ALLIED PILOTS ASSOCIATION
PILOT OCCUPATIONAL
DISABILITY PLAN
(POD)

September 1, 2022

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Amended and Restated Effective September 1, 2022

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.

NGS Insurance Agency, Inc. ("NGS") 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 NGS at the following address and phone number:

NGS Insurance Agency, Inc.
P.O. Box 830846
Richardson, TX 75083-0846
(800) 298-8793

The Guardian Life Insurance Company ("Guardian") has been appointed as the Claims Processor and administers initial claims for Plan benefits, as described in the CLAIMS PROCESSING PROVISIONS section below. If you have questions about filing a claim or about a claim determination, contact Guardian at the following address and phone number:

Guardian Life Insurance Company
P.O. Box 14333
Lexington, KY 40512
(866) 543-0090

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. The first letter of each word of 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 January 1, 2022. It is intended to give you a description of the benefits provided by the Plan, how to file a claim for benefits and your rights under the Plan. **The terms of this Plan document govern all determinations made by the Plan Administrator, in accordance with its discretionary authority under the Plan, such as determinations regarding eligibility and benefits payable from the Plan. Plan terms may not be amended by verbal representations made by APA, an employee, agent, third-party administrator, or representative of APA and/or the Plan, or any other person.** In the event a verbal representation conflicts with any term of the Plan, the Plan terms will control. APA reserves the right to amend or terminate this Plan. These rights are contained in the "Plan Continuance" subsection.

Please note that, although this booklet is intended to reflect relevant updates made to the Plan as of the date indicated herein, it may be necessary for adjustments to be made to the Plan's administrative requirements, such as applicable claim and appeal filing deadlines, during a time of crisis such as the COVID-19 pandemic. The Plan is intended to comply with all such applicable adjustments that are required by law. If you have questions regarding any current adjustments that may be in effect, please contact the APA Benefits Department at (817) 302-2140.

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 $10,000
Maximum Benefit	The Maximum Benefit is 40% of Average Crew Pay;
Duration of Benefits	For a Period of Disability, the duration is the period during which the Basic Benefit and the Extended Benefit are paid.
(A) Basic Benefit	The Basic Benefit is paid after completion of the Elimination Period and ends on the earliest of the following events: (1) The Plan Participant has received 60 Monthly Payments; (2) The Plan Participant has received a total of 24 Monthly Payments for a Limited-Term[2] Disability(ies); (3) The Plan Participant has received a total of 24 Monthly Payments for a Mental or Nervous Disorder(s) with an Onset of Disability that occurred before September 1, 2019, or 60 Monthly Payments with an Onset of Disability that occurs on or after September 1, 2019; (4) The Plan Participant has received a total of 18 Monthly Payments for a Chemical Dependency Disability with an Onset of Disability that occurred before September 1, 2019, or 24 Monthly Payments with an Onset of Disability that occurs on or after September 1, 2019; (5) The Plan Participant is no longer Disabled, retires, returns to Active Flight Status, dies or is otherwise disqualified for payment (see the "Termination of Disability Benefit Payments" subsection); (6) The day before the Plan Participant attains age 60 for a Period of Disability that began 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 (7) The Plan Participant has received the Lifetime Maximum Benefit (see Lifetime Maximum Benefit in DEFINITIONS section).
(B) 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

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

[2] Formerly known as "Self-Reported Disability".

other requirements listed in "Extended Benefit" subsection. The Extended Benefit, as applicable, begins immediately following expiration of the Basic Benefit described in A(1), A(2) or A(3) above and ends upon the earliest of the:

(1) exhaustion of the Lifetime Maximum Benefit (see Lifetime Maximum Benefit in DEFINITIONS section); or

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

(3) earlier of the date described in A(5) or A(6) under Basic Benefit above.

Lifetime Maximum Benefit

The equivalent of 96 Monthly Payments for claims filed before June 1, 2021, and 120 Monthly Payments for claims filed on or after June 1, 2021.

Elimination Period

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

(A) The first day of the month following the day that is 12 months from the Onset of Disability; or

(B) The date that the Plan Participant exhausts:

(1) the number of sick hours either designated by the Plan Participant or required by the working Agreement prior to receiving Company long term disability benefits; and

(2) any vacation[4] from the Company.

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

[4] Both current and accrued vacation

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 effective October 1, 2021 per $100 of monthly benefit.

Attained Age	Monthly Rate per $100 of Benefit	Attained Age	Monthly Rate per $100 of Benefit
35 & Under	$0.41	50	$2.08
36	0.47	51	2.28
37	0.53	52	2.38
38	0.57	53	2.48
39	0.61	54	2.58
40	0.64	55	2.69
41	0.69	56	2.79
42	0.73	57	2.80
43	0.87	58	2.79
44	1.01	59	2.73
45	1.17	60	2.41
46	1.33	61	2.01
47	1.49	62	1.50
48	1.68	63	1.28
49	1.88	64	1.06

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:	$1.68
Monthly Contribution	$84.00 ($1.68 x 50)

Each Plan Participant must provide the appropriate authorization for payment of the required monthly contributions using the procedures established by APA, including without limitation procedures for collection of necessary information with respect to Apprentice Member Benefit Program Participants, as described below.

Notwithstanding anything to the contrary above, for Apprentice Member Benefit Program Participants, there will be no cost for enrollment at the monthly benefit level of $1,200, for the first 12 months after the Apprentice Member Benefit Program Participant’s Membership Date. Additional coverage may be purchased at a premium contribution rate discounted by 75%. (After initial enrollment, Apprentice Member Benefit Program Participants may increase their coverage once every 12 months by up to $2,000).

For months 13 – 24 after the Membership Date, contributions for the monthly benefit level elected will be discounted by 50% for Apprentice Member Benefit Program Participants.

Apprentice Member Benefit Program Participants will be responsible for paying the full contribution amount for the monthly benefit level elected beginning 24 months after the Membership Date. There will be no discounts.

ELIGIBILITY AND COVERAGE PROVISIONS

Eligibility
A Member is eligible to join, change benefit levels, and participate in the Plan if the Member meets the following conditions on the date that NGS receives the completed application and on the Effective Date of Coverage:

(A) Is an Active Member in good standing as defined in the APA Constitution and Bylaws; and

(B) Holds a first class FAA medical certificate; and

(C) Does not owe or is not making payments to recover an overpayment of benefits to any APA sponsored plans.

Enrollment Or Re-enrollment
Benefit Elect currently assists APA with Plan enrollment responsibilities. To enroll in the Plan or to increase your benefit amount, please go to the Benefit Elect portal (www2.benefitelect.com/apa/). Note: For first time users, please log into www.alliedpilots.org and go to the Benefits page to obtain your temporary password. Note that references in this booklet to Benefit Elect and related election processes are intended to include any similar provider that may be selected to assist with enrollment in the future. Current information regarding the Plan's enrollment and re-enrollment processes can be located on the Benefits Page of APA's website listed above.

Effective December 1, 2021, the Apprentice Member Benefit Program was closed to new enrollments and only those Plan Participants who elected this plan option on the Membership Application prior to December 1, 2021, may continue to participate. The Monthly Benefit for such members is provided at no cost for the first 12 months of coverage after the Membership Date. An Apprentice Member Benefit Program Participant must provide any necessary banking or other information in accordance with the Plan's standard procedures in order to remain enrolled in the Plan after the first 12 months of coverage, as required to avoid cancellation of Plan coverage.

Effective Date Of Coverage
An Eligible Member who enrolls, re-enrolls, or changes the benefit amount, becomes a Plan Participant on the first day of a month. If Benefit Elect receives the Member's completed application on the first day of a month, coverage is in effect on that day once NGS verifies eligibility; if Benefit Elect receives the Member's completed application on any other day of the month, coverage is effective on the first day of the next month pending verification of eligibility.

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.

With respect to Members other than Apprentice Members Benefit Program Participants, if the Member was on Active Flight Status when completing the enrollment process, but is not on either Active Flight Status or Union Leave from the Company on the date that would otherwise be the Effective Date of Coverage, then the POD Administrator will pend the application until the first day of the next following month to verify that the applicant is an Eligible Member at that later date. If the Member is an Eligible Member on such later date, then the Eligible Member's Effective Date of Coverage will be the later date. If the Member is not an Eligible Member on the later date, then the Member's application will be pended until the first day of the subsequent month and the Member will be enrolled on such date. If the Member is not an Eligible Member on this later date, then the Member will have to apply upon return to Active Flight Status.

The rules described in this “Effective Date of Coverage” subsection apply to both enrollment and re-enrollment in POD, as well as the Effective Date of Coverage with respect to any increase in a POD Participant’s Monthly Benefit Amount.

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 Plan Participant's membership with APA is terminated (except for Grandfathered Executive Members); or

(B) The date the Plan Participant’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 Plan Participant is Furloughed from the Company, or if receiving Disability benefits or eligible to receive Disability benefits, then the date the Plan Participant is Furloughed; or

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

(E) The date the Plan Participant'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 APA 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

(I) With respect to an Apprentice Member Benefit Program Participants, after 12 months of Plan coverage if the Apprentice Member Benefit Program Participant has not provided information necessary for the Plan to collect required contribution amounts applicable at the end of such initial 12-month coverage period.

(J) The day before the Plan Participant's 65th birthday; or

(K) 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 DISABILITY PLAN section 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. Such contribution amounts may be amended at any time by the APA Board of Directors. Any change in contribution amounts will be communicated to Plan Participants. Contributions must be made monthly.

Beginning at 24 months after the Membership Date, the full contribution amount for the monthly benefit elected will be charged. An Apprentice Member Benefit Program Participant who does not wish to pay applicable contributions after the first 12 months of coverage will be required to notify the Plan of the Apprentice Member Benefit Program Participant's election to terminate coverage in a timely manner, in order to avoid automatic deduction of applicable contributions. In addition, an Apprentice Member Benefit Program Participants will be responsible for providing any necessary documentation or information for the Plan to collect required contributions in a timely manner, as applicable, to avoid cancellation of Plan coverage.

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 such Disabled Plan Participant pays contributions back to the date that his Basic Benefit ended; or

(D) For the first 12 months after the Membership Date for Apprentice Member Benefit Program Participants who enroll in the Plan in accordance with the Plan's terms.

BENEFIT AMOUNT

Selecting A Benefit Amount
The Plan provides monthly benefit amounts in $200 increments from $1,000 to $10,000. Each Plan Participant must select a monthly benefit amount that is within this range by enrolling on the Benefit Elect portal. The monthly benefit amount cannot exceed 40% of a pilot's current monthly gross 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 an Eligible Member may select a higher monthly benefit amount once every 12 months, subject to the following:

(1) such higher benefit amount does not exceed 40% of current monthly gross pay;

(2) such higher monthly benefit amount is not more than $2,000 greater than the previous monthly benefit amount;

(3) if the Onset of Disability is less than six months after the Effective Date of an increase in the monthly benefit amount, the Disabled Participant will not be paid the increased portion of the monthly benefit amount, unless the Disability is due to an Injury that occurs after the Effective Date of the increase; and

(4) such higher amount will be subject to all Plan provisions, including the Pre-Existing Condition exclusion for the increased amount.

Each Plan Participant must select a monthly benefit amount completing the enrollment section on the Benefit Elect portal.

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 his change request is processed by Benefit Elect on the first day of a month, the lower amount is effective on that day. However, if his change request is processed by Benefit Elect 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 Average Crew Pay. During a 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 being an Eligible Member, the Plan Participant may change his monthly benefit amount in accordance with Plan provisions.

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

Basic Benefit
The Basic Benefit is the first benefit that is payable for a Period of Disability. The duration of the Basic Benefit is based on the type of Disability and can be paid for up to 60 Monthly Payments, as described in the SUMMARY OF THE PILOT OCCUPATIONAL DISABILITY PLAN section. 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.

Extended Benefit
The Extended Benefit is the benefit that is payable following the final payment of the Basic Benefit. 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 Guardian 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 Guardian:

(A) Proof that Social Security Disability Benefits are effective on or before the end of the period for which the Basic Benefit is payable; or

(B) A copy of the Social Security Disability Benefit award letter.

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 same as the Basic Benefit.

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 such participant 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 such participant is removed from Active Flight Status; and

(C) The Plan Participant completes the Elimination Period (for a Recurring 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[4] 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 Recurring Disability); and

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

(E) The Plan Participant places themself 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 such participant has complied with any Recommended Therapeutic Program); and

(G) The Plan Participant provides Proof of Disability to Guardian, 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 Guardian's request for such information; and

(H) The Disability is not excluded from coverage (see the "General Exclusions" subsection) or subject to the provisions of the "Limitations and Restrictions" subsection.

Payment Period
Disability benefits during a Period of Disability shall be payable following the completion of the Elimination Period.

Benefit payments for Recurring Disability claims Filed after the Recurring Disability Filing Deadline will be made only for the period that begins on the date the claim was received by Guardian.

Payments shall be made on the last business day of each calendar month. The first and last payments with respect to a Recurring Disability 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.

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

(A) The day before the earliest of 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 (K) in the "Limitations and Restrictions" subsection), or

(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

(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 Guardian, 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 class FAA medical certificate; or

(C) The date the Disabled Plan Participant receives the maximum Basic Benefit Monthly Payments for a 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 for claims filed before June 1, 2021, or 120 Monthly Payments for claims filed on or after June 1, 2021; or

(E) The date the Plan Participant's coverage terminates (see "Termination of Coverage" subsection); 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; 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, 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.

General Exclusions

The Plan does not 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 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, after the Effective Date of Coverage (see "Enrollment or Re-enrollment" subsection). This Pre-Existing Condition exclusion will not apply to a Plan Participant after the earlier of the period of time described below, if such Plan Participant has remained on Active Flight Status during the entirety of such period:

(1) 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) 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.

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 (1) 18 Monthly Payments for an Onset of Disability that occurred prior to September 1, 2019, or (2) 24 Monthly Payments for an Onset of Disability occurring on or after September 1, 2019, per lifetime or the Lifetime Maximum Benefit. The 18 or 24 Monthly Payments, as applicable, may be either consecutive or non-consecutive.

(B) Benefits for any Disability that is determined to be a Limited-Term Disability, or a Mental or Nervous Disorder with an Onset of Disability that occurred prior to September 1, 2019, 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) If a Subsequent Disability that is either a Mental or Nervous Disorder or a Limited-Term Disability occurs during an existing Period of Disability, the lifetime maximum of 24 or 60 Monthly Payments, as applicable, 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.

(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 Monthly Payments up to the Lifetime Maximum, if the Plan Participant is Confined to a Hospital for a Limited-Term Disability or a Mental or Nervous Disorder 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.

(E) 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 for claims filed before June 1, 2021 or 120 Monthly Payments for claims filed on or after June 1, 2021; or

(2) The remaining number of Monthly Payments, up to the Lifetime Maximum Benefit.

(F) 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 such Disabled Plan Participant 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 for claims filed before June 1, 2021, or 60 Monthly Payments for claims filed on or after June 1, 2021; or

(2) The remaining number of Monthly Payments, up to the Lifetime Maximum Benefit.

(G) 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 Guardian which is reasonably necessary to determine the Disabled Plan Participant's eligibility for Disability benefits under the Plan.

(H) A Plan Participant may not choose a monthly benefit amount that exceeds the Maximum Benefit.

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

(J) 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.

(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 the Plan Participant continues to make monthly contributions. A Plan Participant will be ineligible for benefits for any Disability incurred during the military leave, unless such Plan Participant 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 or a Limited-Term Disability and is or becomes Disabled due to another condition that occurs during a Period of Disability shall continue to have the Monthly Payments count toward the Chemical Dependency 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 or Limited-Term Disability.

(M) Regardless of 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.

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

(O) 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 such termination is the subject of a pending grievance for reinstatement (sometimes referred to as TAG status), shall continue to participate, including qualifying for continued Monthly Payments, as long as the Plan Participant 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.

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 Guardian, 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. **Notwithstanding any other provision in this subsection of the Plan and for the avoidance of doubt, all claims must be Filed prior to the date that a Plan Participant is no longer Disabled, or no benefits will be payable from the Plan**. In addition, the following time limits apply to all claims:

(A) Claims Filed during the Elimination Period will be payable upon the completion of the Elimination Period,

(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, and

(C) 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[4] time from the Company,

provided, however, that the limitations in paragraphs (A) - (C) above will be waived if the Plan Participant can show that it was not within his reasonable control to file the claim prior to the applicable date outlined above and that such participant Filed the claim as soon as was reasonably possible.

A Plan Participant who has a Recurring Disability must file a claim for benefits by the Recurring Disability Filing Deadline to avoid a delay in the payment. (See the DEFINITION section for more information.)

A Plan Participant who has a Subsequent Disability during an existing 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.

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. Valid 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 from the Benefits section on the APA Website (www.alliedpilots.org) or by calling the APA Benefits Department at (817) 302-2140.
2. Complete the claim form using the instructions that accompany the form.
3. Send the completed claim form and accompanying information directly to Guardian using the address on the claim form. The date the claim is treated as Filed is defined.

The Plan Participant must provide Proof of Disability to Guardian, 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 Guardian 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 Guardian that processes claims for the Plan. Guardian 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 Guardian, unless further information is required. Guardian 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 Guardian at (866) 543-0090.

Guardian will use the medical information the Plan Participant furnishes or which is obtained from his Physician(s) or medical provider(s) 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.

All claims and appeals considered respect to a Plan Participant's potential Disability will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. The Plan will ensure that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual, such as a medical or vocational expert, are not based upon the likelihood that the individual will support the denial of Disability benefits.

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

Claims Process

Guardian has been appointed the claims processor with respect to the initial claim process and, as such, has the responsibility for completing that claim process and making initial claims determinations, as described below. Guardian 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, Guardian shall provide a written notice of denial within 45 days of the date the claim was Filed. This 45-day period may be extended for up to an additional 30 days if more time is needed for claim processing and if Guardian notifies the Plan Participant during the initial 45-day period. In order to extend the period in this manner, Guardian must determine that such an extension is necessary due to matters beyond the control of the Plan.

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 that prevent a decision on the claim and additional information needed to resolve those issues, any additional circumstances requiring the extension of time, if applicable, and the date by which Guardian expects to render a decision. 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, Guardian determines that a decision cannot be rendered due to matters beyond the control of the Plan, the period for making the determination may be extended up to an additional 30 days. In this case, Guardian 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 Guardian 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 for 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.

Written Notice of Adverse Benefit Determination With Respect to Initial Claim
If a Plan Participant's claim is wholly or partially denied, the Plan Participant will be provided with a culturally and linguistically appropriate written or electronic notification of the adverse benefit determination, in accordance with applicable Department of Labor regulations. The notice of denial must include:

(A) The specific reason(s) for such denial;

(B) Reference to the specific Plan terms and conditions on which the denial was based;

(C) A description of the Plan's appeal procedures, and the time limits applicable to such procedures, including a statement that the Plan Participant will have the right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination by the BRAB on appeal;

(D) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(1) The views presented by the Plan Participant to the Plan of health care professionals treating the Plan Participant and the vocational professionals who evaluated the Plan Participant;

(2) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Plan Participant's adverse benefit determination, without regard to whether the advice was relied on in making the benefit determination; and

(3) Any disability determination regarding the Plan Participant presented by the Plan Participant to the Plan that was made by the Social Security Administration;

(E) If the claim was denied because necessary information was not available to Guardian, a description of the additional material or information that is necessary in order for the Plan Participant to perfect his claim and an explanation of why such material or information is necessary;

(F) If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

(G) Either the specific Protocol(s) that the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such a Protocol does not exist; and

(H) A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Records with respect to the claim.

Appeal Process For Denied Claims
The following describes the appeal process under this Plan:

(A) A Plan Participant who has been sent notice of an adverse benefit determination described above will be provided a reasonable opportunity to appeal that determination to the BRAB. The appeal request must be in writing, explain the basis of the Plan Participant's appeal, and be received by the BRAB no more than 180 days after the Plan Participant receives notice of Guardian's adverse benefit determination. Any notice of appeal received by the BRAB after this 180 day period will be null and void. Appeals must be addressed to the Benefits Review and Appeals Board, c/o Director of Benefits, Allied Pilots Association, 14600 Trinity Blvd., Suite 500, Fort Worth, TX 76155. Upon receipt of a timely appeal, the BRAB will provide a full and fair review of the Plan Participant's initial claim and adverse benefit determination.

(B) All Appeal Materials that a Plan Participant wants to have considered by the BRAB as part of the appeal process must also be submitted to the BRAB prior to the end of the 180 day filing period. The BRAB's review of the appeal will take all such Appeal Materials into account, regardless of whether any of the Appeal Materials were submitted or considered in the initial benefit determination. Appeal Materials that are not received by the BRAB prior to the end of the 180 day filing period will not be considered.

(C) The BRAB will decide the Plan Participant's appeal based on the information provided in accordance with paragraphs (A) and (B) above and the Record provided by Guardian and/or NGS. 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.

(D) If the adverse claim determination was based, in whole or in part, on a medical judgment, including determinations regarding whether treatment, drugs, or other items are experimental, investigational, or not medically necessary or appropriate, the BRAB shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional must not have been involved in the initial adverse claim determination, nor be the subordinate of the professional involved in the initial adverse claim determination. The Plan Participant is entitled to know the identity of any medical or vocational experts whose advice Guardian and/or the BRAB obtained in connection with his claim, regardless of whether such medical or vocational expert's advice was relied upon in making the adverse determination.

(E) The BRAB will advise the Plan Participant of the results of its review, in accordance with paragraph (G) below, 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 up to 45 additional days 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.

(F) As soon as possible, and sufficiently in advance of the date on which the notice of an adverse benefit determination on appeal is required to be provided under paragraph (E) above, the BRAB or its delegate will provide the Plan Participant, free of charge, with any new or additional:

(1) Evidence considered, relied upon, or generated by the Plan in connection with the claim; and

(2) Rationale considered, relied upon or generated by the Plan.

(G) When the review of the appeal is completed, the Plan Participant will receive a written decision in accordance with this paragraph (G). If the Plan Participant's appeal has been denied, in whole or in part, the Plan Participant will be provided with a culturally and linguistically appropriate written or electronic notification of the adverse benefit determination, in accordance with applicable Department of Labor regulations. The notice of denial will include:

(1) The specific reason(s) for such denial;

(2) Reference to the specific Plan terms and conditions on which the denial was based;

(3) A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Records with respect to the claim and appeal;

(4) A description of the Plan's appeal procedures, the right to obtain information about such

procedures, and a statement that the Plan Participant has the right to bring a civil action under Section 502(a) of ERISA, including a description of the limitations period on bringing such action described below, with the date on which such limitations period will expire for the particular claim involved;

(5) A discussion of the appeal decision, including an explanation of the basis for disagreeing with or not following:

a) The views presented by the Plan Participant to the Plan of health care professionals treating the Plan Participant and the vocational professionals who evaluated the Plan Participant;

b) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Plan Participant's appeal, without regard to whether the advice was relied on in making the benefit determination on appeal; and

c) Any disability determination regarding the Plan Participant presented by the Plan Participant to the Plan that was made by the Social Security Administration;

(6) If the denial on appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(7) Either the specific Protocol(s) that the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such a Protocol does not exist.

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

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 Plan 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 delegate. 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, and Guardian with respect to initial claims determinations as described above, 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, in whole or in part, including without limitation amendments to required contribution levels and adjustments to benefits and termination of the Plan with respect to all Plan Participants or any group or class of Plan Participants, 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: (A) the date of approval of the resolution by the Board, if no effective date is stated in the resolution, (B) the effective date expressly set forth in the resolution, or (C) for an amendment required by law, the effective date expressly set forth in writing by the APA President.**

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

Recovery of 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.

Relationship Between Plan Participants and APA
The terms of this Plan are intended solely to govern the relationship between Plan Participants and the Plan. Nothing in this Plan is intended or should be interpreted to define, qualify, limit or provide terms and conditions for the relationship between APA and in the Plan Participants in non-Plan contexts. Nothing contained in the Plan shall limit or interfere with the right of APA to discharge, expel or take other action regarding a Plan Participant in his role as a member of the APA (or employee of the APA, where such role is applicable), regardless of the effect that such action may have upon such participant as a member of the APA.

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. Each Plan Participant should independently evaluate the quality of care received by the Plan Participant's medical provider(s) and act accordingly.

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. Each Plan Participant is responsible for providing the APA with such participant's current contact information. If a Plan Participant fails to do so, neither the APA nor the Plan shall be responsible for any late payment or loss of benefits, nor for failure of any notice to be provided or provided timely under the terms of the Plan to a Plan Participant or any other person entitled to receive benefits or notices from the Plan with respect to a deceased Plan Participant.

Plan Expenses
All 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
Allied Pilots Association
Attn: Benefits Department
14600 Trinity Boulevard, Suite 500
Fort Worth, TX 76155-2512
(817) 302-2140
(800) 323-1470 Ext. 2140

Specific Plan Information or Billing Questions
NGS Insurance Agency, Inc.
P.O. Box 830846
Richardson, TX 75083-0846
(800) 298-8793

Claims Information
Guardian Life Insurance Company
P. O. Box 14333
Lexington, KY 40512
(866) 543-0090

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 Attn: Benefits Department 14600 Trinity Boulevard, Suite 500 Fort Worth, TX 76155-2512 (800) 323-1470 Ext 2140
Agent for Service of Legal Process	Allied Pilots Association Attn: Benefits Department 14600 Trinity Boulevard, Suite 500 Fort Worth, TX 76155-2512
Plan Processor	**NGS Insurance Agency, Inc.** P.O. Box 830846 Richardson, TX 75083-0846 (800) 298-8793
Claims Processor	Guardian Life Insurance Company of America P.O. Box 14333 Lexington, KY 40512 (866) 543-0090
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 Guardian and NGS
Master Trustee	State Street Bank
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 such Member 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. In addition, a Member who is on a Voluntary Short-Term Leave of Absence, as described in Board Resolution R2020-23, will continue to be treated as in Active Flight Status, to the extent provided under such resolution.

Active Member
The term "Active Member" means a pilot of the Company who is also an APA member under the Constitution and Bylaws or other applicable governing documents.

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

Agreement
The term "Agreement" means the Collective Bargaining Agreement (within the meaning of Section 7701(a)(46) of the Internal Revenue Code) between the Company and APA.

APA
The term "APA" means the Allied Pilots Association.

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

Apprentice Member
The term "Apprentice Member" means a Member who is a first time, newly hired pilot of the Company and classified as an "apprentice member" by APA under its Constitution and Bylaws or other applicable governing documents.

Apprentice Member Benefit Program Participant
The term "Apprentice Member Benefit Program Participant" means an Apprentice Member who is participating in POD, in accordance with R2018-69 Rev 2 and the provisions of this booklet.

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 up to 24 Monthly Payments for Chemical Dependency, as applicable) for a Period of Disability.

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. The Guardian Life Insurance Company is the Claims Processor.

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

Constitution and Bylaws
The term "Constitution and Bylaws" means the APA Constitution and Bylaws, as they may be amended from time to time.

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. The Plan Participant must be under the Regular Care and Attendance of a Physician and unable to maintain a first 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 or Effective Date of Coverage
The term "Effective Date" or "Effective Date of Coverage" 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.

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, including without limitation Apprentice Members.

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 Plan Participant is Disabled. It begins with the Onset of Disability and ends on the later of:

(A) The first day of the month following the day that is 12 months from the Onset of Disability, or

(B) The date the Plan Participant exhausts:

(1) the number of sick hours either designated by the Plan Participant or required by the working Agreement prior to receiving Company long term benefits; and

(2) any vacation[4] from the Company.

For a Recurring Disability, this includes any paid sick or vacation[4] 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 Recurring Disability. For a Subsequent Disability that occurs during an existing 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.

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 connections 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.

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 Guardian 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. (See the "Extended Benefit" subsection for more information.) The amount of the Extended Benefit is the same as the amount of the Basic Benefit.

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.

File, Filed or Files
The terms "File," "Filed" or "Files" mean the date the claim form is postmarked, if mailed, or sent by overnight delivery; otherwise, it is the date Guardian 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 American Eagle, 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.

Guardian
See "Claims 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 which causes a Disability provided that the Onset of Disability due to such injury is within six months of the date of the injury.

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 for claims filed before June 1, 2021 or 120 Monthly Payments for claims filed on or after June 1, 2021, 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 paragraph (A) above or described in paragraph (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 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:

(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 example under "Basic Benefits" subsection of BENEFIT AMOUNT section.)

(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.

Member
The term "Member" means each of the following individuals:

(A) An Active Member;

(B) An Apprentice Member;

(C) An Executive Member; and

(D) A Grandfathered Executive Member.

Membership Date
The term "Membership Date" means the date a Member's application for membership in APA is approved by vote by the membership of the domicile that has jurisdiction over the application as described in the APA Constitution and Bylaws.

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.

NGS
See “Plan Processor”.

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.

Overpayment(s)
The term “Overpayment(s)” means any amount paid to or on behalf of a Plan Participant by the Plan that is greater than the benefit to which the Plan Participant is entitled, including without limitation benefits erroneously paid by the Plan based on a mistake of fact or administrative error or as a result of fraud, misrepresentation, or concealment of any relevant fact (as determined by the Plan Administrator in its sole discretion).

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 Recurring Disability.

Any Disability that a Plan Participant incurs following a return to Active Flight Status, that is not a Recurring Disability, will be considered to commence a new Period of Disability, subject to all Plan provisions including the requirement for a new Elimination Period.

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 such practitioner’s 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 (POD).

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. NGS Insurance Agency, 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 care that rises above the level of consultation; or

(B) 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 Guardian 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 such participant’s Disability, among other items.

Protocol
The term “Protocol” means an internal rule, guideline, standard, or other similar criterion with respect to a Plan benefit 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 all documents, records, and other information relevant to a Plan Participant’s claim for benefits.

Recurring Disability
The term “Recurring 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.

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

(A) The date the Plan Participant exhausts Company paid sick and vacation[4] time, or

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

(C) 90 days after the date the Disabled Plan Participant was removed from Active Flight Status because of the Recurring 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:

(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.

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.

Subsequent Disability
The term “Subsequent Disability” means a Disability that occurs while a Plan Participant is in an existing Period of Disability.