American Airlines, Inc.
On-Site Clinic Health Plan

Summary Plan Description

Effective August 8, 2016

Introduction

American Airlines, Inc. (the "Company") provides you with on-site clinic services. To help you make the most of those benefits, this Summary Plan Description ("SPD") describes the provisions of the American Airlines, Inc. On-Site Clinic Health Plan (the "Plan") effective August 8, 2016.

The terms and conditions of the Plan are set forth in this Summary Plan Description and the formal Plan Document. The Summary Plan Description is incorporated by reference into the formal Plan Document, and together these documents constitute the written instruments under which the Plan is established and maintained. An amendment to one of these documents constitutes an amendment to the Plan.

Unless otherwise noted, if there is a conflict between a specific provision under the Plan Document and this Summary Plan Description, the Plan Document controls. If the Plan Document is silent, then the Summary Plan Description controls.

The Company, or its authorized delegate, reserves the right to modify, amend or terminate the Plan, any program described in this SPD, or any part thereof, at its sole discretion. You will be notified of any changes that affect your benefits, as required by federal law.

The On-Site Clinic Health Plan is considered an excepted benefit under HIPAA, as described in ERISA 733(c)(1)(G), including the HIPAA Privacy & Security Rules, as described at 45 CFR 160.103 (definition of "health plan" at paragraph (2)(i)).

There is a "Glossary" at the end of this SPD that defines capitalized terms and how they apply to the benefits described in this SPD.

Eligibility and Enrollment

Employee eligibility

Dependents

When coverage begins

When coverage ends

Employee Eligibility

Eligible Employees

Generally, all full-time or part-time domestically based employees of American Airlines, Inc. who are either active or on a leave of absence are eligible for the Plan, except for any employee or individual specifically listed as ineligible in the "Ineligible Employees" section below.

Ineligible Employees

The following individuals are not eligible to participate in the Plan:

- **A leased employee, as defined in section 414(n) of the Internal Revenue Code.** This includes any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service ("IRS"), or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker. This term includes any of the following former classifications:
    - **Temporary employee.** If a temporary worker becomes a Regular Employee, and meets all of the other requirements to participate in the Plan without a break in service, the time worked as a full-time temporary worker will be credited solely toward the eligibility requirement for the Plan. Under no circumstances will time worked as a temporary worker entitle the individual to retroactive coverage under the Plan.
    - **Provisional employee.**
    - **Associate employee.**

- An **independent contractor.**

- **Any person:**
    - Who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion);
    - Who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate; or
    - Who tells the Company he/she is an independent contractor, or is employed by another company while providing services to the Company, even if the worker is, or may be reclassified at a later date as, an employee of the Company by the courts, the IRS or the DOL.

Dependents

Dependents are **not eligible** to participate in the Plan, including your spouse, domestic partner, or child.

When Coverage Begins

New Employees
As a new eligible employee, you will be automatically enrolled in the Plan. Your coverage under the Plan will begin on your first day of employment as an eligible employee with the Company. Note that you can only access a particular Clinic if you have a badge that allows access to areas identified as secured.

Current Employees
Current eligible employees will be automatically enrolled in the Plan. Your coverage under the Plan will begin on the effective date of the Plan. Note that you can only access a Clinic if you have a badge that allows access to areas identified as secured.

Clinic Opening Dates
Not all Clinics will be open on the Plan's effective date, August 8, 2016. Opening dates will vary by Clinic. Please check www.newjetnet.aa.com for Clinic opening dates.

When Coverage Ends

Your coverage will automatically terminate on the earliest of:

- The date the Plan terminates;
- The date on which your employment terminates (subject to the Plan's Continuation Coverage provisions);
- The date you are no longer eligible for this coverage;,
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan.

Clinic Benefits

Clinic Benefits

Cost-Sharing

Clinic Locations and Hours of Operation

Clinic Benefits

The Plan offers medical care services through Premise Health Clinics ("Clinics") around the country, including but not limited to Preventive Health Services, Acute/Urgent Care Services, Clinical Laboratory Services, and Referral Management.

The Clinics are operated by Premise Health ("Clinic Provider") and staffed with some or all of the following personnel: physicians, nurse practitioners, registered nurses, licensed practical nurses, medical assistants and administrative assistants.

The Plan will provide the following services:

Preventive Health Services

1. Onsite screening and special services programs including but not limited to: heart-rate and blood pressure checks, biometric screens, and flu vaccines.
2. Travel health consultations including inoculations and medications for foreign travel.
3. Immunizations, vaccinations and allergy management.

Acute/Urgent Care Services

1. Acute care, symptom treatment and management.
2. Comprehensive evidence based management programs for acute conditions including, but not limited to:
    a. Community Acquired Pneumonia
    b. Ear infections (Otitis Media)
    c. Sinus infections (Sinusitis)
    d. Nasal inflammation (Rhinitis)
    e. Sore throat (Pharyngitis)
3. Minor outpatient surgical procedures, including suturing and cryotherapy.

Clinical Laboratory Services

Routine clinical laboratory services, including onsite laboratory specimen collection, lab work, and follow-up lab interpretation/monitoring.

Referral Management

The Clinic Provider will provide the following services:

1. Identification of highly qualified specialists and facilities for referrals
2. Coordination with other American benefit programs, as appropriate
3. Provide a specialist referral list, which contains community providers who have demonstrated quality and compliance with follow-up, such as reports, appointment accommodations, etc.

Costs

Costs for Preventive Care Services at the Clinics:

Type of Employee	Copay
Employees enrolled in Value, Standard, HMOs and LUS PPO Medical Plan Options	$0
Employees enrolled in Core Medical Plan Option and Employees not enrolled in American Airlines-sponsored medical coverage	$0

Costs for Acute/Urgent Care Services at the Clinics:

Type of Employee	Copay
Employees enrolled in Value, Standard, HMOs and LUS PPO Medical Plan Options	$20
Employees enrolled in Core Medical Plan Option and employees not enrolled in American Airlines-sponsored medical coverage	$40 (Applies toward Core Medical Plan Option deductible and coinsurance)

Costs for Lab Work Performed Through The Clinic:

Type of Employee	Copay
Employees enrolled in Value, Standard, HMOs and LUS PPO Medical Plan Options	$0
Employees enrolled in Core Medical Plan Option	$0 (However, Employees will be required to pay the $40 fee described above under "Acute/Urgent Care Services" in order to receive lab work for non-preventive care services)

Type of Employee	Copay
Employees not enrolled in medical plan option under the American Airlines, Inc. Health and Welfare Plan for Active Employees	$0

The Clinic Locations and Hours of Operation

The Clinics will be located at:

- American Headquarters/ Fort Worth (HDQ2)
- Charlotte Airport (CLT)
- Chicago O'Hare Airport Ground Engineering Maintenance Building (GEM)
- Chicago O'Hare Airport Terminal K Room 100 (ORD)
- Dallas Fort Worth Airport Terminal A (DFW)
- Los Angeles Airport (LAX)
- Miami Airport (MIA)
- New York John F Kennedy Airport (JFK)
- New York LaGuardia Airport (LGA)
- Philadelphia Airport (PHL)
- Tulsa Maintenance Base (TULE)

Not all of the Clinics will be open on the Plan's effective date, August 8, 2016. Opening dates will vary by Clinic. Please check www.newjetnet.aa.com for Clinic opening dates.

The Clinics are located at the addresses in the table below. For the Clinics' hours of operation, and room & directions where not indicated below, please see www.newjetnet.aa.com.

Location	Address	Room & Directions
American Headquarters	HDQ Building 2 4255 Amon Carter Blvd Fort Worth, TX 76155	AA Headquarters 2, 1st floor, across from Security
Charlotte Airport	Gate B11/B12 5501 R C Josh Birmingham Pkwy Charlotte, NC 28208	
Chicago O'Hare Airport (ORD/ GEM)	GEM Building 723, 1st Floor Chicago IL 60666	Mt Prospect & Touhy Road, Bus Stop #7
	Terminal 3 K19 Concourse Ramp Level Room100	Room 100
Dallas Fort Worth Airport	Terminal A 39, Ramp Level Fort Worth, TX	

Los Angeles Airport	Terminal 4, 400 World Way Los Angeles CA 90045	Concourse level, office next to credit union
Miami Airport	4450 NW 22nd Street Bldg 3095, Miami FL 33159	
New York John F Kennedy Airport	Terminal 8 Jamaica NY 11432	Room 15-250, Floor 2A
	JFK Hangar 10, JFK Airport Hangar Road, NY, NY 11430	
New York LaGuardia Airport	Hangar 3 Flushing NY 1366	Room 117
Philadelphia Airport	A East Concourse 8000 Essington Ave Philadelphia PA 19153	Next to security entrance
Tulsa Maintenance Base	Turbine Building 3900 North Mingo Road, Tulsa OK 74116	

COBRA

Overview

Eligibility

Continuation of Coverage for You (Qualifying Events)

How to Elect Continuation of Coverage

Paying for COBRA Coverage

Refund of Premium Payments

When Continuation of Coverage Begins

When Continuation of Coverage Ends

Keep Us Informed of Address Changes

Additional Questions

Overview

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your Plan benefits are cancelled, along with your other benefits. You may elect to continue your on-site medical clinic benefits as part of your continuation of coverage options available through Blue Cross Blue Shield of Texas Urgent Care Clinics. Aon Hewitt, Inc., the Plan's COBRA administrator, will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your Plan coverage through COBRA, claims incurred after the date of your termination are not payable by the Plan.

The Plan provides for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain Qualifying Events. If you have coverage at the time of the Qualifying Event, you may be eligible to elect continuation of coverage under the Plan.

Once you elect BCBS Urgent Care Clinics as your plan under COBRA continuation coverage, you will have access to Urgent Care Clinics in the Blue Cross Blue Shield of Texas Network. These Urgent Care Clinics provide the same medical benefits as those provided to similarly situated employees at the Clinics described in the chapter "Clinic Benefits" who have not had a COBRA event.

Eligibility

Eligibility for continuation of coverage depends on the circumstances that result in the loss of existing coverage for you. The sections below explain who is eligible to elect continuation of coverage and the circumstances that result in eligibility for this coverage continuation.

Continuation of Coverage for You (Qualifying Events)

You may elect continuation of coverage for yourself for a maximum period of 18 months, if your coverage would otherwise end because of:

- layoff or termination of your employment for any reason (except in the event of termination for gross misconduct).

If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you are disabled at any time during the first 60 days of continuation of coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself. To qualify for this additional coverage, you must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (Aon Hewitt, Inc.) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.

How to Elect Continuation of Coverage

Solicitation of Coverage Following Layoff or Termination

In the event that your employment ends through layoff or termination, you will automatically receive information from Aon Hewitt, Inc. about electing continuation of coverage through COBRA.

Enrolling for Coverage

Following notification of any Qualifying Event, the Benefits Service Center will advise Aon Hewitt, Inc., who in turn will notify you of the right to continuation of coverage.

You must provide written notification of your desire to elect to purchase continuation of coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage, or else you lose your right to elect to continue coverage. See the *For More Information* section for Aon Hewitt, Inc.'s address.

Once you elect continuation of coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election.

If you waive continuation of coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify the Benefits Service Center before your 60-day election period expires.

Paying for COBRA Coverage

To maintain COBRA continuation of coverage, you must pay the full cost of continuation of coverage on time, including any additional expenses permitted by law. Your first payment is due within 45 days after you elect continuation of coverage. Premiums for subsequent months of coverage are due on the first day of each month for that month's coverage. If you elect continuation of coverage, you will receive invoices from Aon Hewitt, Inc. indicating when each payment is due. Contributions are due even if you have not received your invoice. Failure to pay the required contribution on or before the due date, or by the end of the grace period will result in termination of COBRA coverage, without the possibility of reinstatement.

Refund of Premium Payments

If you elect continuation of coverage and later discover that you do not meet the eligibility requirements for coverage, for example, if you enroll in Medicare benefits, you must contact Aon Hewitt, Inc. immediately, but no later than three months after you make your first COBRA premium payment in order for you to be eligible for a refund. No payments will be refunded after this three-month period, regardless of the reason.

If claims have been paid during this three-month time period, the Plan will request reimbursement from you. If the amount of your premium payments for continuation of coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the Plan receives reimbursement for your claim, the Plan will refund your premiums.

This time limit for refunds also applies if the Company discovers that continuation of coverage has been provided to you in error.

When Continuation of Coverage Begins

If you elect continuation of coverage within 60 days of receiving your election forms, the coverage becomes effective on the date your other coverage would otherwise end. Thus, the first premium for continuation of coverage includes payment for this retroactive coverage period.

When Continuation of Coverage Ends

Continuation of coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period expires (18 months or 29 months, if you are disabled during the time periods discussed under "Continuation of Coverage for You (Qualifying Events)").
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a Pre-Existing Condition Limitation that affects the plan participant. In that event, the participant is eligible for continuation of coverage up to the maximum time period.
- The Plan participant continuing coverage becomes enrolled in Medicare.
- The Company no longer provides the coverage for any of its employees.

Keep Us Informed of Address Changes

In order to protect your rights, you should keep the Company informed of any changes in your address.

Additional Questions

If you have any additional questions on continuation of coverage under COBRA, you should contact American Airlines Benefit Service Center.

Claims Procedures

Claims for Benefits Subject to These Claims Procedures

Claims Filing Deadline

Time Frame for Initial Claim Determination

Appealing a Denial

Deadline to Bring Legal Action

Claims for Benefits Subject to These Claims Procedures

A claim for benefits is a request for a Plan benefit or benefits made by a participant in accordance with the procedures described in this chapter. One example of a claim for benefits is challenging the amount of cost-sharing that was charged. In order to challenge the amount of cost-sharing that was charged, you must submit a claim for benefits in accordance with the procedures described in this chapter.

The following do not constitute claims for benefits that are subject to these claims procedures (note that this is not an exhaustive list):

- Asking questions about eligibility for coverage under the Plan
- Asking questions about benefits or the circumstances under which benefits might be paid under the terms of the Plan

Claims Filing Deadline

You must submit all claims for benefits within one year of the date the expenses were incurred. Claims submitted more than 12 months after expenses were incurred will not be considered for payment. You should file your claim for benefits with the Clinic Provider at the following email address: RCMCustomerservice@premisehealth.com. Alternatively, you can file your claim by mail to the following address:

Premise Health- Revenue Cycle Group
Attn: AA ERISA Appeal
PO Box 743628
Atlanta, GA 30374-3628

Your claim must include the following information:

- Name of individual;
- Date the service was provided;
- Itemized description and charges for the service; and
- Clinic location where the service was performed.

Time Frame for Initial Claim Determination

Unless otherwise provided in the applicable insurance policy/evidence of coverage, your claim for benefits will be processed under the procedures described below.

The Clinic Provider will notify you of an adverse benefit determination within 30 days after receipt of a claim. A 15-day extension may be allowed to make a determination, provided that the Clinic Provider determines that the extension is necessary due to

matters beyond its control. If such an extension is necessary, the Clinic Provider must notify you before the end of the first 15- or 30-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If You Receive an Adverse Benefit Determination

The Clinic Provider will provide you with a notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits.

Effect of Failure to Submit Required Claim Information

If the Clinic Provider determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the Clinic Provider's request for information or upon a demonstration to the satisfaction of the Clinic Provider that under the circumstances the

Clinic Provider's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the Clinic Provider, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the Clinic Provider deems relevant.

Appealing a Denial

Filing an Appeal

If you receive an adverse benefit determination, you must ask for an appeal from the Employee Benefits Committee (EBC) You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file a your appeal. If you do not file your appeal (with the EBC) within this time frame, you waive your right to file an appeal of the determination.

To file an appeal with the EBC, please complete an Application for Appeal, which is attached to your notice of adverse benefit determination, and include with the Application all comments, documents, records, and other information relating to the denied/withheld benefit. (The Application for Appeal provides information about what to include with your appeal).

The EBC will review your appeal and will communicate its appeal decision to you in writing within 60 days of receipt of your appeal.

Upon its receipt your appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the EBC. Appointed officers of American Airlines, Inc. are on the EBC. In some cases, the EBC designates another official to determine the outcome of the appeal. Your case, including evidence you submit, if appropriate, will be reviewed by the EBC or its designee(s).

Rights on Appeal

In the filing of appeals under the Plan, you have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record or other information is treated as "relevant" to your claim if it:
    - Was relied upon in making the benefit determination

  - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
  - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
  - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination
- Be allowed to review your claim file documents and to present evidence/testimony.
- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the Plan Administrator has taken steps to avoid conflicts of interest and impartiality of the individuals making claim decisions
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is Experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision.

Notice of Determination

If your appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will set forth:

- The specific reason(s) for the adverse benefit determination
- References to the specific Plan provisions on which the benefit determination is based
- A description of your right to bring a civil action under ERISA after an appeal of an adverse benefit determination
- Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request

- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures.

Deadline to Bring Legal Action

You must use and exhaust the Plan's administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

Plan Administration

Administrative Information

Other Legal Information

Administrative Information

Plan Name & Number

American Airlines, Inc. On-Site Clinic Health Plan (517)

Plan Sponsor

American Airlines, Inc., or its authorized delegate

Mailing address:
Mail Drop 5141-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Street address (do not mail to this address):
4333 Amon Carter Blvd.
Fort Worth, Texas 76155

Plan Administrator

American Airlines, Inc., or its authorized delegate

Mailing address:
Mail Drop 5141-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616
General Phone: 1-800-433-7300
American Airlines, Inc. has delegated certain administrative functions to Aon Hewitt, including answering questions on behalf of American Airlines, Inc. They can be reached at: 1-888-860-6178

Street address (do not mail to this address):
4333 Amon Carter Blvd.
Fort Worth, Texas 76155

The Plan Administrator (or its delegate(s)) shall have complete discretion to interpret and construe the provisions of the Plan described in this SPD, to determine benefit eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations of the Plan Administrator (or its delegate(s)) made pursuant to the Plan described in this SPD 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 Plan Administrator may delegate this discretionary authority to selected service Providers. In certain circumstances, for all purposes of overall costs savings or efficiency, the Plan Administrator (or its delegate(s)) may, in their sole discretion, offer benefits for services that would not otherwise be covered. The fact that the Plan Administrator (or its delegate(s)) do this in any particular case shall

not in any way be deemed to require the Plan Administrator (or its delegate(s)) to do so in similar cases.

The Plan Administrator for Appeals

Employee Benefits Committee (EBC)

American Airlines, Inc.
Mail Drop 5134-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Agent for Service of Legal Process
Managing Director, Health and Wellness
American Airlines, Inc.

Mailing address:
Mail Drop 5126-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Express Delivery address:
4333 Amon Carter Blvd.
Fort Worth, TX 76155

Employer ID Number

13-1502798

Plan Year

January 1 through December 31. However, the first Plan Year is August 8, 2016 through December 31, 2016.

Plan Type

On-site medical clinic services.

Claims Administration & Funding

Benefits are self-funded and are administered by Premise Health:

5500 Maryland Way-Suite 200
Brentwood, TN 37027
937-734-2612

Source of Contributions

Contributions will be paid out of the Company's general assets.

Other Legal Information

Plan Amendment and Termination

The Company or its authorized delegate has the sole authority to adopt new employee benefit plans, amend existing plans, and terminate plans. The Company may at any time amend the Plan by written instrument executed by an officer of the Company. Further, the Company reserves the right to terminate the Plan at any time. On or after the effective date of a termination, no further benefits shall be payable to or on behalf of any participant to whom such terminate applies.

No Commitment to Employment

Nothing in the Plan shall be construed as a commitment or agreement upon the part of any person to continue his employment with the Company, and nothing contained in the Plan shall be construed as a commitment on the part of the Company to any rate of compensation of any person for any period, and all employees of the Company shall remain subject to discharge to the same extent as if that Plan had never been put into place.

No Precedent

Except as otherwise specifically provided, no action taken in accordance with the provisions of the Plan by the Plan Administrator or the Company shall be construed or relied upon as precedent for similar action under similar circumstances.

Severability

If a provision of the Plan is held illegal or invalid, the illegality or invalidity does not affect the remaining parts of the Plan and the Plan must be construed and enforced as if the illegal or invalid provision had not been included in the Plan.

Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service Provider. Benefits are paid after the Clinic Provider receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the Clinic Provider may pay all or part of the benefit to:

- Your guardian
- Your estate
- Any institution or person (as payment for expenses in connection with the claim)

- Any one or more persons among the following relatives: your eligible Domestic Partner, parents, Children, brothers or sisters.

Payment of a claim to anyone described above releases the Plan Administrator from all further liability for that claim.

Claims are processed in order of receipt. Payment of a claim depends upon the amount and type of coverage available at the time the claim is submitted, and the claim is still subject to all provisions, limitations, and exclusions of the Benefit Option under the Plan (such as eligibility and enrollment requirements, coverage rules, benefit amounts and maximums, etc.).

The right to benefits under the Plan may not be exchanged for, or substituted for, other benefits or cash compensation.

Right to Recovery

The Plan and the Clinic Provider shall have the right to recover from any participant or former participant the amount of any benefits paid by the Plan (i) for expenses incurred on behalf of a participant which were not paid by the participant and were not legally required to be paid by the participant, (ii) which exceeded the amount of benefits payable under the Plan, or (iii) for expenses which were recovered from or paid by a source other than this Plan. If the participant or former participant, or any other person or organization, does not repay to the Plan the amount owed in a lump sum within 30 days of receiving notice, then notwithstanding any provision in this SPD to the contrary and without limiting any other remedies available to the Plan, the Plan may reduce the amount of any benefits that become payable to the participant or the participant's service Providers to recover the amount owed to the Plan.

The Clinic Provider may also seek recovery from one or more of the following:

- Any Plan participant to or for whom benefits were paid
- Any other self-funded plans or insurers
- Any institution, Physician, or other service Provider
- Any other organization.

Your Rights Under ERISA

Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Information about Your Plan and Benefits

You have the right to:

- 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, 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 Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue group health coverage for yourself if there is a loss of coverage under the Plan as a result of a Qualifying Event. You may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation rights.

Prudent Actions 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 pension 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.

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We believe that the Plan that has been developed is only good if you receive the benefits to which you are entitled. We encourage you to come to us if you have any questions or problems. In addition, as already noted, the Plan Documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, 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 that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 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.

For general information contact:

American Airlines Benefits Service Center
PO Box 564103
Charlotte, NC 28256-4103
1-888-860-6178

For information about your claims, contact the Clinic Provider or Plan Administrator at the addresses and phone numbers located in the *Reference Information* section.

Glossary of terms

American Airlines Benefits Service Center or **Benefits Service Center:** The online enrollment tool, available on my.aa.com.

Clinic Provider: Premise Health.

Company: American Airlines, Inc. and any successor thereto.

Plan Administrator: American Airlines, Inc., or its authorized delegate, is the Plan Administrator. The Plan Administrator maintains sole responsibility for the Plan and the benefits it provides. The Plan Administrator has the sole discretion to determine all matters relating to eligibility, coverage and benefits under the Plan, including entitlement to benefits. The Plan Administrator also has the sole discretion to determine all matters relating to interpretation and operation of the Plan and may contract with third parties to provide some or all of these services to participants.

Plan Document: A written document or documents that establish the terms of employer sponsored group coverage.

Plan Sponsor: American Airlines, Inc. is the Plan Sponsor.

Regular Employee: An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, or a Flexible Work Arrangement, depending on the business needs of the organization or the terms of the applicable labor agreement. A Regular Employee is eligible for the benefits and privileges that apply to his or her workgroup or as outlined in his or her applicable labor agreement.

Summary Plan Description: A document provided to participants outlining terms of employer sponsored group coverage. This document serves as the Summary Plan Description for the Plan, along with any other benefits summary published by the Company that contains a description of these plans. In our efforts to provide you with multimedia access to benefits information, American Airlines, Inc. has created online versions of the Summary Plan Descriptions for our benefit plans. If there is any discrepancy between the online version and the official hard copy of this document, then the official hard copy, plus official notices of Plan changes/updates will govern.

Reference information

For Information About:	Contact
• General questions • Information updates	American Airlines, Inc. Benefits Service Center P.O. Box 564103 Charlotte, NC 28256-4103 Phone: 1-888-860-6178
Online Help from a Benefits Service Center Representative	American Airlines, Inc. Benefits Service Center Chat www.my.aa.com or www.newjetnet.aa.com Click on Pay and Benefits, click Benefits Service Center, click on "chat" on the upper right portion of the screen.
Forms, Guides and Contact Information	my.aa.com (Benefits page)
Continuation of Coverage (COBRA)	COBRA Administrator: Aon Hewitt, Inc. P.O. Box 1345 Carol Stream, IL 60132-1345 Phone: 1-888pay-860-6178 Fax: 1-847-554-1884
Clinic Provider	Premise Health 5500 Maryland Way-Suite 200 Brentwood, TN 37027 937-734-2612
Appeals	Employee Benefits Committee American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616 ICS or 1-817-967-1412