AMERICAN AIRLINES, INC.
HEALTH AND WELFARE PLAN WRAP DOCUMENT FOR ACTIVE EMPLOYEES

(Adopted Effective January 1, 2016)

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APPENDIX A A

AMERICAN AIRLINES, INC.
HEALTH AND WELFARE PLAN FOR ACTIVE EMPLOYEES
WRAP DOCUMENT

ARTICLE I

ESTABLISHMENT AND INTERPRETATION OF THE PLAN

1.01 The Plan. The terms and conditions of the American Airlines, Inc. Health and Welfare Plan for Active Employees are set forth in this document (the "Wrap Document") and in the Welfare Program Documents. This Wrap Document and the Welfare Program Documents together constitute the plan document for the American Airlines, Inc. Health and Welfare Plan for Active Employees and the written instrument under which the Plan is maintained for purposes of section 402(a) of ERISA.

1.02 Purpose and Intent. The purpose of the Plan is to provide Participants and Beneficiaries certain welfare benefits described herein. All of the Welfare Programs incorporated herein shall be treated as a single welfare plan for purposes of ERISA. This Plan is intended to meet all applicable requirements of the Code and ERISA, as well as rulings and regulations issued or promulgated thereunder. Nothing in this Plan shall be construed as requiring compliance with Code or ERISA provisions to the extent not otherwise applicable.

1.03 Definitions. When used herein, the following words shall have the meanings set forth below unless the context clearly indicates otherwise:

(a) "Administrator" as defined in section 3(16)(A) of ERISA means the Employee Benefits Committee, as described in Section 4.01.

(b) "Employee" means any person treated by the Employer as providing services to such Employer as a common law employee, including a common law employee who is on a Leave of Absence, whether the Employee is full-time or part-time. "Employee" does not include:

(1) any individual who performs services for the Employer pursuant to a leasing agreement between the Employer and a third-party, as defined in section 414(n) of the Internal Revenue Code, regardless of whether such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of the Employer;

(2) any individual who is a Temporary Employee, a Provisional Employee, or an Associate Employee, as defined in the Welfare Program Documents, regardless of whether such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of the Employer; and

(3) any individual who performs services for the Employer and is working in a classification described as independent contractor, is paid directly or

indirectly through the Employer's accounts payable systems, or performs such services pursuant to a contract or agreement which provides that the individual is an independent contractor or consultant, regardless of whether any such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of the Employer.

(c) "Beneficiary" means a beneficiary of a Participant as designated or determined under a Welfare Program.

(d) "Code" means the Internal Revenue Code of 1986, as amended from time-to-time, and any subsequent Internal Revenue Code. References to any section of the Code shall be deemed to include similar sections of the Code as renumbered or amended.

(e) "Dependent" means a covered dependent of an Employee, as determined under a Welfare Program.

(f) "Employer" means American Airlines, Inc. or any successor entity by merger, consolidation, purchase or otherwise.

(g) "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time-to-time. References to any section of ERISA shall be deemed to include similar sections of ERISA as renumbered or amended.

(h) "Former Employee" means any person formerly employed by the Employer as an Employee.

(i) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

(j) "Leave of Absence" means a personal leave, medical leave or military leave of an Employee, as approved by the Employer employing the Employee.

(k) "Participant" means any Employee or Former Employee who satisfies the requirements of Article II, is covered by one or more of the Welfare Programs under the Plan, and whose participation has not terminated in accordance with Section 2.04. The term "Participant" shall also include any former Dependent who is entitled to elect, and so elects, any continuation coverage on his or her own behalf.

(l) "Participant Contributions" means any pre-tax or after-tax contributions required to be paid by a Participant for coverage under any Welfare Program.

(m) "Plan" means the American Airlines, Inc. Health and Welfare Plan for Active Employees, as set forth in this Wrap Document and the Welfare Program Documents, as amended from time to time.

(n) "Plan Sponsor" as defined in section 3(16)(B) of ERISA means American Airlines, Inc. or any successor entity by merger, consolidation, purchase or otherwise.

(o) "Plan Year" means the 12-consecutive month period beginning each January 1 and ending on the following December 31.

(p) "Summary Plan Description" means the summary plan description for the Plan, as required by ERISA.

(q) "Third Party Administrator" means any insurer, third party administrator or other entity selected by the Employee Benefits Committee for the administration of the Plan, including initial and/or appeals claims determinations, under a self-insured Welfare Program.

(r) "Welfare Program" means the employee welfare benefits offered as part of this Plan, identified in Appendix A, and described in the Welfare Program Documents.

(s) "Welfare Program Documents" means (i) all provisions of any summary plan description for the Plan that set forth terms and conditions of the Welfare Programs, including without limitation the following sections of the Summary Plan Description: Eligibility and Enrollment; Medical Benefits; Prescription Drug Program; Dental Benefits; Vision Benefit; Health Care Flexible Spending Account; Limited Purpose Flexible Spending Account; Health Reimbursement Account; Life Insurance Benefits; Ground Employees – Accidental Death & Dismemberment (AD&D) Insurance Benefits; Flight Employees – Accidental Death & Dismemberment (AD&D) Insurance Benefits; Ground Employees – Short-Term Disability Benefits; Flight Employees – Short-Term Disability Benefits; Additional Rules That Apply to the Plan; COBRA; Claims Procedures; Plan Administration; Your Rights Under ERISA; and Benefits Under the Plan and Contact Information; (ii) any and all insurance policies and certificates of insurance and other documents that set forth the terms and conditions of an insured Welfare Program; and (iii) any and all benefits books or other formal documents provided by third party administrators of any self-insured Welfare Programs. Any amendment to a Welfare Program Document will constitute automatically an amendment to the Plan. The Summary Plan Description, together with supplements, is attached as Appendix C. The American Airlines, Inc. Cafeteria Plan (the "Cafeteria Plan") is attached as Appendix D for administrative convenience only. The Cafeteria Plan is not a Welfare Program Document and is not a part of the Plan.

1.04 Incorporation. The terms and conditions, including any limitations or restrictions, of each Welfare Program as set forth in the applicable Welfare Program Documents are incorporated by reference in this Wrap Document and constitute a part of the Plan.

1.05 Interpretation. If there is a conflict between a specific provision under this Wrap Document and the Welfare Program Documents, this Wrap Document controls. If this Wrap Document is silent, then the applicable Welfare Program Document controls. With respect to insured benefits, the terms of the certificate of insurance coverage control over the Wrap Document and any other Welfare Program Document when describing specific benefits that are covered or insurance-related terms.

1.06 Effective Date. The effective date of this Wrap Document is January 1, 2016.

ARTICLE II

ELIGIBILITY AND PARTICIPATION

2.01 Participation. Eligibility to participate in a Welfare Program shall be determined by the provisions of the applicable Welfare Program Documents.

2.02 Enrollment Procedures. The Administrator shall establish procedures for the enrollment of Participants in a Welfare Program. The Administrator shall prescribe enrollment forms, which may include electronic equivalencies that must be completed by a prescribed deadline prior to commencement or continuation of coverage under a Welfare Program.

2.03 Automatic Re-Enrollment for Medical Benefits. A Participant who is enrolled in a self-insured medical benefit option or in a Health Maintenance Organization ("HMO") under the Plan automatically will be re-enrolled in the same medical benefit option or HMO for the subsequent Plan Year, unless the Participant affirmatively changes options or disenrolls during an enrollment period. If the Participant's medical benefit option is no longer available, the Participant will be re-enrolled in the default medical benefit option as described in the applicable Welfare Program Document at the time.

2.04 Termination of Participation. A Participant will cease being a Participant in a Welfare Program and coverage under such Welfare Program for the Participant and his Dependents and Beneficiaries shall terminate in accordance with the provisions of the applicable Welfare Program Document.

2.05 Continuation of Coverage. A Participant may continue coverage for benefits under the Plan, as described in the applicable Welfare Program Documents.

ARTICLE III

CONTRIBUTIONS, BENEFITS AND CLAIMS

3.01 Employer Contributions. The Employer may make payments or contributions in such amounts and at such times as the Plan Sponsor shall from time-to-time direct. Such payments or contributions may be paid directly to each insurance company issuing a policy or contract in connection with an insured Welfare Program, or may be used to pay benefits directly (including through a Third Party Administrator) in the case of benefits under a self-insured Welfare Program. Nothing herein shall require the Employer to make payments or contribute to any Welfare Program or to pre-fund any benefit through any trust or otherwise.

3.02 Participant Contributions. Participation in the Plan and the payment of Plan benefits shall be conditioned on a Participant contributing to the Plan such amounts as the Plan Sponsor shall establish from time-to-time. The Plan Sponsor may establish different contribution rates for different classes of Employees, Former Employees, Participants, Dependents, or Beneficiaries for any Welfare Program. The Plan Sponsor may require that any Participant Contributions be made by payroll deduction.

3.03 Salary Reduction. Required Participant Contributions under the Plan may be made on a pre-tax basis through salary reductions, to the extent permitted by Code section 125 and the American Airlines, Inc. Cafeteria Plan. All other Participant Contributions will be made on a post-tax basis, except to the extent the Code is amended to provide otherwise.

3.04 Funding. Nothing herein shall require the deposit of any Employer payments or contributions or Participant Contributions to a trust. No Employee, Former Employee, Participant, Dependent or Beneficiary shall have any right to, or interest in, the assets of the Plan Sponsor or any Employer, or the assets of any trust or any other funding vehicle of the Plan.

3.05 Insurance. The Administrator may, but shall not be required to, insure any of the benefits provided by a Welfare Program. To the extent the Administrator elects to purchase insurance, any such insured benefits shall be the sole responsibility of the insurer, and neither the Plan Sponsor, nor the Plan shall have responsibility for the payment of such benefits. In the event that any insurer pays dividends, rebates, demutualization proceeds or similar payments, such amounts shall be paid to the Plan Sponsor to the extent permitted by law unless the Plan Sponsor elects to contribute such amounts to the Plan.

3.06 Benefits. Benefits under each Welfare Program (including limitations and restrictions) will be determined by the Administrator, Third Party Administrator or insurer, as applicable, in its discretion pursuant to the terms of the applicable Welfare Program Documents.

3.07 Claims Procedures. Each claim for benefits under a Welfare Program must be filed in accordance with the procedures set forth in the applicable Welfare Program Documents. All claims for benefits must be duly filed no later than the deadline for such Welfare Program set forth in the applicable Welfare Program Documents. All claims for benefits will be processed and may be appealed in accordance with the procedures for such Welfare Program as set forth in the applicable Welfare Program Documents.

3.08 Limitations on Actions. Participants must follow the claims procedures, including exhausting their rights to appeal, before taking action in any other forum regarding a claim for benefits under a Welfare Program. Any suit or legal action initiated by a participant for benefits under a Welfare Program must be brought by the Participant no later than two years following a final decision on the appeal of the claim for benefits by the person or entity described in the applicable Welfare Program Documents with the discretionary authority to determine appeals with respect to such claim. In no case may a suit or legal action be brought if the claim for benefits was not made within the time period prescribed in the claims procedures of the applicable Welfare Program Documents. This limitation on suits for benefits applies in any forum where a Participant initiates a suit or legal action.

3.09 Right to Request Medical Records. The Plan has the right to request medical, dental, and vision records for any Participant, Beneficiary or Dependent.

3.10 Right to Audit. The Plan has the right to audit Participant, Beneficiary and Dependent claims, including claims of medical providers. The Plan may reduce or deny benefits for otherwise covered services for all current and/or future claims with the provider, Participant, Beneficiary or Dependent based on the results of an audit.

3.11 Right to Recover Overpayment. Participants, Beneficiaries and Dependents are entitled to the benefits specified in Wrap Document and the applicable Welfare Program Documents, and benefit payments are made in accordance with the provisions of the applicable Welfare Program Documents. If it is determined that an overpayment was made (for example, due to an ineligible charge or because other insurance was considered primary), the Plan has the right to recover the overpayment. The Plan will attempt to collect the overpayment from the party to whom the payment was made, or a Participant, Beneficiary or Dependent, if and as applicable. Failure to refund any overpayment may result in the Plan offsetting future benefits by the amount of the overpayment.

3.12 Participant's Right to Recover Overpayments. If a Participant overpays contributions or premiums for coverage under the Plan, the Plan will refund excess contributions or premiums upon request of the Participant to the extent administratively feasible.

3.13 Right to Reduction, Reimbursement, and Subrogation.

(a) In General. The Plan has the right to reduce or deny medical or dental benefits otherwise paid by the Plan, and recover or subrogate 100% of the medical or dental benefits paid by the Plan for a Participant, Beneficiary or Dependent, to the extent of any and all of the following: (i) any judgment, settlement, or payment made or to be made because of an accident or malpractice, including but not limited to other insurance, (ii) any automobile or recreational vehicle insurance coverage or benefits, including but not limited to uninsured or underinsured motorist coverage, (iii) any business medical and/or liability insurance coverage or payments, and (iv) any attorney's fees. The Plan's right to reimbursement applies when the Plan pays benefits, and a judgment, payment, or settlement is made on behalf of the Participant, Beneficiary or Dependent for whom the benefits were paid. Reimbursement to the Plan of 100% of these charges shall be made at the time any such payment is received by a Participant, Beneficiary, Dependent or their

representative or any other entity. The Plan's right to reduction, reimbursement and subrogation is based on the terms of the Plan in effect at the time of judgment, payment or settlement.

(b) First Priority Right. The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation. The Plan has the right to recover interest on the amount paid by the Plan. The Plan has the right to 100% reimbursement in a lump sum. The Plan is not subject to any state laws or equitable doctrines, including, but not limited to, the common fund doctrine, which could otherwise require the Plan to reduce its recovery by any portion of a Participant, Beneficiary or Dependent's attorney's fees or costs. The Plan is not responsible for the Participant, Beneficiary or Dependent's attorney's fees, expenses, or costs. The Plan's right applies regardless of whether any payments to a Participant, Beneficiary or Dependent are designated as payment for, but not limited to, (i) pain and suffering, or (ii) medical benefits. This applies regardless of whether a Participant, Beneficiary or Dependent has been fully compensated for injuries. The Plan's right to reduction, reimbursement, and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any Participant, Beneficiary or Dependent. The Plan's first priority right shall not be reduced due to the negligence of the Participant, Beneficiary or Dependent.

(c) Cooperation. The Plan requires a Participant, Beneficiary, Dependent, and their representatives to cooperate in efforts to obtain reimbursement to the Plan from third parties. To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, Participants, Beneficiaries, Dependents and their representatives must, at the Plan's request and at its discretion (i) take any action, (ii) give information, and (iii) sign documents as required by the Plan. Failure to aid the Plan and to comply with such requests may result in the Plan's withholding or recovering benefits, services, payments, or credits due or paid under the Plan to a Participant, Beneficiary or Dependent under the Plan. A Participant, Beneficiary or Dependent and/or their representatives may not do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by a Participant, Beneficiary, Dependent or their representatives.

(d) Right to File An Action. The Plan has the right to file suit on behalf of a Participant, Beneficiary or Dependent for the condition related to the medical or dental expenses in order to recover benefits paid or to be paid by the Plan.

(e) Claim for Benefits and Right to Appeal. The application of the provisions in this Section 3.13 shall be treated as a benefit determination under the Plan that is initially made by the Employee Benefits Committee or its delegate and may be appealed to the Employee Benefits Committee or its delegate in accordance with the procedures set forth in this Wrap Document and in the applicable Welfare Program Documents. The Employee Benefits Committee or its delegate will have complete discretion to interpret and construe the provisions of the Plan in connection with any claim for benefits and appeal associated with this Section 3.13.

3.14 Coordination of Benefits.

(a) In General. The Plan has the right to coordinate its payment of medical or dental benefits with "other plans" under which a Participant, Beneficiary or Dependent are covered so that the total medical or dental benefits paid by the Plan together with other plans does not exceed the level of benefits that would otherwise be paid by the Plan. When a Participant, Beneficiary or Dependent is covered by more than one plan, under this coordination of benefits rule, one plan is designated the primary plan. The primary plan will pay benefits first and will not take into account benefits payable under other plans when determining the benefits it pays. Any other plan that pays benefits after the primary plan is designated the secondary plan. A secondary plan reduces its benefits by those benefits payable under "other plans" and may limit the benefits it pays. These rules apply whether or not a claim is made under the other plan. If a claim is not made, benefits under the Plan will be pended or denied until documentation is received showing a claim made with the primary plan.

For purposes of this coordination of benefits rule, "other plans" is defined to include the following types of medical and health care benefits:

(1) Coverage under a program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or regulation;

(2) Property or homeowner's insurance;

(3) Group insurance or other coverage for a group of individuals, including coverage under another employer plan or student coverage obtained through an educational institution;

(4) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

(5) Any coverage under governmental plans, such as Medicare, but not including a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private insurance, or nongovernmental program;

(6) Any private or association policy or plan of medical expense reimbursement which is group or individual rated;

(7) Any excess insurance policy; and

(8) Any retiree medical plan.

(b) Determining when the Plan is Primary and When it is Secondary. A plan without a coordination of benefits provision is always primary. The Plan has a coordination of benefits provision. If all plans have a coordination of benefits provision the following will apply:

(1) The plan that covers the participant or beneficiary as an employee pays first, and the other plan pays second.

(2) The plan covering the participant or beneficiary for whom the claim is made as a dependent or a former employee, pays second, the other plan pays first.

(3) If both plans cover the participant as an active full-time or part-time employee, the plan that has covered the Employee the longest pays first, the other plan pays second.

(4) For dependent children's claims, the plan of the parent whose birthday occurs earlier in the calendar year is primary.

(5) When the birthdays of both parents are on the same day, the plan that has been effective for the longer period of time is primary.

(6) When the parents of a dependent child are divorced, (4) and (5) apply unless a Qualified Medical Child Support Order requires otherwise.

(7) When the beneficiary is a stepchild or legal dependent, if the other plan has a gender rule, that plan determines which plan is primary.

(8) When a person is covered under a right of continuation coverage pursuant to federal or state law (such as the Consolidated Omnibus Budget and Reconciliation Act) and also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary.

(9) When none of the above establishes an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time will be primary.

(c) Additional Rules. The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation. The Plan is secondary to any excess insurance policy. The Participant, Beneficiary or Dependent must follow guidelines of the primary plan in order for the Plan to pay as secondary payer.

(d) Medicaid. If a Participant, Beneficiary or Dependent is covered by the Plan and is also covered under Medicaid, the Plan will pay before Medicaid. The Plan will not take the Medicaid coverage into account for purposes of enrollment or payment of benefits. If a Participant, Beneficiary or Dependent is covered under Medicaid and benefits are required to be paid by the Plan, but benefits are first paid by the Medicaid

plan, payment by the Plan to the state will be made as required by any applicable state law.

(e) Medicare. In general, the Social Security Act requires that the Plan be the primary payer if a Participant, Beneficiary or Dependent is eligible or enrolled in Medicare and meets certain requirements. To the extent permitted by law, in certain limited circumstances the Plan will pay benefits secondary to Medicare.

ARTICLE IV

ADMINISTRATION AND FIDUCIARY PROVISIONS

4.01 Administrator. The Employee Benefits Committee shall be the Administrator and the "named fiduciary" of the Plan, as defined in ERISA Section 402(a)(2).

Except where responsibilities have been assigned to the Third Party Administrator, insurer or another fiduciary, the Employee Benefits Committee shall have the general responsibility for the administration of the Plan and for carrying out its provisions as follows:

(a) The Employee Benefits Committee shall have the discretion and authority to control and manage the operation and administration of the Plan.

(b) The Employee Benefits Committee shall have complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Employee Benefits Committee made pursuant to the Plan shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Employee Benefits Committee shall have all other duties and powers necessary or desirable to administer the Plan, including, but not limited to, the following:

(1) To communicate the terms of the Plan to Employees, Participants, and Beneficiaries;

(2) To prescribe procedures and related forms (which may be electronic in nature) to be followed by Participants and Beneficiaries, including forms and procedures for making elections and contributions under the Plan;

(3) To receive from Participants, Dependents, and Beneficiaries such information as shall be necessary for the proper administration of the Plan;

(4) To keep records related to the Plan, including any other information required by ERISA or the Code;

(5) To appoint, discharge and periodically monitor the performance of Third Party Administrators, insurers, service providers and other agents in the administration of the Plan;

(6) To purchase any insurance deemed necessary for providing benefits under the Plan;

(7) To prepare and file any reports or returns with respect to the Plan required by the Code, ERISA or any other laws;

(8) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan;

(9) To issue rules and regulations necessary for the proper conduct and administration of the Plan and to change, alter, or amend such rules and regulations;

(10) To determine all questions arising in the administration of the Plan, to the extent the determination is not the responsibility of a Third Party Administrator, insurer or some other entity;

(11) To propose and accept settlements of claims involving the Plan, including claims for benefits;

(12) To direct the Third Party Administrator, insurer, or some other entity to pay benefits and Plan expenses properly chargeable to the Plan; and

(13) Such other duties or powers provided in the Plan.

(d) The Employee Benefits Committee shall have exclusive authority and discretion to manage and control the assets of the Plan.

(e) Except as expressly provided in the Plan, the Employee Benefits Committee shall have complete discretion to interpret and construe the provisions of the Plan, make findings of fact, correct errors, supply omissions, with respect to determining the benefits payable and eligibility for benefits under the Plan. All decisions and interpretations of the Employee Benefits Committee pursuant to the Plan shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious. The Employee Benefits Committee shall have the powers necessary or desirable to carry out these responsibilities, including, but not limited to, the following:

(1) To prescribe procedures and related forms (which may be electronic in nature) to be followed by Participants filing claims for benefits under the Plan;

(2) To receive from Participants, Dependents, and Beneficiaries such information as shall be necessary for the proper determination of benefits payable under the Plan;

(3) To keep records related to claims for benefits filed and paid under the Plan;

(4) To determine and enforce any limits on benefit elections hereunder;

(5) To correct errors and make equitable adjustments for mistakes made in the payment or nonpayment of benefits under the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a Participant, Dependent or Beneficiary, in whatever manner the Employee Benefits Committee deems appropriate, including suspensions or recoupment of, or offsets

against, future payments, including benefit payments due that Participant, Dependent or Beneficiary;

(6) To determine questions relating to coverage and participation under the Plan and the rights of Participants to the extent the determination is not the responsibility of a Third Party Administrator, insurer or some other entity;

(7) To propose and accept settlements and offsets of claims, overpayments and other disputes involving claims for benefits under the Plan; and

(8) To compute the amount and kind of benefits payable to Participants, Dependents and Beneficiaries, to the extent such determination is not the responsibility of a Third Party Administrator, insurer, or some other entity.

The Employee Benefits Committee shall be deemed to have delegated its responsibilities for determining benefits and eligibility for benefits to a Third Party Administrator, insurer or other fiduciary where such person has been selected by the Employee Benefits Committee to make such determinations. In such case, such other person shall have the duties and powers as the Employee Benefits Committee as set forth above, including the complete discretion to interpret and construe the provisions of the Plan.

(f) Notwithstanding any other provision of this Wrap Document, the Employee Benefits Committee shall have the discretion and authority to carry out any duty or function that is necessary or desirable to administer the Plan that either is not clearly allocated to the Employee Benefits Committee or another Plan fiduciary, or, at its discretion, is otherwise allocated to another Plan fiduciary.

4.02 Allocation and Delegation of Duties.

(a) The Committee shall have the authority to allocate, from time-to- time, all or any part of its responsibilities under the Plan to one or more of its members, including a subcommittee, as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In the exercise of such allocated responsibilities, any action of the member or subcommittee to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Committee. The Committee shall not be liable for any acts or omissions of such member or subcommittee.

(b) The Committee shall have the authority to delegate, from time-to-time, all or any part of its responsibilities under the Plan to such person or persons as the Committee may deem advisable (and may authorize such person to delegate such responsibilities to such other person or persons as the Committee shall authorize) and in the same manner to revoke any such delegation of responsibilities. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Committee. The Committee shall not be liable for any acts or omissions of any such delegate.

4.03 Indemnification.

(a) To the fullest extent authorized by law, and to the extent not otherwise covered by insurance, the members of the Committee, officers and employees of the Plan Sponsor who provide services to the Plan shall be indemnified by the Plan Sponsor against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted gross negligence or willful misconduct, or (2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted gross negligence or willful misconduct.

4.04 Bonding. The members of the Committee shall serve without bond (except as otherwise required by section 412 of ERISA) and without additional compensation for their services.

4.05 Plan Expenses. All fees and expenses incurred in connection with the operation and administration of the Plan, including, but not limited to, Committee, legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of Plan assets to the extent that it is legally permissible for these fees and expenses to be so paid.

4.06 Information to be Supplied by Employer. The Employer shall provide the Committee or its delegates with such information as they shall from time-to-time need or reasonably request in the discharge of its duties. The Committee may rely conclusively on the information provided by the Employer.

4.07 HIPAA Compliance.

(a) Disclosures to Plan Sponsor. The Plan may disclose participant information to the Plan Sponsor, as permitted under the Standards for Privacy of Individuality Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose protected health information to the Plan Sponsor as necessary to allow the Plan Sponsor to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

(b) Use of PHI. The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

(c) Access to Medical Information. The following employees or individuals under the control of the Plan Sponsor shall have access to the Plan's protected health information to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

(1) Benefits personnel at the Plan's claims processing locations;

(2) Members of the Employee Benefits Committee

(3) Members of the Legal, Finance, Information System, Audit, Accounting, and Human Resources Departments to the extent they perform functions with respect to the Plan; and

(4) Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

(d) Plan Sponsor Agreement to Restrictions. The Plan will not disclose protected health information to the Plan Sponsor until the Plan Sponsor has certified to the Plan that it agrees to:

(1) Not use or disclose protected health information other than as permitted or required by law or as specified above;

(2) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(3) Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which Plan Sponsor becomes aware;

(4) Make protected health information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;

(5) Allow the subject individuals to amend or correct their protected health information and incorporate any amendments to protected health information in accordance with the HIPAA Privacy Regulations;

(6) Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;

(7) Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses to those that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;

(9) Ensure that any agents, including a subcontractor, of the Plan Sponsor to whom the Plan Sponsor provides protected health information shall also agree to these same restrictions;

(10) Ensure that adequate separation between the Plan Sponsor and Plan is established as required under the HIPAA Privacy Regulations and restrict access to protected health information to those classes of Employees or individuals identified in Section 4.07(c); and

(11) Restrict the use of protected health information by those Employees identified in Section 4.07(c) for plan administration functions within the meaning of the HIPAA Privacy Regulations.

(e) Permitted Disclosure to Plan Sponsor. Notwithstanding the foregoing, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor the following types of information:

(1) Summary health information may be disclosed to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or (2) modifying, amending, or terminating the Plan.

(2) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(3) Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulation.

(f) Noncompliance. In the event of noncompliance with the restrictions of Section 4.07(a) through (c) by a designated Employee or other individual receiving protected health information on behalf of the Plan Sponsor, the Employee or other individual shall be subject to discipline in accordance with the Plan Sponsor's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Officer.

(g) HIPAA Security Standards.

(1) Safeguards. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

(2) Agents. The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

(3) Security Incidents. The Plan Sponsor shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

(4) Adequate Separation. The Plan Sponsor shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Plan Sponsor, in support of the requirements described in this Section 4.07.

(h) Application. The provisions of this Section 4.07 shall only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

ARTICLE V

AMENDMENT AND TERMINATION OF THE PLAN

5.01 Amendment. The Plan Sponsor reserves the right to amend the Plan at any time, and the Plan Sponsor (or such other person to whom such authority has been delegated) may amend the Plan by adopting an amendment to this Wrap Document or any Welfare Program Document. Any such amendment may include the addition, modification or deletion of a Welfare Program. The right to amend the Plan provided for in Section 5.01(a) and (b) applies to any current or future benefits for any Employee, Former Employee, Participant, Dependent, or Beneficiary.

5.02 Termination and Partial Termination. The Plan Sponsor, in its sole discretion, may terminate all or any part of the Plan at any time, including termination of all or any part of any Welfare Program, by written resolution. This right to terminate the Plan applies to any current or future benefits for any Employee, Former Employee, Participant, Dependent or Beneficiary.

5.03 Effect of Amendment or Termination. In the event of an amendment to or termination of the Plan as provided under this Article, each Participant shall have no further rights hereunder, and the Plan Sponsor shall have no further obligations hereunder except as otherwise specifically provided under the terms of the Plan and each Welfare Program Document; provided, however, that no amendment or termination shall be made that would diminish any benefits arising from incurred but unpaid claims of Participants prior to the effective date of such modification, alteration, amendment, suspension, or termination.

ARTICLE VI

MISCELLANEOUS PROVISIONS

6.01 Action by the Plan Sponsor. Any action to be taken by the Plan Sponsor hereunder, to the extent not otherwise provided, may be taken by any authorized officer of the Plan Sponsor.

6.02 Nonalienation of Benefits. Except as otherwise may be provided in the applicable Welfare Program Documents or in a Qualified Medical Child Support Order as described in section 609 of ERISA, no benefit, right or interest of any Participant, Dependent or Beneficiary under a Welfare Program shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder, shall be void.

6.03 Limitation of Rights. Nothing contained herein shall operate or be construed to give any person any legal or equitable right against the Plan Sponsor, except as expressly provided herein or required by law, or to create a contract of employment between the Employer and any Employee, obligate the Employer to continue the service of any Employee or affect or modify the terms of any Employee's employment in any way.

6.04 Gender and Number. Except when the context indicates to the contrary, when used herein, masculine terms shall be deemed to include the feminine and neuter, and terms in the singular shall be deemed to include the plural, and the plural the singular.

6.05 Headings. The headings of Articles and Sections are included solely for convenience of reference and, if there is any conflict between such headings and the text of this Plan, the text shall control.

6.06 Severability. If any provision of this Plan shall be held invalid or, unenforceable, such invalidity or unenforceability shall not affect any other provisions hereof and the Plan shall be construed and enforced as if such provisions had not been included herein.

6.07 Governing Law. The Plan shall be construed and enforced according to the laws of the State of Texas other than its laws respecting choice of law, to the extent not preempted by federal law.

6.08 Participant's Responsibilities. Each Participant shall be responsible for providing the Administrator and/or the Employer with the Participant's and each Dependent's or Beneficiary's current address. In the event that a Participant, Dependent, or Beneficiary becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

(a) because the current address according to the Employer's records is incorrect;

(b) because the Participant, Dependent or Beneficiary fails to respond to the notice sent to the current address according to the Employer's records;

(c) because of conflicting claims to such payments; or

(d) because of any other reason

the amount of such payment, if and when made, shall be that determined under the provisions of this Plan without payment of any interest or earnings. If, after reasonable efforts, the Administrator is unable to locate any Participant, Dependent or Beneficiary, such benefits may be forfeited in accordance with the terms of the Plan. If the Participant subsequently applies for benefits, the amount so forfeited will be paid to the Participant. Notwithstanding the forgoing, with respect to any benefit or arrangement that is underwritten by insurance, the terms of the insurance policy shall control to the extent such terms are inconsistent with this Section 6.10.

6.09 Payments to Minors and Incompetents. Upon proof satisfactory to the Administrator, or the appropriate insurer or Third Party Administrator (if applicable), that an individual entitled to receive a payment under the Plan is legally incompetent, including by reason of being a minor, the Administrator may direct that benefit payments be made in any one or more of the following ways:

(a) to the individual's spouse, child, parent, other blood relative, or dependent whom he has the duty to support;

(b) to the individual's legal guardian or conservator; or

(c) to any other person, including a recognized charity or governmental institution, to be held and used for the individual's benefit.

The decision of the Administrator is final and binding upon all parties. The Administrator is not obliged to see to the proper application or expenditure of any payments so made.

6.10 Withholding Taxes. The Administrator, or the appropriate insurer or Third Party Administrator (if applicable), may make any appropriate arrangements to deduct from all amounts paid under the Plan any taxes required to be withheld by any government or government agency. The Participant bears all taxes on amounts paid under the Plan to the extent that no taxes are withheld, irrespective of whether withholding is required.

6.11 Clerical Errors or Omissions. Clerical errors or omissions in information provided to a Participant do not deprive a Participant of his right to receive a benefit, and do not affect the amount of his benefit. Conversely, clerical errors or omissions do not cause a Participant to have the right to receive a benefit to which he is not entitled, and a Participant receiving an overpayment by mistake must repay the overpayment, if requested to do so. The Administrator reserves the right to correct any mistake in any reasonable manner, including but not limited to, adjusting the amount of future benefit payments, repaying to the Plan any

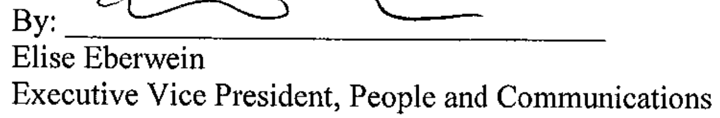
overpayment, or making catch-up payments to a Participant for an underpayment. The failure to enforce any provision of the Plan does not affect the Plan's right thereafter to enforce this provision, nor does such failure affect its right to enforce any other Plan provision.

6.12 No Vested Right to Benefits. No Participant or person claiming through such Participant shall have any right to, or interest in, any benefits provided under the Plan or any Welfare Program upon termination of his employment, retirement, termination of Plan participation, or otherwise, except as specifically provided under the Plan or a Welfare Program Document.

* * * * *

Executed this 18th day of December, 2015.

AMERICAN AIRLINES, INC.



By: ______________________________

Elise Eberwein
Executive Vice President, People and Communications

APPENDIX A

The terms and conditions of the Welfare Programs (including limitations and restrictions) are set forth in the Welfare Program Documents. The following employee benefits constitute the Welfare Programs offered by the Employer under the Plan:

- Self-insured Medical Benefits (including Health Care Flexible Spending Account, Limited Purpose Flexible Spending Account, and Health Reimbursement Account), self-insured Dental Benefits, and fully insured Vision Benefits
- Benefits provided through Health Maintenance Organizations (HMOs)
- Life Insurance Benefits
- Accidental Death & Dismemberment (AD&D) Insurance Benefits – Ground Employees
- Accidental Death & Dismemberment (AD&D) Insurance Benefits – Flight Employees
- Short Term Disability Benefits (except that certain payment policies described in the Summary Plan Description as Short-Term Disability Benefits shall not be considered a Welfare Program, or part of an ERISA plan).
- Long-Term Care Insurance Plan