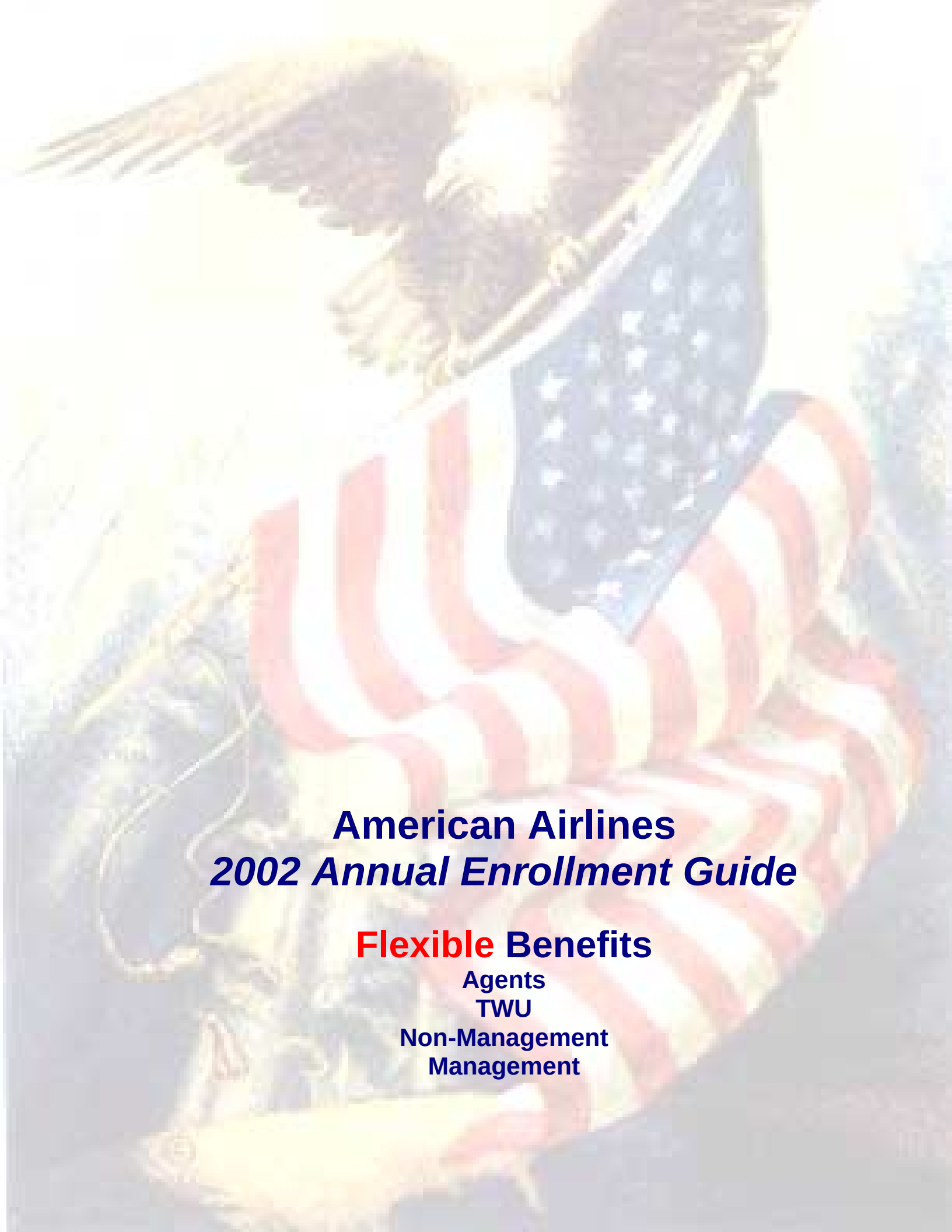

American Airlines
2002 Annual Enrollment Guide

Flexible Benefits

Agents
TWU
Non-Management
Management

Table of Contents

What's New for 2002

New and Improved Benefits

- **Dental**

Plan 1 now covers more of your dental needs. Preventive care is covered completely—100% when you use a network provider. And…adult orthodontia has been added. More details are provided on page 9.

- **Vision**

You asked for it! We've added an entirely new Vision Plan. This is not the discount program currently offered. The new Vision Plan covers eye exams, lenses and frames, or contacts for each covered member. More details are provided on page 10.

- **Life Insurance**

Optional life insurance coverage levels will increase from six up to seven times your annual salary. You can increase your current coverage one level when you submit a Statement of Health Form to MetLife. More details are provided on page 11.

Medical Plan Changes

You've probably seen the headlines proclaiming the increase in health care costs. Medical costs have increased each year for the last four years, and many employers and their employees, including American, are feeling the hit. We've seen the average cost per employee for medical claims increase by 17%. Prescription drugs increased a whopping 35% over last year, according to national surveys.

Obviously, this poses a real challenge for us. How do we continue to offer employees the quality benefits plans they expect and deserve when costs are increasing so dramatically?

American has always provided better benefits at a lower cost to employees than most other companies. For example, our employees generally contribute less than 10% toward the cost of their medical coverage, depending on the plan. The average employee contribution for other large companies is 22%.

We looked at ways to keep the employee contribution low and still control the increasing cost of providing coverage. The best way to accomplish that was to make changes to the medical plans and to the prescription drug benefit, where our costs are substantially increasing.

There will be some increases in what you pay for medical care in 2002, but depending on how you use your medical benefits, you may not see much of a difference. However, employees who frequently use some of the more expensive services (such as name-brand prescriptions) will see greater increases in their out-of-pocket expenses. Basically, the more you use, the more you'll pay. The following pages list the changes for 2002.

What's New for 2002

Point-of-Service (POS) Plan

- Network physician office visit copayments will increase by $5. The primary care physician copayment will be $15. The specialist copayment will be $25.
- The current $100 copayment maximum for some network specialist visits (including physical, speech, and occupational therapy; allergy specialist visits; and outpatient chemical dependency) will be eliminated. Each visit will continue to require a $25 copayment.
- The network maternity copayment will be $150 for births occurring after 12/31/01.
- Prescriptions from a network retail pharmacy (up to a 30-day supply) will increase to a $7 copayment for generic drugs and $15 for brand name. If a brand name drug is requested but a generic is available, the copayment will be $7 plus the cost difference between the retail price of generic and brand name, regardless of whether a physician prescribes a brand name.
- A $50 annual deductible for network hospital-based (inpatient and outpatient) services will be introduced. Participants will pay the first $50 of hospital-based services, after which the 10% coinsurance will apply and accumulate to the out-of-pocket maximum.
- Out-of-pocket maximum for network hospital-based services will increase to $1,500. Out-of-pocket maximum for out-of-network hospital services will increase to $3,000.
- Emergency room copayment will increase to $75. The annual deductible does not apply. (The $25 copayment for urgent care will not increase.)

Mail Order Prescriptions

- Mail order prescription (90-day supply) copayments will remain $10 for generic and increase to $30 for brand name prescriptions. If a brand name drug is requested but a generic is available, the copayment will be $10 plus the cost difference between the generic and brand name, regardless of whether the physician prescribes a brand name.

HMO Changes

HMOs are available in most locations throughout the country for those who prefer HMO services for their medical care. Three of those HMOs will no longer be available in 2002. Only employees currently enrolled in either Maxicare of California, HIP of Florida, or Pacificare of Texas will be affected. **Important: If you are currently enrolled in one of these plans, you will need to select another medical plan. Some employees may have received Texas Health Choice as an HMO option for 2002 on the worksheek - please disregard as this HMO is no longer an option.** You can choose another HMO in your area, if available, or you can select from the POS or Standard plans. Available options will be listed on your enrollment worksheet.

Why have you made so many changes to the POS plan?

This is still the most comprehensive plan we have and a lot of employees like it. What you may not realize is that the other plans, Standard and HMO, already allow for increases in medical care costs within their plan structures or employee contributions.

What's New for 2002

Employees enrolled in the Standard Plans pay 20% of the cost for most services rather than a fixed copayment. So, when costs increase, so does the amount paid by the employee. HMOs set their fees individually, and most of them are increasing their rates this year also. Since the fixed copayments for POS do not make allowances for medical cost increases, we must periodically review them to ensure that they are realistic.

We think we've come up with some effective ways to minimize the cost increases for most employees. And, although we've listed several increases, the annual cost for typical services will not be significantly higher for most employees. For example, if you have a family of three and each of you goes to your primary care doctor three times during the year, your copayments in 2002 will only be $45 more for the year. And, you're still receiving coverage for the features that employees choose POS for, like preventive services. Even with these changes, employees are still receiving a lot of benefit for their contribution dollars.

What about the monthly contribution from my paycheck?

The company absorbs most of the increased cost in medical coverage, but there will be some increases this year to employees' monthly contributions. The amount of increase depends on which medical plan you choose. It also depends on whether you cover yourself only, employee plus one, or employee plus two or more. The level of increase for 2002 will be greater for the larger family size.

2002 Medical Plan Monthly Rates

Plan	Employee		Employee +1		Employee +2 or more	
	2001	2002	2001	2002	2001	2002
Point-of-Service	14.67	15.52	29.26	30.96	38.81	46.56
Standard Plan 1	15.55	16.45	30.93	32.72	40.91	43.28
Standard Plan 2	11.55	12.22	23.20	24.55	30.92	32.71
Standard Plan 3*	(9.59)	(1.71)	(19.96)	(4.19)	(26.00)	(5.39)
Waive—no coverage*	(9.59)	(1.71)	(19.96)	(4.19)	(26.00)	(5.39)

* Cash back in your paycheck

Medical Plan Options

Our employees and their families have very different needs when it comes to benefits. So the company offers you a choice in medical plan options. You choose the plan that's right for you.

Point-of-Service Plan (POS)

The Point-of-Service Plan, administered by United Healthcare, is currently available in most locations and offers a network of physicians and hospitals that provide medical services to participants at negotiated rates. This means lower out-of-pocket expenses for you when you use network providers. Your benefits enrollment worksheet will list POS as an option if it is available in your area.

- You select a primary care physician (PCP) who coordinates your network services for you.
- Participants pay only a copayment or coinsurance for network services.
- Preventive care, such as annual physicals, well child exams, and preventive gynecological exams are covered when you use network providers.
- You have the option of using physicians and other service providers who are not part of the network, but you may have higher out-of-pocket costs and some services may not be covered.

If you are changing plans and choose to participate in POS, you will need to select a PCP for you and your dependents. **If you do not select a PCP, one will be selected for you.** You and your dependents may each choose your own PCP. If you are already enrolled in POS, you won't need to change your PCP unless you wish to change physicians. You can search for a participating physician in your area at United Healthcare's on-line directory at www.provider.uhc.com/american or by contacting United Healthcare at 800-545-9075. (When you enroll online, you can select a PCP on United Healthcare's website from the "Additional Contacts" page.)

Standard Medical Plans

The Standard Medical Plans, also administered by United Healthcare, pay benefits for eligible medical expenses. When you enroll, you may choose Plan 1, Plan 2, or Plan 3.

- All three plans require you to satisfy an annual deductible before the plan pays a percentage of your medically necessary expenses. The plans differ in the amount of deductible and the annual maximum out-of-pocket expense.
- After you meet the annual deductible, the plan pays 80% of eligible expenses for medically necessary services up to the usual and prevailing fee limits.
- All three plans have the same features and cover the same eligible expenses.

The Standard Medical Plans allow you the option of using any licensed physician. However, to keep your out-of-pocket costs down, the Standard Medical Plan offers a Preferred Provider Organization (PPO) of physicians, hospitals, and other medical service providers that offer discounted fees for medical services. The PPO helps save you and the company money when you choose a participating provider. You can locate PPO providers online at www.provider.uhc.com/american or by contacting United Healthcare at 800-638-9599.

Medical Plan Options

Medical Plan Deductibles and Maximums				
Features	**Standard Medical Plans**			**Point-of-Service**
	Plan 1	**Plan 2**	**Plan 3**	**In-network**
Individual annual deductible	$150	$300	$1000	$50 for hospital-based services
Family annual deductible	$400	$900	$3,000	None
Individual annual out-of-pocket maximum*	$1,000	$1,500	$2,000	$1,500*

* Does not include deductibles and copayments

Health Maintenance Organizations (HMOs)

HMOs are insured programs whose covered services are paid by the HMO. HMOs are offered in many areas, but the plans vary by location. If you live in an area that offers one or more HMOs, the names of those will appear as options on your annual Enrollment Worksheet. **Please keep in mind that many HMOs are introducing benefits changes for 2002.** A comparison of each HMO's plan (including changes for 2002) can be viewed online at **PeopleLink.aa.com**. From the "Welcome" page, select "Additional Contacts" at the bottom of the screen to access UltraLink's website for this information. A list of HMO contact numbers is also provided at the end of this Enrollment Guide.

- HMOs include a network of physicians, hospitals, and other medical service providers. Your medical care is only covered when you use network providers.
- Usually, a primary care physician coordinates your medical care.

Ask for Generic and Save!

Prescription drugs can be a costly expense. Depending on your prescription needs, using generic prescriptions can result in significant savings.

A mail-order prescription (90-day supply) for a common blood pressure brand name medication may cost you $98. The generic version may cost you $10. That's an annual savings of $352!

Medical Plan Options

Medical Plan Comparison			
Feature	**Standard Medical Plans**	**Point-of-Service Plan**	
		Network	**Out of Network**
Copayments, deductibles and 50% coinsurance amounts do not apply to the annual out-of-pocket maximum			
Annual preventive exam including gynecological, prostate exams	Not covered	$15 copay	Not covered
Primary care office visit	20% coinsurance	$15 copay	30% coinsurance
Specialist office Visit	20% coinsurance	$25 copay	30% coinsurance
Well-child care	20% for children up to age 2, for initial hospitalization following birth, all immunizations, and up to 7 well-child care visits	$15 copay with no age limit	30% for children up to age 2, for initial hospitalization following birth, all immunizations, and up to 7 well-child care visits
Urgent care clinic	20% coinsurance	$25 copay	30% coinsurance
Outpatient surgery in hospital or surgical facility	20% coinsurance	10% coinsurance[1]	30% coinsurance
Diagnostic x-ray or lab	20% coinsurance	10% coinsurance[1] in hospital; no charge at network lab or physician office	30% coinsurance
Hospitalization	20% coinsurance	10% coinsurance[1]	30% coinsurance
Surgery	20% coinsurance	10% coinsurance[1]	30% coinsurance
Emergency room	20% coinsurance (Accidents covered at 100% up to $250 with no deductible)	$75 copay or 10% coinsurance[1] if admitted	30% coinsurance
Inpatient mental health care	20% coinsurance	10% coinsurance[1]	50% coinsurance (up to 30 days per year)
Outpatient mental health care	50% coinsurance	$25 copay per visit	50% coinsurance (up to 60 visits per year)
Retail pharmacy (up to 30-day supply)	20% coinsurance 50% for psychotherapeutic drugs	$7 copay generic $15 copay brand name[2], including psychotherapeutic drugs	30% coinsurance 50% for psychotherapeutic drugs
Mail order pharmacy (up to 90-day supply)	$10 copay generic $30 copay brand name[2] 50% coinsurance for psychotherapeutic drugs		

[1] $50 deductible for hospital-based services applies

[2] If a generic drug is available and brand name is requested, you pay the generic copayment, plus the cost difference between the name brand and the generic drug, regardless of physician request for brand name

Dental

Great News! Enhancements to Dental Plan 1!

We've got two plans for you to choose from – Dental Plan 1 and Dental Plan 2. Both plans are administered by MetLife and pay benefits for routine dental care and treatment for disease, defect, and injury. **Features new to Plan 1 are:**

- Preventive services will be covered at 100% when you use a network provider
- Maximum benefit per person will be $1,500 each year
- Adult orthodontia services will be covered at 50%
- Maximum lifetime orthodontia benefit (adult or child) will be $1,500

Features	You Pay…	
	Plan 1	Plan 2
Deductible per person each year	$50	$50
Preventive services (exams, cleanings, and routine x-rays), maximum 2 visits per year	0%[1] (deductible does not apply)	20%[1]
Basic and Major services (fillings, extractions, crowns, inlays, and dentures)	20%[1]	50%[1]
Maximum benefit per person each year	$1,500	$1,000
Orthodontia services	50%[1]	50%[1] (dependent children only)
Maximum lifetime orthodontia benefit	$1,500	$1,000 (dependent children only)

[1] This represents the amount you pay when you visit a dentist in the Preferred Dental Program. If you choose an out-of-network dentist, you may have additional out-of-pocket expenses.

2002 Dental Plan Monthly Rates			
	Employee	Employee + 1	Employee + 2 or more
Dental Plan 1	.80	1.88	2.63
Dental Plan 2*	(2.94)	(5.47)	(7.81)
Waive*	(14.47)	(27.44)	(39.12)

* Cash back

The Preferred Dental Program (PDP)

You may see any dentist you like, but if you see a dentist that participates in MetLife's PDP, you'll most likely pay less. The PDP offers a network of over 40,000 dentists nationwide who provide discounts to plan participants. MetLife negotiates rates with participating dentists; therefore, in most cases your out-of-pocket expenses are reduced. You can locate a participating dentist on-line at **www.metlife.com** or contact MetLife at 800-474-7371.

Vision Plan

New this year!

We've added a vision plan as a new benefit for 2002, which replaces the current vision discount program. If you or members of your family wear glasses or contacts, you may want to consider this. It's structured more like the medical plan—there are network providers, and copayments for certain vision services.

Spectera®, a national vision care company, will insure this benefit. Spectera's network of providers includes retail chains such as Eyemasters®, as well as independent providers. You can locate participating providers by visiting Spectera's website at **www.spectera.com** or by calling 800-839-3242. (If you visit the website for information during enrollment, use 999-99-9999 in place of your Social Security number for access.)

The vision plan covers the following services, available once per year for each covered member.

Covered Services	You Pay…
Comprehensive Vision Exam	$10 copayment
Pair of lenses[1] (for glasses) ▪ Clear single vision ▪ Clear lined bifocal ▪ Clear lined trifocal ▪ Clear Lenticular **Frames**[1] ▪ Selection[2] frame ▪ Non-Selection[2] frame	 $25 copayment $25 copayment $25 copayment $25 copayment $25 copayment $25 copayment plus the difference (if any), at Spectera's preferred price.
Contact Lenses (in lieu of lenses and frame) ▪ Selection[2] contact lenses ▪ Non-Selection[2] contact lenses	 $25 copayment $105 allowance toward the evaluation, fitting fees and contact lenses.

[1]Single $25 copayment covers 1 pair of frame and lenses.
[2] Retailer may have a select group of vision products available under the plan.

2002 Vision Plan Monthly Rates	
Employee only	$6.70
Employee + one	$13.00
Employee + two or more	$18.99

Will I still be able to use my EPCA discount card next year?

No, the discount program is being replaced by the vision plan, which covers more of the cost for vision services.

Last year I selected the vision discount. If I don't want to make any changes to my benefits, will I be automatically enrolled in the new Vision Plan?

No, due to the differences between the previous discount program and the new Vision Plan, you'll need to select the Vision Plan this year if you want to take advantage of the benefit.

Life Insurance

Eligible employees may participate in Employee, Spouse and Child Term Life Insurance plans. Employee Term Life Insurance coverage is for you only and pays a benefit to your designated beneficiary in the event of your death. Life Insurance coverage for your spouse and/or children is also available. MetLife administers this benefit.

The company provides **Basic Coverage** equal to two times your pay, up to $70,000. You may increase your coverage one level each year with proof of good health. If you choose to increase during annual enrollment, you must provide proof of good health by completing a Statement of Health Form, included in your enrollment packet, or available on-line at **PeopleLink.aa.com** and forward it to MetLife for approval.

New Option for 2002…

The maximum Life Insurance coverage has increased from 6 to 7 times salary, with proof of good health.

Employee/Spouse Contributory Term Life Insurance Age Rates	
Age as of January 1, 2002	2002 Monthly Rate per $1,000 of Coverage
16-24	$0.05
25-29	$0.06
30-34	$0.07
35-39	$0.08
40-44	$0.13
45-49	$0.22
50-54	$0.36
55-59	$0.57
60-64	$0.88
65 +	$1.58

Proof of Good Health

Proof of good health, or Statement of Health, is a MetLife form that you must complete when you:

- Increase your level of Life Insurance
- Add or increase Spouse Life Insurance
- Add Long-Term Disability or Optional Short-Term Disability

Important: You can make these selections at the time of enrollment, however, they are not effective until MetLife receives and approves your Statement of Health.

Flexible Spending Accounts

Flexible Spending Accounts offer you a great opportunity to save money and taxes on expenses not covered by your health care plan(s) and some dependent day care expenses. Flexible Spending Accounts, **administered by FBD Consulting**, allow you to set aside money from each paycheck before taxes are deducted. Money that previously went to taxes can be used to pay your eligible health care and day care expenses.

When you enroll for benefits, you determine how much you want to deposit in your account. Payroll will automatically divide that amount over the year, and deduct equal amounts from each paycheck, beginning in January 2002.

You should **carefully** determine the predictable health care and/or day care expenses you and your family incur during the year that may be eligible under the Flexible Spending Account Plan. Federal tax law requires that any money in your account which exceeds the amount of eligible expenses incurred for the year must be forfeited. In other words, **what you don't use, you lose**, so plan to contribute only as much as you will actually use during 2002.

How much can I deposit?

Each year, you can deposit any amount up to **$4,000** in a Health Care Flexible Spending Account and up to **$5,000** in a Dependent Day Care Flexible Spending Account.

What health care expenses are eligible for reimbursement?

Most deductibles, copayments and other out-of-pocket expenses not already covered by your medical, dental or vision plans. These include, but are not limited to medical, dental (except cosmetic procedures), vision, or hearing, and prescription drugs. Check your Employee Benefits Guide for a more comprehensive listing of eligible expenses.

What about Dependent Day Care Flexible Spending Accounts?

You may receive reimbursement from a Flexible Spending Account for Dependent Day Care services for your eligible dependents including children under age 13 and for a person over the age of 13 (including your child, spouse or parent) meeting specific criteria. An eligible dependent must live with you and depend on you for support, be physically or mentally incapable of selfcare, and be claimed as a dependent on your federal income tax return.

Good Things to Know

Vacation Buying

As a Flexible Benefits participant, you may have the option of purchasing up to five additional days to add to your regular earned vacation time. You may only purchase vacation days during annual enrollment. Your Enrollment Worksheet shows your cost to buy additional vacation days. The rate is determined by your rate of pay and job status on July 31 of the previous year. You receive your vacation pay based on your base pay rate in effect at the time you take your vacation. Eligibility requirements apply, so please refer to your Employee Benefits Guide or go on-line to **PeopleLink.aa.com** for more information.

Life Events

Certain circumstances may allow you to change your benefit elections at times other than the annual enrollment period. These circumstances are called Life Events and are subject to IRS rules. Here are a few examples of what is considered a Life Event:

- Marriage, divorce, legal separation
- Birth or adoption of a child
- Adding eligible dependents to your household
- Death of a covered dependent
- Dependent child no longer qualifies
- Adding an eligible domestic partner or ending a domestic partner relationship
- Return from unpaid leave of absence
- You or your spouse/domestic partner change from full-time to part-time or vice-versa
- Change in spouse/domestic partner employment or health coverage
- Relocation
- Dependent care provider changes

If you experience a Life Event during or after your enrollment you may update your records and make any **eligible** changes to your benefits within 60 days on-line at **PeopleLink.aa.com**. However, the following Life Events require that you contact a PeopleLink Representative at 800-447-2000:

- Add or Drop a Domestic Partner
- Dependent care provider changes
- You or your spouse/domestic partner change from full-time to part-time or vice-versa
- Death of a covered dependent
- Relocation
- Return from unpaid leave of absence
- Legal Guardian
- Legal Separation

Good Things to Know

Eligible Dependents

Your eligible dependents include the following:

- Spouse or Domestic Partner.
- Unmarried child under age 19 (natural, legally adopted, stepchild or special dependent if the child lives with you and you claim the child as a dependent on your federal income tax return).
- Unmarried, incapacitated child age 19 or over (special circumstances apply).
- Unmarried child age 19-22 if registered as a full-time student.

Employees Married to Other Employees

If you are married to another AMR employee (American Airlines, American Eagle, or TWA), your marital status will affect the total cost of your family coverage, how deductibles are applied, and Flexible Spending Accounts. Please contact PeopleLink for details.

If you or your spouse experience a change in job status with American Airlines please call PeopleLink to obtain more information regarding your benefits.

Domestic Partners

If you wish to enroll a Domestic Partner for benefits or travel, call PeopleLink at 800-447-2000 to obtain a kit. If you are covering a Domestic Partner under your medical benefits, you are not eligible to participate in an HMO and may not be reimbursed for their claims under Flexible Spending Accounts. For more information regarding tax implications, please refer to your Domestic Partner kit.

Imputed income values for tax purposes will increase for 2002 in line with the increase in costs.

Long-Term Care

Long-Term Care is the type of help you need when you're no longer able to do the things you take for granted everyday, such as getting out of bed, eating or even taking a shower. Long-Term Care Insurance is an option available to employees and other eligible family members, and is handled directly through MetLife. For information or an enrollment package, call MetLife at 888-526-8495. You may enroll any time, but if you enroll later than 60 days after your hire date, you will be required to provide proof of good health.

For the Record…

Naturally, we know you know, but for the record, the information you provide when enrolling must be true and accurate, and all covered dependents must qualify for coverage according to the eligibility requirements listed in the Employee Benefits Guide. Although we don't require dependent documentation, random audits are conducted from time to time to ensure that only eligible dependents are covered. Falsification of information may result in disciplinary action, up to and including dismissal.

How to Enroll

Before you get started, take a moment to review your Enrollment Worksheet to make sure your personal information is correct. This form lists your dependents and shows the benefits you and your dependents are currently enrolled in.

We've made it simple, but you have to follow the steps and enroll before your deadline!

Step 1: Review your dependents

- Make sure your dependents (including spouse, child(ren), or domestic partner) are correct and are eligible for benefits.

- If one or more of your dependents are no longer eligible for benefits, or you need to add a dependent, you must update your records before enrolling. You can complete a **Life Event** change online at **PeopleLink.aa.com,** or you can call PeopleLink at 800-447-2000. If you add a dependent during enrollment, coverage will be effective January 1, 2002.

Step 2: Check out your options

- Your benefits options for 2002 are listed on your Enrollment Worksheet. Review your options carefully and make your selections based on what is best for you and your family. Feel free to use your worksheet as a guide and mark your choices. Because you don't turn in your worksheet, it is yours to keep.

- **Are you happy with what you've got and don't need to make any changes? You're done!** You will automatically be re-enrolled in your current selections, including your Flexible Spending Accounts, if any. (Your amounts will be the same as last year.) If you are currently participating in the Point-of-Service plan, there is no need to re-select your primary care physician, unless you wish to do so. **Please note: The current vision discount program will not be offered next year. If you wish to participate in the new Vision Plan, you will need to enroll in it.**

Step 3: Enroll for 2002

- You can enroll online or by phone through PeopleLink. Either way, be sure you **complete your enrollment before the deadline** shown on your Enrollment Worksheet.

How to Enroll

ENROLL ONLINE

You can access PeopleLink at work on the Intranet. From the company web page, click on "Employee Information" on the left margin. Then click on "PeopleLink" and you will be directed to the PeopleLink website.

From home, you can access the PeopleLink website at **PeopleLink.aa.com**.

- If this is your first visit, log onto PeopleLink using your personnel number (no leading zeros) as your user name and the last six digits of your Social Security number as your password. You will be prompted to change your password and log in again.
- If you've forgotten your previous password, click "Reset Password" and follow the prompts.
- After logging on, the first page you'll see is "Contact Information". You can make corrections if necessary by selecting the "Edit" button at the bottom of the page. Otherwise, select "PeopleLink Homepage", and you will be directed to the "Welcome" page. From there, you can select "Benefits Enrollment" to begin enrollment.
- Choose your benefits. As you select each option, you can view your monthly cost for each benefit. When you are comfortable with your selections, click on "Confirm". You will then be prompted to request forms, if needed. If you click on "No Changes", your current elections will remain in place.
- After you have made your selections and clicked "Confirm", you'll see a "Confirmation Summary" listing the choices you've just made for 2002. If you would like to change something, click on the "Change" button and go back and make another selection. When you are satisfied with your changes, click on "Confirm" again and your new choices will be accepted. This is a good time to print a copy of your screen so that you have a list of your selections.
- You will be directed to the "Additional Contacts" page. If you have enrolled in Point-of-Service for the first time, you can click on the United Healthcare website to select your primary care physician.
- During your enrollment period, you can make changes at any time up to your deadline date. **After your deadline date, your selections are final.**

ENROLL BY PHONE

If you are adding any dependent children, please complete page 2 of your worksheet before you make the call. Your dependent's names will need to be converted to numbers in order to add them over the phone.

Call PeopleLink at 800-447-2000 and you will hear a series of four options. Press 2 and you'll be guided step-by-step through the enrollment process.

How to Enroll

Sign-in and Confirm Status

- Enter your personnel number and numeric PIN at the prompt. If you forgot your PIN, you will be prompted to reset it. You may also call a PeopleLink rep (at the same number) for assistance with resetting your PIN.
- Verify the your zip code, as shown on your worksheet. Your zip code determines availability of certain options, such as medical plans.
- You will be asked if your spouse also works for an AMR company. Follow the prompts to provide this information.
- You will be asked to make any necessary changes to your dependents on file. Follow the instructions if you want to enroll or drop any dependents from your current coverage, or if you wish to add an eligible dependent child to your records. Enter the two-digit number (on page 2 of your worksheet) that represents each letter of the dependent's name. (For example: "21" for A, "22" for B, etc.) If the dependent's last name is the same as yours, you will not need to enter the codes for the last name.

Select Benefits Options

- You will hear your benefit options and be asked which plans you wish to select. Listen carefully and press the appropriate number for the option you wish to select.
- The system will read your elections back to you and ask that you confirm them. You can either confirm your selections, or follow the instructions to elect a different option.

Confirm Your Choices

- After you have selected your options, the system will repeat your elections. If you are satisfied with your choices, press "1" to enroll. The system will tell you that your elections have been accepted. This may take a few seconds. If you don't hear this message, call a PeopleLink representative at 800-447-2000 to confirm that your elections were accepted.
- If you would like to review your elections, press "9" and follow the instructions to hear a recap of your options. You may go back to any selection you wish to change. Once you have made changes, review and confirm your elections.

Keep your enrollment worksheet for your records. Since the process is automated, you don't need to return the worksheet.

Important Contacts

PeopleLink (800) 447-2000

UnitedHealth Care (800) 545-9075 – Point-of-Service Plan
www.provider.uhc.com/american (800) 638-9599 – Standard Medical Plans

MetLife (800) 474-7371 – Dental Plans
www.metlife.com

Merck-Medco RX Services (800) 988-4125 – Prescription Drug Program
www.merck-medco.com
Note: When presented with firewall, ***proxy.aa.com*** box, click on CANCEL to proceed.

Spectera (800) 839-3242 – Vision Plan
www.spectera.com

FBD Consulting, Inc.
www.fbdconsult.com/services/aafsa/index.html (888) 537-4643 – Flexible Spending Accounts

HMOs

State	HMO Name	Phone	Web Address
AZ	Health Net of Arizona, Inc.	(800)289-2818	www.az.health.net
CA	Health Net	(800) 522-0088	www.healthnet.com
CA	Kaiser Foundation Health Plan, Inc. Northern CA	(800) 464-4000	www.kaiserpermanente.org /california
CA	Kaiser Foundation Health Plan, Inc. Southern CA	(800) 464-4000	www.kaiserpermanente.org /california
CO	Kaiser Foundation Health Plan of CO	(800) 632-9700	www.kaiserpermanente.org
FL	Health Options, Inc.	(800)320-7091	www.bcbsfl.com
GA	Kaiser Foundation Health Plan of Georgia, Inc.	(800) 611-1811	www.kp.org
HI	Health Plan Hawaii	(808) 948-6372	www.hmsa.com
HI	Kaiser Foundation Health Plan, Inc.	(800) 966-5955	www.kaiserpermanente.org
IL	HMO Illinois	(800) 892-2803	www.bcbsil.com
IL	UNICARE Health Plans	(888)234-8855	www.unicare.com
MA	Harvard Pilgrim Health Care	(800) 542-1499	www.harvardpilgrim.org
MA	Tufts Health Plan	(800) 462-0224	www.tufts-healthplan.com
MD	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	(301) 816-5800	www.kaiserpermanente.org
MO	Aetna U.S. Healthcare, Inc.-Kansas City	(800)323-9930	www.aetnaushc.com
NC	Aetna U.S. Healthcare, Inc. NC-Raleigh-Durham	(800)323-9930	www.aetnaushc.com
NC	Blue Care	(877) 258-3334	www.bcbsnc.com
NY	Aetna U.S. Healthcare, Inc. New York	(800)323-9930	www.aetnaushc.com
NY	Blue Choice (BCBS of the Rochester Area)	(800) 462-0108	www.bcbsra.com
NY	HIP Health Plan of New York	(800) 447-8632	www.hipusa.com
NY	Univera Healthcare, WNY	(800) 427-8490	
OH	United HealthCare of Ohio, Inc. Columbus	(800) 225-7951	www.uhc.com
OK	CommunityCare Managed Healthcare Plans of Oklahoma	(800) 777-4890	www.ccmhp.com
OK	PacifiCare of Oklahoma	(800) 825-9355	www.pacificare.com
OR	Kaiser Foundation Health Plan of the Northwest	(800) 813-2000	www.kp.org/nw
PA	Aetna U.S. Healthcare, Inc. PA	(800)323-9930	www.aetnaushc.com
PR	Humana Health Plans of Puerto Rico	(787) 282-7900	www.humana.com
PR	TRIPLE-S, Inc	(787) 749-4777	www.ssspr.com
TX	HMO Blue Southwest Texas-Dallas	(877)299-2377	www.bcbstx.com
TX	HMO Blue Southwest Texas-Houston	(800)833-5318	www.bcbstx.com
VA	OPTIMA Health Plan	(800) 741-9910	www.optimahealth.com

Note: If Texas Health Choice is listed on your enrollment worksheet; please disregard as the news of their insolvency came after some enrollment packets were mailed