously Disabled; or

(B) the Plan Participant has a Recurrent Disability.

Upon return to Active Flight Status, any subsequent Disability that is not a Recurrent Disability will be considered a new Period of Disability subject to all Plan provisions including the requirement for a new Elimination Period.

7. Amend the definition of "Elimination Period" on page 44 to add the following penultimate sentence:

For a subsequent Disability that occurs during a Period of Disability, the Elimination Period shall run concurrently and shall not end later than the Elimination Period applicable to the initial Period of Disability.

8. Replace the last sentence in the definition of “Elimination Period” on page 44 of the Plan booklet with the following:

> (See the SUMMARY OF PILOT OCCUPATIONAL DISABILITY PLAN section on page 6.)

9. Replace the text of the definition of “Extended Benefit” on page 45 of the Plan booklet as follows:

> **Extended Benefit**
> The term “Extended Benefit” means the Disability benefit paid immediately following the exhaustion of the Basic Benefit. (See the “Extended Benefit” subsection beginning on page 14 for more information.

10. Replace the term “Any One Period of Disability” with the new term “Period of Disability” throughout the Plan document.

11. For consistency in formatting throughout the Plan booklet, change the formatting of second level bullets from numeric followed by a period to parenthesis-numeric-parenthesis. An example would be to change 1. to (1).

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed APA Pilot Occupational Disability Plan (POD) amendment to be published as Amendment Two is consistent with R2009-47 Rev.1 and R2009-48 Rev.1, and that the clarifying changes are consistent with the Board’s intent when it adopted the changes to the POD effective July 1, 2008.

Approved:

/signed/

_____

Captain Keith Wilson
Chairman, Benefits Review and Appeals Board

Date 7/21/2009

AMENDMENT THREE TO THE ALLIED PILOTS ASSOCIATION ("APA") PILOT OCCUPATIONAL DISABILITY PLAN ("PLAN")

Effective Date: January 16, 2009

Due to the change in third party administrators from HealthFirst TPA, Inc. to WEB-TPA Employer Services LLC, the Plan is amended as follows:

1. Throughout the Plan document, replace "HealthFirst TPA, Inc.", "HealthFirst", and "HealthFirst Third Party Administrators" with "WEB-TPA Employer Services, LLC " and "WEB-TPA", as appropriate.

2. Replace the HealthFirst logo wherever it appears in the Plan document with WEB-TPA logo.

3. Replace the contact information for "Specific Claims Information" in the **"GENERAL PLAN PROVISIONS"** section on page 40 with the following:

   WEB-TPA Employer Services, LLC
   P.O. Box 1987
   Grapevine, TX 76099-1987
   (800) 477-8957
   FAX (469) 417-1979
   apa@webtpa.com

4. Replace the contact information for "Plan Processor" in the **"GENERAL PLAN INFORMATION"** section on page 41 with the following:

   WEB-TPA Employer Services, LLC
   P.O. Box 1987
   Grapevine, TX 76099-1987
   (800) 477-8957
   FAX (469) 417-1979
   apa@webtpa.com

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed APA Pilot Occupational Disability Plan amendment to be published as Amendment Three is consistent with the change from HealthFirst TPA, Inc. to WEB-TPA Employer Services, LLC.

Approved:

/signed/

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Captain Keith Wilson
Chairman, Benefits Review and Appeals Board

Date: December 8, 2009

AMENDMENT FOUR TO THE ALLIED PILOTS ASSOCIATION ("APA") PILOT OCCUPATIONAL DISABILITY PLAN ("POD") ("PLAN")

Effective Date: July 1, 2008

Delete Paragraph (C) of the Termination of Coverage subsection on page 9 of the Plan in its entirety and replaced with the following:

(C) The first day of the month in which a Member is Furloughed from the Company, or if receiving Disability benefits or would have been eligible to receive Disability benefits after the first day of the month but prior to the date of Furlough, then the date he is Furloughed; and

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed APA Pilot Occupational Disability Plan amendment to be published as Amendment Four is consistent with R2010-29.

Approved:

/signed/

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Captain Keith Wilson
Chairman, Benefits Review and Appeals Board

Date: June 10, 2010

AMENDMENT FIVE TO THE ALLIED PILOTS ASSOCIATION ("APA") PILOT OCCUPATIONAL DISABILITY PLAN ("POD") ("PLAN")

Effective Date: October 1, 2011

Delete definition of Injury on page 47 of the Plan in its entirety and replaced with the following:

Injury
The term "Injury" means accidental bodily injury which causes a Disability provided that the Onset of Disability due to such injury is within six months of the date of the injury.

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed APA Pilot Occupational Disability Plan amendment to be published as Amendment Five is consistent with the Plan changes in R2011-67.

Approved:

/signed/

_____

Captain Keith Wilson
Benefits Review and Appeals Board Chairman

Date: November 15, 2011

AMENDMENT SIX TO THE ALLIED PILOTS ASSOCIATION ("APA") PILOT OCCUPATIONAL DISABILITY PLAN ("PLAN")

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

Whereas, the Board passed resolution R2012-31 and delegated to the BRAB the authority to implement this resolution including the drafting of the amendment to the Plan that is consistent with this resolution;

1. Add the following new definitions to the Plan's DEFINITIONS section in alphabetical order:

   Equitable Defense(s)
   The term "Equitable Defense(s)" means a defense based on: (A) the Plan Participant not having received third party payments for 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 reimbursement.

   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.

2. Amend the Plan's DEFINITIONS section to replace the definition of "Reimbursement Agreement" with the following:

   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 PMA regarding an overpaid benefit from PMA.

3. Replace the subsection entitled “Right Of Recovery” in the GENERAL PLAN PROVISIONS section of the Plan with a new subsection entitled “Recovery Of Overpayment(s)” that states:

   Recovery Of Overpayment(s)

   (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 any Overpayment.

   (C) The Plan may withhold or reduce future benefit payments as an offset for an Overpayment, sue to recover Overpayments, or may use any other lawful remedy to recover Overpayments.

   (D) The Plan has the right to recover an 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.

4. Amend the Plan to replace paragraphs (G) and (H) of the subsection entitled “Termination of Coverage” in the ELIGIBILITY AND COVERAGE PROVISIONS section with the following:

   (G) 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 PMA, 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

   (H) The end of the month following the month a payment is due but unpaid to either PMA or the Plan in

accordance with a Reimbursement Agreement entered into with PMA or the Plan, unless the Plan Participant can show, to the satisfaction of, and in the sole discretion of, the BRAB, that failure to make such payment was not within his reasonable control; or

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed APA Pilot Occupational Disability Plan amendment to be published as Amendment Six is consistent with the Plan changes in R2012-31

Approved:

/signed/

Keith Wilson
Chairman, Benefits Review and Appeal Board

Date: November 19, 2012

AMENDMENT SEVEN TO THE ALLIED PILOTS ASSOCIATION ("APA") PILOT OCCUPATIONAL DISABILITY PLAN ("POD") ("PLAN")

Effective Date: October 1, 2013

The following changes are made in accordance with R2013-27 and R2013-28 Rev.1:

1. Delete the definition of "Elimination Period" in its entirety and replace it with the following:

   Elimination Period
   The term "Elimination Period" means the period(s) during a Period of Disability for which no benefit is payable and during which the Eligible Member is Disabled. It begins with the Onset of Disability and ends on the later of:

   (a) the first day of the month coincident with or next following the day that is 14 months after the Onset of Disability, or

   (b) the date of the exhaustion of paid sick and vacation time from the Company.

   For a Recurrent Disability, this includes any paid sick or vacation time credited by the Company from the date the Plan Participant returned to Active Flight Status to the date the Plan Participant was Disabled due to the Recurrent Disability. For a subsequent Disability that occurs during a Period of Disability, the Elimination Period shall run concurrently and shall not end later than the Elimination Period applicable to the initial Period of Disability.

2. Delete "Elimination Period" in the SUMMARY OF THE PILOT OCCUPATIONAL DISABILITY PLAN section in its entirety and replace it with:

   Elimination Period The Elimination Period for benefits other than for Recurrent Disability[3] ends on the later of:

   (a) The date of the exhaustion of paid sick and vacation time from the Company; or

   (b) The first day of the month coincident with or next following 14 months from the Onset of Disability

3. Delete the “Time Limit For Filing A Claim” subsection through paragraph (C) in its entirety and replace it with:

Time Limit For Filing A Claim
A Plan Participant must file written proof of a claim with the Claims Processor. A Plan Participant should file a claim as soon as possible because delayed filing can lead to a delay in the start of benefit payments or a denial of benefit payments. The following time limits apply to all claims unless the Plan Participant can show that it was not within his reasonable control to file the claim and that he Filed the claim as soon as was reasonably possible.

(A) Claims Filed during the Elimination Period will be payable upon the completion of the Elimination Period, unless (C) below applies.

(B) Claims Filed after the Elimination Period will be payable from the first day of the month coincident with or next following the date the claim was Filed.

(C) Claims Filed but not in payment status as of October 1, 2013, will be payable from the latest of: (1) the first day of the month coincident with or next following the date that is 14 months after the Onset of Disability, (2) the day following the exhaustion of Company paid sick and vacation time, or (3) October 1, 2013.

Example: Below is an example of two pilots who Filed claims prior to October 1, 2013 but were not in payment status as of that date. The first pilot, CA Finn, Filed his claim on May 1, 2013. His Onset of Disability was June 28, 2012, and he exhausted his Company sick and vacation time on June 16, 2013. The second pilot, First Officer Elle, Filed her claim on June 27, 2013. Her Onset of Disability was November 8, 2012 and she exhausted her Company sick and vacation time on August 14, 2013. The following chart demonstrates how their payment effective dates are calculated:

	Date Claim Filed	**CA Finn 5/01/2013**	**FO Elle 6/27/2013**
	Onset of Disability	6/28/2012	11/8/2012
1.	First day of month coincident with or next following fourteen months after Onset of Disability	9/01/2013	2/01/2014
2.	Exhaustion of Company sick and vacation	6/16/2013	8/14/2013
3.	October 1, 2013	10/01/2013	10/01/2013
	Payment Effective Date (later of 1, 2, or 3)	**10/01/2013**	**2/01/2014**

(D) Notwithstanding the above, no claim will be eligible for payment if Filed after the later of:

(1) more than 24 months after the Onset of Disability, or (2) the exhaustion of paid sick and vacation time from the Company.

4. Delete the definition of "Maximum Benefit" and replace it with the following:

Maximum Benefit
The term "Maximum Benefit" means the maximum monthly benefit amount that a Plan Participant is eligible to receive under the Plan. The Maximum Benefit may be less than the monthly benefit amount that the Plan Participant has selected due to limitations imposed by the Plan. The Maximum Benefit is as follows:

(A) For claims with a Period of Disability beginning on or after October 1, 2012, the Maximum Benefit is 40% of the Plan Participant's Average Crew Pay. (See page 13 for an example.)

(B) For claims with a Period of Disability beginning prior to October 1, 2012, the Maximum Benefit is the amount in effect under the Plan when such Period of Disability began.

5. Delete "Maximum Benefit" in the SUMMARY OF THE PILOT OCCUPATIONAL DISABILITY PLAN section in its entirety and replace it with:

Maximum Benefit The Maximum Benefit is as follows:

(a) For claims with a Period of Disability beginning on or after October 1, 2012, 40% of Average Crew Pay;

(b) For claims with a Period of Disability beginning prior to October 1, 2012, the Maximum Benefit is the amount in effect under the Plan when such Period of Disability began.

6. Delete the text in its entirety after the first paragraph under the "Basic Benefit" subsection and replace it with the following:

(A) For claims with a Period of Disability beginning on or after October 1, 2012, the Maximum Benefit is 40% of

the Plan Participant's Average Crew Pay. The following is an example of how this benefit and the monthly benefit payable is calculated.

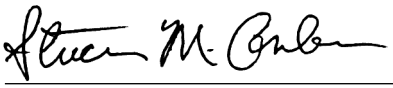
Example: The following two pilots each have a Period of Disability beginning on or after October 1, 2012. First Officer Jane is enrolled in the Plan with a monthly benefit amount $3,600 and her Average Crew Pay is calculated to be $8,000. Captain Bill is enrolled in the Plan with a monthly benefit amount of $5,000 and his Average Crew Pay is calculated to be $15,000.

	Average Crew Pay	**FO Jane $8,000**	**CA Bill $15,000**
Step I	**Determine the Maximum Benefit** (40% of Average Crew Pay)	$3,200	$6,000
Step II	**Monthly Benefit Selected**	$3,600	$5,000
Step III	**Determine Monthly Benefit Payable** (lesser of Maximum Benefit or monthly benefit amount selected)	$3,200	$5,000
	Monthly Benefit Payable	**$3,200**	**$5,000**

(B) For claims with a Period of Disability beginning prior to October 1, 2012, the Maximum Benefit is the amount in effect under the Plan when such Period of Disability began.

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed APA Pilot Occupational Disability Plan amendment to be published as Amendment Seven is consistent with the Plan changes in R2013-27 and R2013-28 Rev. 1.

Approved:



First Officer Steve Conlon
Chairman, Benefits Review and Appeal Board

Date: November 26, 2013

AMENDMENT EIGHT TO THE ALLIED PILOTS ASSOCIATION (“APA”) PILOT OCCUPATIONAL DISABILITY PLAN (“POD”) (“PLAN”)

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

Whereas, the Board passed resolution R2014-33 Rev.2 and delegated to the BRAB the authority to implement this resolution including the drafting of the amendment to the Plan that is consistent with this resolution,

Therefore, the Plan is amended effective October 1, 2014 as follows:

1. Delete subparagraph (e) under (1) “Basic Benefit” in the SUMMARY OF THE PILOT OCCUPATIONAL DISABILITY PLAN section in its entirety and replace it with the following:

   Duration of Benefits

   (1) Basic Benefit

   (e) The day before the Plan Participant attains age 60 for a Period of Disability that begins prior to October 1, 2014, or the day before the Plan Participant attains age 65 for a Period of Disability that begins on or after October 1, 2014; or

2. Delete the subsection entitled “Monthly Plan Participant Contributions” in the SUMMARY OF THE PILOT OCCUPATIONAL DISABILITY PLAN section in its entirety and replace it with the following:

   MONTHLY PLAN PARTICIPANT CONTRIBUTIONS
   Contributions are based on the Plan Participant's attained age and selected benefit amount. The age category is determined by the Plan Participant's attained age on January 1 of each year. The chart below contains the contribution rates effective October 1, 2014 per $100 of monthly benefit. *(See chart on next page)*.

Attained Age	Monthly Rate per $100 of Benefit	Attained Age	Monthly Rate per $100 of Benefit
35 & Under	$0.82	50	$4.15
36	0.94	51	4.55
37	1.06	52	4.75
38	1.13	53	4.96
39	1.21	54	5.16
40	1.28	55	5.37
41	1.37	56	5.57
42	1.45	57	5.60
43	1.73	58	5.57
44	2.02	59	5.46
45	2.33	60	4.82
46	2.65	61	4.02
47	2.98	62	3.00
48	3.36	63	2.55
49	3.75	64	2.11

The Plan Participant's monthly contribution is determined by dividing his monthly benefit amount by 100 and multiplying the result by the rate from the chart. The following example shows how to calculate the monthly contribution, assuming that the Plan Participant is age 48 and has selected the $5,000 monthly benefit amount.

Amount of Monthly Benefit selected divided by 100	50 ($5,000 ÷ 100)
Monthly Rate per $100 of Benefit:	$3.36
Monthly Contribution	$168.00 ($3.36 x 50)

The monthly contribution required during the Elimination Period for Plan Participants with a Period of Disability that began prior to October 1, 2014 will be based on the contribution rates in effect immediately prior to October 1, 2014.

3. Delete in its entirety paragraph (I) under the "Termination of Coverage" subsection in the ELIGIBILITY AND COVERAGE PROVISIONS section and replace it with the following:

. . .

Termination Of Coverage

(I) The last before the Plan Participant's 65th birthday; or

. . .

4. Delete in its entirety paragraph (A) (4) under the "Termination of Disability Benefit Payments" subsection of the BENEFIT PAYMENT PROVISIONS section and replace it with the following:

   Termination of Disability Benefit Payments

   . . .

   (A) The day before the Plan Participant:

   . . .

   4. attains age 60 for a Period of Disability that begins prior to October 1, 2014, or attains age 65 for a Period of Disability that begins on or after October 1, 2014; or

      . . .

Statement of Consistency: After review and consideration, the BRAB has determined that the proposed APA Pilot Occupational Disability Plan amendment to be published as Amendment Eight is consistent with the Plan changes in R2014-33 Rev. 2

Approved:

/signed/

First Officer Steve Conlon
Chairman, Benefits Review and Appeal Board

Date: June 20, 2014