

**American Airlines, Inc. Flexible Benefit Plan
for Certain Legacy Employees**

Summary Plan Description

Effective January 1, 2018

SUMMARY PLAN DESCRIPTION

This document summarizes the main provisions of the American Airlines, Inc. Flexible Benefit Plan for Certain Legacy Employees, effective January 1, 2018, and serves as the Summary Plan Description (“SPD”) for these benefits. It describes the benefits as they apply to eligible employees and their eligible dependents. This document replaces the SPD dated January 1, 2013, and incorporates the changes to that SPD that are set forth in the Summaries of Material Modification effective January 1, 2015, January 1, 2016, and January 1, 2017, as well as other changes and clarifications.

This SPD provides a comprehensive overview of the benefits available under the Plan. Complete details of this Plan are contained in legal Plan documents. If there is any difference between the information in this SPD and in the legal Plan documents, the Plan documents will govern. American Airlines, Inc. (“American Airlines” or “the Company”) sponsors the Plan and reserves the right to amend or terminate the Plan at any time, subject to the terms of an applicable collective bargaining agreement. You will be notified of any changes that affect your benefits, as required by federal law.

Please read this SPD carefully. If you have any questions about the benefits information contained in this SPD, please contact the American Airlines, Inc. Benefits Service Center at 1-888-860-6178.

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How the Flexible Benefit Plan Works

The American Airlines, Inc. Flexible Benefit Plan for Certain Legacy Employees (the “Flexible Benefit Plan”) offers eligible employees a choice of health benefit options. Each year, during annual enrollment, you can elect coverage under the following benefit plans:

- Medical
- Dental
- Vision
- Health Care Flexible Spending Account (“HCFSA”)
- Dependent Care Flexible Spending Account (“DCFSA”)

Your contributions for your benefit elections are deducted from your paycheck on a pre-tax basis. Pre-tax dollars can save you money because they are deducted from your paycheck before taxes are calculated, including Federal, Social Security and, in most cases, state and local taxes.

Who Is Eligible

You are eligible to participate in the Flexible Benefit Plan if you are:

- An active, full-time or part-time employee of American Airlines, Inc. in the fleet and maintenance and related groups who are covered by collective bargaining agreements entered into between Legacy US Airways, Inc. and the IAM.

Please note: For purposes of eligibility, "employees" are individuals who are classified by the Company as employees under Section 3121(d) of the Internal Revenue Code. In the event the classification of an individual who is excluded from eligibility under the preceding sentence is determined to be erroneous or is retroactively revised by a court, administrative agency or other administrative body, the individual shall nonetheless continue to be excluded from the Plan and shall be ineligible for benefits for all periods prior to the date that it is determined that its classification of the individual is erroneous or should be revised.

Eligible Dependents

You can enroll your eligible spouse and dependent children for medical, dental and vision coverage.

Eligibility for your spouse and dependent children is determined under the terms of the applicable medical, dental, or vision plan.

When Participation Begins

If you are a new hire and you are eligible, you can enroll yourself and your eligible dependents in the Flexible Benefit Plan within 31 days of your hire date. Your participation will begin on your first day of work, provided you enroll within that 31-day period. Your initial election will remain in effect through December 31 of that year. If you do not enroll within 31 days of your hire date, you will not be able to participate that year. You will have to wait until the next annual enrollment period and your participation will begin January 1 of the following calendar year, unless you experience a qualifying change in family or work status as described in "[An Overview of Life Events](#)."

Annual Enrollment

Each fall, during annual enrollment, you have the opportunity to change your coverage and your dependents' coverage under the Flexible Benefit Plan. You can enroll or re-enroll for coverage during annual enrollment through the American Airlines Benefits Service Center. Any changes you make will take effect the following January 1 and remain in effect through December 31 of that year. If you are on a leave of absence during annual enrollment and return in the following Plan year, you must re-enroll within 31 days of your return. If you return in the same Plan year you went out on leave, you do not have to re-enroll.

Default Coverages

If you do not re-enroll for coverage during annual enrollment, your current elections (except for HCFSA and DCFSA coverage) will automatically renew effective January 1 of the following year.

If you participate in the HCFSA or the DCFSA, you will need to re-enroll in order to participate for the following year. If you do not re-enroll, your HCFSA and DCFSA participation will end on December 31 of the current year.

An Overview of Life Events

The following table provides a detailed look at various circumstances that may be considered change in status events under the Plan, as well as what changes to HCFSA and DCFSA elections may be permitted, according to IRS regulations.

- You must register the life event within 31 days of the event with the American Airlines Benefits Service Center. You must submit proof of the dependent's eligibility to the American Airlines Benefits Service Center within 31 days of the date the documentation is requested. Proof of eligibility cannot be submitted until you receive the request from the American Airlines Benefits Service Center. If you miss the 31 day deadline, your life event change will not be processed. You will have to wait until the next annual enrollment period or experience another life event, whichever happens earlier, to make changes to your benefits

If You Experience the Following Life Event...	Then, You May be Able to...
You become eligible for Company-provided benefits for the first time	Enroll online through the American Airlines Benefits Service Center .
<p>Your spouse or eligible dependent child dies</p> <p>You or your spouse gives birth to or adopts a child or has a child placed with you for adoption or you gain an eligible dependent(s)</p> <ul style="list-style-type: none"> To add a natural child to your coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth. You should not wait to receive the baby's Social Security number or official birth certificate. These documents may take more than 31 days to arrive and prevent you from starting coverage effective on the baby's birth date. To add an adopted child to your benefit coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective the date the child is placed with you for adoption and is not retroactive to the child's date of birth. 	<p>Health Flexible Spending Accounts:</p> <ul style="list-style-type: none"> If you lose a spouse/eligible dependent child: Stop/Decrease contributions If you gain a spouse/eligible dependent child: Start/Increase contributions If you, your spouse or your eligible dependent child gain eligibility under another employer's Health FSA plan: Stop/Decrease contributions If you, your spouse or your eligible dependent child lose eligibility under another employer's Health FSA plan: Start/Increase contributions. Cannot reduce to an amount less than what has already been deducted or paid <p>Dependent Care Flexible Spending Account:</p> <ul style="list-style-type: none"> Increase/Decrease contributions
You get legally married (including common law marriage), divorced or legally separated	
<p>Change in your employment with an employer other than the Company</p> <p>OR</p> <p>Change in spouse's/ eligible dependent child's employment or other health coverage</p>	

If You Experience the Following Life Event...	Then, You May be Able to...
<p>OR</p> <p>Your spouse's eligible dependent child's employer no longer contributes toward health coverage</p> <p>OR</p> <p>Your spouse's eligible dependent child's employer no longer covers employees in your spouse's/eligible dependent child's position</p>	
<p>Your covered eligible dependent child no longer meets the Plan's eligibility requirement, i.e.:</p> <ul style="list-style-type: none"> • If the dependent attains the age at which he/she is no longer eligible to be covered as your eligible dependent • If the dependent marries and is no longer eligible for dental and vision benefits • If the dependent marries and enrolls in his/her spouse's employer group health plan 	<p>Health Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Stop/Decrease contributions • Cannot reduce to an amount less than what has already been deducted or paid <p>Additionally:</p> <ul style="list-style-type: none"> • Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible Dependent's address.
<p>Your dependent child attains age 13 or he or she or no longer requires Dependent Day Care</p> <p>OR</p> <p>Your elderly parent or spouse who is incapable of caring for himself/herself no longer meets the definition of "dependent" under the Dependent Care FSA or no longer requires Dependent Day Care.</p>	<p>Dependent Care Flexible Spending Account:</p> <ul style="list-style-type: none"> • Reduce/Stop Dependent Care Flexible Spending Account contributions. • No other changes to benefits are allowed
<p>Your benefit coverages are significantly improved, lowered or lessened by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")</p> <p>OR</p> <p>Your contribution amount is significantly increased or decreased by the Company (Plan Administrator/Sponsor will determine whether or not a change is "significant")</p>	<p>Make changes to the applicable benefit options:</p> <ul style="list-style-type: none"> • The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
<p>You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMCSO) that requires you to provide health care coverage for a child</p>	<p>Health Flexible Spending Accounts:</p> <ul style="list-style-type: none"> • Start/Increase as long as it is not within 60 days of the end of the Plan Year
<p>You move to a new home address:</p>	<p>Flexible Spending Accounts:</p>

If You Experience the Following Life Event...	Then, You May be Able to...
<ul style="list-style-type: none"> • Update both your legal payroll address and benefits address on MyHR. • Submit a revised Federal Form W-4 Form for payroll tax purposes. The form is available online through the Pay and Compensation page of American Airlines Benefits Service Center. • Provide your new address and current emergency contact numbers to your manager/supervisor, as well. <p>If you move or relocate to a new location within the last two months of the year, contact American Airlines Benefits Service Center so they can ensure your elections are filed for this current year and for next year.</p>	<ul style="list-style-type: none"> • No changes allowed
You start an unpaid leave of absence	Flexible Spending Accounts: <ul style="list-style-type: none"> • See the section titled "Additional Rules That Apply to Flexible Spending Accounts: Leaves of Absence."
You return from an unpaid leave of absence	Flexible Spending Accounts: <ul style="list-style-type: none"> • See the section titled "Additional Rules That Apply to Flexible Spending Accounts: Leaves of Absence."
You change from part-time to full-time employment or full-time to part-time employment	Flexible Spending Accounts: <ul style="list-style-type: none"> • No changes allowed
You die	Continuation of Coverage: Your eligible dependents should contact your manager/supervisor, who will coordinate with a survivor support representative at the American Airlines Benefits Service Center to assist with all benefits and privileges, including the election of continuation of coverage, if applicable.
You end your employment with the Company or you are eligible to retire	Review: " When Participation Ends " in the <i>How the Flexible Benefit Plan Works</i> section. Review: The information you receive regarding continuation of coverage through COBRA. Contact: American Airlines Benefits Service Center for information on retirement.
You transfer to another workgroup	Health Flexible Spending Accounts:

If You Experience the Following Life Event...	Then, You May be Able to...
	<ul style="list-style-type: none"> • Changes are allowed only to the extent that the change in workgroup affects Health Flexible Spending Account eligibility • Start/ Stop Health Flexible Spending Accounts • Increase/Decrease contributions • Cannot reduce to an amount less than what has already been deducted or paid <p>Dependent Care Flexible Spending Account:</p> <ul style="list-style-type: none"> • Increase/Decrease contributions
The cost of dependent care changes (only if the change is imposed by a dependent care provider who is not your relative)	<p>Dependent Care Flexible Spending Account:</p> <ul style="list-style-type: none"> • Increase/decrease contributions

When Participation Ends

Your participation in the Flexible Benefit Plan will end when:

- Your employment ends;
- You retire;
- American Airlines terminates this Plan;
- You are no longer eligible for the Plan;
- You stop making the required contributions; or
- You die.

In addition, your participation in the HCFSA will end on December 31st following the close of the plan year if you do not enroll for the next calendar year (all expenses incurred on or before that date need to be submitted as claims by June 15th to be eligible for reimbursement). Notwithstanding the foregoing, the Plan allows you to carryover up to \$500 of any amount remaining in your HCFSA as of the end of the plan year.

Your participation in the DCFSA will end on March 15th following the close of the plan year if you do not enroll for the next calendar year (all expenses incurred on or before that date need to be submitted as claims by June 15th to be eligible for reimbursement).

If you leave American Airlines during the year for any reason, including termination of employment, furlough or leave, you may be able to continue your HCFSA contributions on an after-tax basis through the Consolidated Omnibus Budget Reconciliation Act ("COBRA"). (See the "[COBRA Continuation](#)" section.) If you leave American Airlines, COBRA does not allow for continued participation in the DCFSA.

The Health Care Flexible Spending Account (HCFSA)

How the Health Care Flexible Spending Account (HCFSA) Works

The HCFSA allows you to set aside money on a pre-tax basis to pay for eligible health care expenses. Paying for these expenses pre-tax helps reduce your taxes.

Benefit Overview		
Option	Who Can Be Reimbursed	Key Features
HCFSA-Health Care FSA	<p>You can be reimbursed for expenses for:</p> <ul style="list-style-type: none"> • You • Your spouse • Your natural, step, adopted or foster children who will be below age 27 at the end of the year • Any individual: <ul style="list-style-type: none"> ○ who has the same principal place of abode as you ○ is a member of your household, and ○ for whom you provide over half of his or her support for the year. 	<ul style="list-style-type: none"> • Deposit up to \$2,600 in 2018. • Pre-tax contributions • Have until June 15 to file claims for previous year's eligible expenses • For your 2018 HCFSA, you have until December 31, 2018 to incur eligible claims • Up to \$500 remaining in your 2018 HCFSA will be carried over to the 2019 plan year • Eligible dependents do not have to be covered under your medical, dental or vision benefit option to be eligible for reimbursement • If both you and your spouse are employed by American Airlines, both employees may each deposit up to \$2,600 in an HCFSA during 2018

Contributions

You can contribute through payroll deduction up to \$2,600 in 2018 in your HCFSA. A minimum annual election amount of \$120 is required to complete enrollment.

At the beginning of each plan year, the full amount of your elected HCFSA amount for the entire year is available for your use, regardless of the actual balance in your account.

Deadline to Incur Claims

For your 2018 HCFSA, you have until December 31, 2018 to incur eligible claims and until June 15, 2019 to request reimbursement for those claims.

\$500 Carryover of Remaining Account Balance

If you have an HCFSA in 2018, the Plan allows you to carryover up to \$500 of any amount remaining in your 2018 HCFSA as of the end of the 2018 plan year. Such carryover amount may be used to pay or reimburse medical expenses incurred during all of 2019. Any unused amount of more than \$500 remaining in your 2018 HCFSA at the end of the 2018 will be forfeited.

Account Administrator

The HCFSA administrator is Your Spending Account (YSA). The [YSA website](#) allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access “Frequently Asked Questions (FAQs),” and manage direct deposit.

Special Provisions

Special rules apply to mid-year election changes to your HCFSA:

- You can only stop or change your election mid-year if you experience certain life events. If you experience a life event and decide to reduce the amount of your HCFSA, you cannot stop or reduce your account balance to an amount that is less than the claims that have already been paid.
- If you incur expenses after your life event, your claims are payable up to the amount of your newly elected deposit amount.
- If you decide to stop the amount of your HCFSA deposits mid-year, this will affect how your claims are paid. If your eligible health care expense was incurred before the life event, your claim is payable up to the original amount you contributed in your HCFSA. You cannot receive reimbursement for expenses incurred after the date you stopped making contributions to your HCFSA; however you can submit claims up to the amount in your account, provided they were incurred before the date you stopped.

If you experience a Qualifying Event (as described in the [“COBRA Continuation”](#) section), your HCFSA terminates.

- As described in the COBRA section, you may elect to continue your HCFSA as part of your COBRA continuation of coverage options, for the remainder of the calendar year in which you became eligible for continuation of coverage. In addition, the Plan allows you to carryover up to \$500 of any amount remaining in your HCFSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the

COBRA continuation period (i.e. 18, 29, or 36 months, as applicable). Any unused amount of more than \$500 remaining in your HCFSA at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.

- If you do not continue your HCFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any contributions that were made and not used before your termination date.

Covered Expenses

Expenses that can be reimbursed through an HCFSA include the following:

- Out-of-Pocket expenses, deductibles, co-insurance, co-pays, prescription medications and supplies not paid by your medical, dental or vision benefit options, whether your coverage is under an American Airlines-sponsored plan or any other health plan.
- Certain types of over-the-counter medicine/drugs purchased with a physician's written prescription (or insulin) and used to alleviate or treat personal injuries or sickness of the employee and/or the eligible dependents may be eligible for reimbursement through your HCFSA. For instance, bandages, crutches and contact lens solution, and the like. Refer to the list of eligible items by visiting the [YSA website](#).
- **Reimbursable Medical Expenses.** Some medical expenses may not be covered at all by your medical benefit option. However, some of those expenses may be reimbursed under your HCFSA. Examples include:
 - Acupuncture
 - Ambulance service
 - Artificial insemination
 - Bandages, support hose, other pressure garments (when prescribed by a physician to treat a specific ailment)
 - Blood, blood plasma or blood substitutes
 - Braces, appliances or equipment, including procurement or use
 - Car controls for the handicapped
 - Charges in excess of maximum out-of-network charge
 - Confinement to a facility primarily for screening tests and physical therapy
 - Experimental procedures
 - Foot disorders and treatments such as corns, bunions, calluses and structural disorders
 - Halfway house care
 - Home health care, hospice care, nurse or home health care aides
 - Hypnosis for treatment of illness
 - In-vitro fertilization and infertility treatment
 - Learning disability tutoring or therapy

- Nursing home care
- Physical therapy
- Prescription vitamins
- Psychiatric or psychological counseling
- Radial keratotomies, Lasik and vision correction procedures
- Sexual transformation or treatment of sexual dysfunctions or inadequacies
- Smoking cessation program costs and prescription nicotine withdrawal medications
- Speech therapy
- Syringes, needles and injections
- Transportation expenses to receive medical care, including fares for public transportation and private auto expenses (consult your tax advisor for the current IRS mileage allowance)
- Work-related sickness or injury (not covered by workers' compensation)

For a full list of covered medical expenses, go to the [IRS website](#).

- **Reimbursable Hearing and Vision Expenses.** Some hearing and vision expenses that may be reimbursed under your HCFSA include:
 - Hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading) and the cost of acquiring and training a service animal for the deaf.
 - Vision expenses, including eyeglasses, contact lenses, ophthalmologist fees, the cost of a service animal for the blind and special education devices for the blind (such as an interpreter).

For a full list of covered hearing and vision expenses, go to the [IRS website](#).

- **Reimbursable Dental Expenses.** Some medical expenses may not be covered at all by your dental benefit. However, they may be reimbursed under your HCFSA. Examples include:
 - Anesthesia
 - Cleaning more than twice per year
 - Charges in excess of usual and prevailing fee limits
 - Drugs and their administration
 - Experimental procedures
 - Extra sets of dentures or other dental appliances
 - Medically necessary orthodontia expenses for adults or dependents
 - Myofunctional therapy
 - Replacement of dentures or bridgework less than five years old
 - Replacement of lost, stolen, or missing dentures or orthodontic devices

For a full list of covered dental expenses, go to the [IRS website](#).

Excluded Expenses

Some expenses may not be reimbursed through your HCFSA, including the following:

- Medical insurance premiums/contributions
- Air conditioning units
- Capital expenses
- Cosmetic medical treatment, surgery, and prescriptions and cosmetic dental procedures, such as cosmetic tooth bonding or whitening
- Electrolysis
- Health club fees and exercise classes (except in rare cases for treatment of medically diagnosed obesity where weight loss is part of the program)
- Massage therapy
- Over-the-counter drugs/medications without a prescription
- Personal care items including cosmetics and toiletries
- Structural additions or changes
- Swimming pools
- Transportation expenses for the handicapped to and from work
- Vacation travel for health purposes
- Vitamins and nutritional supplements, unless prescribed by a doctor
- Weight loss programs (unless for treatment of medically diagnosed morbid obesity)
- Wheelchair ramps
- Whirlpools

For a full list of excluded expenses, go to the [IRS website](#).

Filing Claims

You have until June 15 to file claims on your previous year's eligible expenses.

Participants who have a Health Care Flexible Spending Account may file claims on the [YSA website](#), by fax, or through the U.S. Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the [YSA website](#).

Please see the "[Claims Procedures](#)" section for a detailed description of the claims procedures that apply to your Health Care Flexible Spending Account benefits.

Dependent Care Flexible Spending Account (DCFSA)

How the Dependent Care Flexible Spending Account (DCFSA) Works

The DCFSA allows you to set aside money on a pre-tax basis to help pay for eligible day care expenses for your eligible adult and child dependents (up to age 13). Paying for these expenses with pre-tax money helps reduce your taxes.

Benefit Overview		
Option	Reimbursement	Key Features
Dependent Care FSA	<p>You can be reimbursed for:</p> <ul style="list-style-type: none"> • Licensed child and adult day care centers • Private kindergarten (used for day care rather than education) • Babysitters • Au pairs 	<ul style="list-style-type: none"> • Contribute up to \$5,000 a year • Pre-tax contributions • Have until March 15 of the benefit year to use your prior year's balance • Have until June 15 to file claims for previous year's eligible expenses • You cannot use your funds until they are deposited in your account

Contributions

Your family and tax filing status determine the maximum amount you can contribute per calendar year:

- A single employee may contribute up to \$5,000.
- A couple filing a joint income tax return, where both spouses participate in DCFSAs, may contribute a combined amount of up to \$5,000.
- A couple filing separate income tax returns may each contribute up to \$2,500.
- A couple (if both individuals are employed) may contribute up to \$5,000 or the income amount of the lower-paid spouse (if it is less than \$5,000).
- If you are a Highly Compensated Employee, as defined by the Internal Revenue Code, your allowable annual pre-tax contribution may be less than \$5,000 per calendar year. For example, as defined by the Internal Revenue Code in 2015, a Highly Compensated Employee is an individual who has an annual income of \$120,000 or more. This amount may be subject to change, and you will be notified if your maximum contribution changes. For more information about Highly Compensated Employee limits, go to the [IRS website](#).

If both you and your spouse work for American Airlines, your combined DCFSA total contribution cannot exceed \$5,000.

A minimum annual election amount of \$120 is required to complete enrollment.

Important Note about your DCFSA: You will only be able to submit claims, and be reimbursed, for amounts up to the existing balance in your DCFSA.

Deadline to Incur Expenses

You have until March 15 of the following year to incur claims reimbursable under your DCFSA balance, and until June 15 of the following year to request reimbursement.

Account Administrator

The DCFSA administrator is Your Spending Account (YSA). The [YSA website](#) allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access “Frequently Asked Questions (FAQs),” and manage direct deposit.

Special Provisions

As funds are deposited into your account, you can pay for eligible day care expenses.

You and your spouse (if you are married) must be employed, actively seeking employment, or a full-time student for at least five months of the year to be eligible to receive reimbursement from your DCFSA.

Special rules apply to mid-year election changes to your DCFSA:

- You can only stop or change your election mid-year if you experience certain life events.
- If you experience a life event and decide to reduce the amount of your DCFSA, you cannot stop or reduce your account balance to an amount that is less than the claims that have already been paid.
 - If you incur expenses after your life event, your claims are payable up to the amount of your newly elected deposit amount.
- If you decide to stop the amount of your DCFSA deposits mid-year, this will affect how your claims are paid.
- If your eligible expense was incurred before the life event, your claim is payable up to the original amount you contributed in your DCFSA.

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your DCFSA terminates.

Who is Covered

You may claim dependent day care expenses for your eligible dependents, including:

- Children under age 13
- An individual who satisfies all of the requirements to be your dependent under the Internal Revenue Code (except for the requirements pertaining to the individual's claimed dependents, marital status and gross income), if the person meets **all** of the following criteria:
 - Lives with you for over half of the calendar year, and
 - Is physically or mentally incapable of self-care
- Your spouse who meets the following criteria:
 - Lives with you for over half of the calendar year, and
 - Is physically or mentally incapable of self-care

Covered Expenses

Expenses that you incur may be reimbursed through your DCFSA if they are:

- Incurred for your eligible dependents described above under "[Who is Covered](#)," or for related household services;
- Paid or payable to a Dependent Care Service Provider described below; and
- Incurred to enable you and your spouse to be gainfully employed or to be in active search of gainful employment.

Expenses incurred for services outside your household for the care of an eligible dependent described above under "[Who is Covered](#)," may only be reimbursed through your DCFSA if the eligible dependent is:

- A child under age 13; or
- Regularly spends at least eight hours each day in your household.

A Dependent Care Service Provider means a person who provides care or other services for an eligible dependent described above under "[Who is Covered](#)" or related household services. A Dependent Care Service Provider **does not** include:

- A facility that is paid to provide care for more than six individuals, unless such center complies with all applicable state and local laws and regulations, such as licensing requirements; or
- Your spouse or your dependent child under age 19.

Filing Claims

You have until June 15 to file claims on your previous year's Eligible Expenses. Participants who have a Dependent Care Flexible Spending Account may file claims on the [YSA website](#), by fax, or through the US Mail.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link on the [YSA website](#).

If you do not have adequate funds in your DCFSA account, a partial payment of the claim will be made and the balance of your claim will pay out as payroll deposits are made.

If You Elect Both a HCFSA and a DCFSA

Your FSA and DCFSA funds are managed separately.

Additional Rules That Apply to Flexible Spending Accounts

Keeping Spending Accounts Separate

You cannot transfer or mix funds between your HCFSA and DCFSA. The money set aside in a HCFSA can only be used for eligible health care expenses, and the money in a DCFSA can only be used for eligible dependent care expenses.

Leaves of Absence

- If you participate in the HCFSA and you go on an unpaid leave of absence:
 - You can continue to contribute to your account, but only on an after-tax basis. You will receive COBRA information shortly after your leave date and may elect to continue your HCFSA participation through COBRA; or
 - You can choose not to contribute while on leave. In this case, you can only request reimbursement for services or products purchased while you were in pay status. If you return in the same year, you can (i) increase the level of contributions you were making prior to your leave of absence to an amount that will satisfy your original annual pledge, or (ii) resume the same level of contributions you were making prior to your leave of absence, with your original annual pledge correspondingly reduced. If you return in a different year from the one in which your leave began, you will be allowed to re-enroll in the Plan within 31 days of your return.

- If you participate in the DCFSA and you go on an unpaid leave of absence:
 - Only eligible dependent care services paid for in the same Plan year as the year your leave began while you are actively participating (making contributions) in the Plan are eligible for reimbursement; and
 - When your leave of absence ends, and if you return in the same Plan year your leave started, you can (i) increase the level of contributions you were making prior to your leave of absence to an amount that will satisfy your original annual pledge, or (ii) resume the same level of contributions you were making prior to your leave of absence, with your original annual pledge correspondingly reduced. If you return in a different year from the one in which your leave began, you will be allowed to re-enroll in the Plan within 31 days of your return.

Continuation of Spending Account Participation for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

When you go on military leave, your work hours are reduced. As a result, you may become eligible to continue your HCFSA participation through COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible. During the COBRA continuation period you will be charged your full contribution amount plus a two percent (2%) administrative fee.

If you choose not to continue your participation in the HCFSA while on military leave, you are entitled to reinstated participation with no waiting periods or exclusions when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled work day following your leave, safe transport home and an eight-hour rest period if you are on a military leave of less than 31 days;
- Return to or reapply for reemployment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days; or
- Return to or reapply for reemployment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Using your Flexible Spending Accounts

You have three options to use the balance in your Flexible Spending Accounts (FSAs):

1. YSA Health Card

If you are currently enrolled in a Flexible Spending Account (FSA), you will use the same YSA card to access FSA funds. If you are not currently enrolled in an FSA, you will receive a new YSA Visa debit card in the mail to access your rewards. You must activate the card in order to use it to pay for eligible medical, dental, prescription, and vision expenses. Always be sure to save your receipts, as the FSAs may require you to submit documentation.

2. Automatic Reimbursement

If you select the automatic reimbursement method on the [Benefits Service Center YSA site](#), your FSAs will automatically reimburse you (via check or direct deposit) whenever you have a claim for eligible medical, dental, prescription, or vision expenses under the Plan.

3. Submit Manual Claims

You may submit eligible medical, dental, prescription, and vision claims for reimbursement online, by mail, or by fax. Visit the [Benefits Service Center YSA site](#) or call YSA at 1-888-860-6178 for instructions and claim forms.

Circumstances That May Result in Denial, Loss or Forfeiture of Flexible Spending Account Benefits

You will not be eligible to participate in the Plan (for the Plan year) if you:

- Do not enroll by the annual enrollment deadline;
- Were on leave, chose not to continue participation during leave (for HCFSA only) and did not enroll within 31 days of your return to work; or
- Were on leave and chose not to participate (for HCFSA only) during leave.

You will not be entitled to request reimbursements if you fail to submit eligible expenses for reimbursement by June 15 of the following year and you will lose any unused account balance. Unclaimed funds will be used to offset the Plan's future administrative expenses.

Remember that you cannot claim the same amount of eligible expenses for both a health care tax deduction and reimbursement through a HCFSA. You may want to consult with a tax advisor before you determine your HCFSA contribution amount.

Also, remember that you cannot claim the same amount of eligible expenses for both a dependent care tax credit and reimbursement through a DCFSA. You may want to consult with a tax advisor before you determine your DCFSA contribution amount.

If your employment ends:

- Your contributions will end as of your last paycheck. Only services or products purchased before your last day of employment will be eligible for reimbursement. Your contribution will remain in your account until the latest of the following:
 - The date you exhaust your balance with submitted eligible claims, or
 - June 15 of the following year, the deadline for filing claims.
- If you fail to submit eligible expenses by June 15 of the following year, you will lose the remaining account balance(s).

You can choose to continue making contributions to the HCFSA through the end of the year in which your employment ends (under the provisions of COBRA). Since you will not be receiving pay from American Airlines, your contributions will be made on a post-tax basis and will include a 2% administrative fee.

Rules Applicable to the Health Care Account

Qualified Medical Child Support Order

The HCFSA will comply with all the terms of a Qualified Medical Child Support Order (“QMCSO”). A QMCSO is an order or judgment from a court or administrative body, which directs a plan to cover a child of a participant under the HCFSA. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child’s representative) covered by the order will be given notice of the receipt of the order and a copy of the procedures for determining if the order is valid. Coverage under the HCFSA pursuant to a medical child support order will not become effective until the Plan Administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedures for determining whether a QMCSO is valid, please contact American Airlines, Inc. Benefits Service Center at 1-888-860-6178.

COBRA Continuation

Under a federal law commonly known as COBRA (Consolidated Omnibus Budget Reconciliation Act), you, your spouse and your dependent children may elect to continue coverage temporarily under the HCFSA, in certain instances, where coverage otherwise would be reduced or terminated. Individuals entitled to COBRA continuation coverage (qualified beneficiaries) are you, your spouse and your dependent children who are covered at the time of a qualified family or work status event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

You may continue participation in your HCFSA under COBRA on a post-tax basis for the remainder of the year in which your qualified family or work status event occurs. Generally, if the COBRA premium for the remainder of the Plan year would exceed the maximum benefit still available under the HCFSA as of the date of the qualified family or work status event, American Airlines is not required to offer COBRA continuation. In contrast, if the maximum benefit available under your HCFSA is greater than the remaining COBRA premium, American Airlines must offer you COBRA continuation within the current Plan year. For the year after a qualified family or work status event occurs, you will not be able to elect HCFSA participation, even if your COBRA continuation period is still in effect for your other health care coverage(s).

In addition, you may carryover up to \$500 of any amount remaining in your HCFSA as of the end of the calendar year in which you became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the COBRA continuation period (i.e. 18, 29, or 36 months, as applicable). Any unused amount of more than \$500 remaining in your HCFSA at the end of the calendar year in which you became eligible for continuation of coverage will be forfeited.

Qualified Family or Work Status Events

If you experience one of the following qualified family or work status events, you may be eligible to continue your HCFSA participation under COBRA:

- You terminate employment for any reason (other than gross misconduct);
- You become entitled to benefits under Medicare;
- You and your spouse divorce;
- Your child no longer qualifies as an eligible dependent;
- You retire; or
- You die.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation upon divorce or loss of your child's dependent status under the Plan, you, your spouse or one of your covered dependents must notify American Airlines, Inc. Benefits Service Center of the divorce or loss of dependent status within 60 days of the later of the event date or the date the individual would lose coverage under the Plan. Your spouse and your covered dependents will then be provided with instructions for continuing your health coverage.

If your employment ends or you retire, you, your spouse and covered dependents will receive instructions for continuing your participation in the HCFSA. In the event of your death, American Airlines will notify your spouse and covered dependents about how to continue participation.

Electing and Paying for COBRA Continuation Coverage

You must choose to continue coverage within 60 days after the later of the following dates:

- The date you would lose coverage as a result of the qualified family or work status event; or
- The date the COBRA administrator notifies you of the right to choose to continue coverage as a result of the qualified family or work status event.

Premium Due Date: If you elect COBRA continuation coverage, you must make the initial contribution (including all contributions due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation and fail to make the contribution due within the initial 45-day grace period, or you fail to pay any subsequent contribution within 30 days after the date it is due, your participation will be terminated retroactive to the last day on which timely payment was made.

Cost: The cost of COBRA coverage is 102% of your contribution amount.

When COBRA Continuation Coverage Ends

COBRA continuation for any person will end when the first of the following occurs:

- The applicable continuation period ends;
- The initial contribution for continued participation is not made within 45 days after the date COBRA is elected, or any subsequent contribution is not made within 30 days after it is due; or
- American Airlines terminates participation in the HCFSA for all employees.

For questions, please contact the COBRA administrator.

Reporting Dependent Care Provider Information on Your Tax Return

The IRS requires you to report on your federal tax return the "taxpayer identification number" of any dependent care providers you use. You must also report the appropriate taxpayer identification number(s) when you request a reimbursement from your DCFSA.

Remember that the HCFSA and DCFSA are not interchangeable. You cannot use money from your HCFSA to pay dependent care expenses, or vice versa.

Notice of Privacy Rights – Health Care Records

This notice applies to all Plan participants. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of February 17, 2010, and applies to health information received about you by the health care components of the American Airlines, Inc. Health & Welfare Plan for Active Employees (particularly, the CORE Medical Benefit Option, the STANDARD Medical Benefit Option the VALUE Medical Benefit Option, the OUT-OF-AREA Medical Benefit Option, the HMOs, Dental, Vision Insurance, Health Care Flexible Spending Accounts, Limited Purpose Flexible Spending Account, Health Savings Account), the Supplemental Medical Plan for Employees of Participating American Airlines Group Subsidiaries, the Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group Subsidiaries, TransWorld Airlines, Inc. Retiree Health and Life Benefits Plan and any other group health plan for which American Airlines, Inc. (“American”) serves as Plan Administrator (collectively, the “Plan”).

You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”) mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the “Privacy Regulations”) and as amended by the Genetic Information Nondiscrimination Act (“GINA”) and the American Recovery and Reinvestment Act (“ARRA”). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan’s privacy procedures with respect to your health information that is created or received by the Plan (your “Protected Health Information” or “PHI”). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan’s duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan’s privacy practices.

The following uses and disclosures of your PHI may be made by the Plan:

For Appointment Reminders and Health Plan Operations. Your PHI may be used so that the Plan, or one of its contracted service Providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you, such as case management, disease management, wellness programs or employee assistance programs.

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of

benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claims for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop-loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by American Airlines, Inc. for any of the purposes described above. ARRA requires disclosures for purposes of payment to meet its minimally necessary standard.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care Providers and conducting cost management and customer service and resolution of internal grievances. ARRA requires disclosures for purposes of the Plan's operations to meet its minimally necessary standard. The Plan is prohibited from disclosing any of your PHI that constitutes genetic information (as defined by GINA) for underwriting purposes.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you (for example, if your doctor requests information on what other drugs you are currently receiving).

For Workers' Compensation. The Plan may disclose your PHI as authorized by you or your representative and to the extent necessary to comply with laws relating to Workers' Compensation and similar programs providing benefits for work-related injuries or illnesses if either, (1) the health care Provider is a member of the employer's workforce and provides health care to the individual at the request of the employer, the PHI is provided to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace, and the information is required for the employer to comply with OSHA or with laws with similar purposes or (2) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

Pursuant to Your Authorization. Any other use or disclosure of your PHI will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

To the Plan Sponsor. Information may be provided to the Sponsor of the Plan, provided that the Sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to disclose or use your PHI for certain other purposes (for example, if certain types of wounds occur that require reporting or a disclosure to comply with a court order, a warrant, a subpoena, a summons or a grand jury subpoena).

Other Uses or Disclosures of Protected Health Information

- Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release
- Disclosure of your Protected Health Information to family members, other relatives and your close personal friends is allowed if:
 - The information is directly relevant to the family's or friend's involvement with your care or payment for that care, and
 - You have either agreed to the disclosure or have been given an opportunity to object and have not objected.
- Uses and disclosures for which authorization or opportunity to object is not required
- Use and disclosure of your Protected Health Information is allowed without your authorization or any opportunity to agree or object under the following circumstances:
 - When required by law.
 - When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
 - When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.
- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against Providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. State laws may provide you with additional rights or protections.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. The Plan is required to comply with your request not to disclose to another plan any PHI related to any claim for which you paid in full. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to make a written request to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following: Director, Benefit Programs.

To Access. You have the right to request access to your PHI and to inspect and copy your PHI in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal or administrative actions or

proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. You may also direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by you.

You or your personal representative will be required to make a written request to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following Director, Benefit Programs, at American Airlines, Mail Drop 5126-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the following officer: Director, Benefit Programs, at American Airlines, Mail Drop 5126-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. You or your personal representative will be required to complete a written form to request amendment of the PHI in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (such disclosures occurring after January 1, 2014, will be required to be included in the accounting); (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by

which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Obtain a Paper Copy of This Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Plan's Privacy Officer by calling the Director, Benefit Programs, or by writing to American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

To Request Confidential Communication. You have the right to request confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the following officer: Director, Benefit Programs, American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

A Note About Personal Representatives

You may exercise your rights through a personal representative (e.g., having your Spouse call for you). Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public,
- A signed authorization completed by you,
- A court order of appointment of the person as the conservator or guardian of the individual, or
- An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care Provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the Secretary of the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

The Plan may use or disclose "summary health information" or a limited data set on and after February 17, 2010 to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a "Limited Data Set" that may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o EBC Appeals Group, at American Airlines, Mail Drop 5134-HDQ, P.O. Box 619616, DFW Airport, TX 75261-9616, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. You may obtain the address of the appropriate regional office of the

Office for Civil Rights from the Privacy Complaint Official. If you would like to receive further information, you should contact the Privacy Official, the Director, Benefit Programs at American Airlines, Mail Drop 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616, or the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o EBC Appeals Group, at American Airlines, Mail Drop 5134-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. This notice will first be in effect on February 17, 2010 and shall remain in effect until you are notified of any changes, modifications or amendments.

How American Airlines, Inc. May Use Your Health Information

The Plan Sponsor and/or Plan Administrator of the Plan may use and disclose your personal medical information (called "Protected Health Information") created and/or maintained by the Plan that it receives from the Plan as permitted and/or required by, and consistent with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations found at 45 CFR Part 164, Subpart A. This includes, but is not limited to, the right to use and disclose a participant's PHI in connection with payment, treatment and health care operations.

The Plan includes the Health Care Flexible Spending Account component of the American Airlines, Inc. Flexible Benefit Plan for Certain Legacy Employees.

This Section Applies To

The information in this section applies only to health-related benefit plans that provide "medical care," which means the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, transportation primarily for and essential to medical care, and insurance covering medical care. This means that, for the American Airlines, Inc. Flexible Benefit Plan for Certain Legacy Employees, only the Health Care Flexible Spending Account benefits are subject to the limitations described in this section.

This Section Does Not Apply To

By law, the HIPAA Privacy rules, and the information in this section, do not apply to the following components of the American Airlines, Inc. Flexible Benefit Plan for Certain Legacy Employees:

- Dependent Care Flexible Spending Account

In addition, the Company may have personal medical information about you that is used for routine employment activities. Medical information held or used by the Company in its employment records for employment purposes is not subject to the HIPAA Privacy rules.

This includes, but is not limited to, medical information, files or records related to compliance with government occupational and safety requirements, the Americans with

Disabilities Act (ADA) or other employment law requirements, occupational injury, disability insurance eligibility, sick leave requests or justifications, drug or alcohol screening results, workplace medical surveillance, fitness-for-duty test results or other medical information needed to meet Federal Aviation Administration (FAA), Department of Transportation (DOT) or other company policy or government requirements. Information used by the Employee Assistance Program (EAP) in its role in administering employment-related programs, such as drug and alcohol testing, is not subject to the HIPAA Privacy rules.

The Plan will disclose PHI to the employer Plan Sponsor only upon receipt of a certification by the employer that the plan documents have been amended to incorporate all the required provisions as described below. To the extent that PHI is maintained by the Plan, the Company has agreed to:

- Not use or further disclose the information other than as permitted or required by this Summary Plan Description, as it may be amended by the Company from time-to-time, or as required by law.
- Ensure that any agents, including a subcontractor, to whom the Plan give PHI, agree to the same restrictions and conditions that apply to the employer Plan Sponsor with respect to such information.
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the employer Plan Sponsor, unless that use or disclosure is permitted or required by law (for example, for Workers Compensation programs) or unless such other benefit is part of an organized health care arrangement with the plan.
- To the extent that the employer Plan Sponsor becomes aware that there is any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures, to report such improper uses or disclosures to the Plan.
- Make available PHI in accordance with individual rights to review their PHI.
- Make available PHI for amendment and consider incorporating any amendments to PHI consistent with the HIPAA rules.
- Upon request and to the extent mandated by applicable law, make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules.
- Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Plan.
- Agree to the same restrictions and conditions that apply to the Plan with respect to such information and enter into Business Associate agreements that comply with the standards for such agreements in the Privacy Regulations.
- Enter into limited data set use agreements when the Plan discloses data de-identified in compliance with the requirements for a limited data set as provided in the Privacy Regulations pursuant to a Limited Data Set use or disclosure agreement that meets the standards of the Privacy Regulations.

- Terminate any Business Associate agreement or Limited Data Set agreement in the event the Plan becomes aware of a pattern of non-compliance with the terms of the agreement.
- Provide the individual who is the subject of the PHI with the opportunity to request restrictions on the PHI's disclosure in accordance with the Plan's policy on requesting restrictions on disclosure of PHI.
- Provide the individual who is the subject of the PHI with the opportunity to request confidential communication of PHI from the Plan to the individual in accordance with the Plan's policies and procedures.
- Incorporate any amendments or corrections to PHI when such amendment is determined to be required by the Plan's policy on amendment of PHI.
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plan.
- If feasible, return or destroy all PHI received from the Plan that the employer Plan Sponsor still maintains in any form. The employer Plan Sponsor will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if the return or destruction is not feasible, but the Plan must limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that there is an adequate separation between the Plan and the employer Plan Sponsor as will be set forth below.

Separation of American Airlines, Inc. and the Group Health Plan

The following employees or classes of employees or other persons under the control of the Company shall be given access to PHI for the purposes related to the Plan:

- Benefits Strategy employees involved in health plan design, vendor selection and administration of the Plan, and including the Plan Managers, and administrative assistants, secretarial and support staff
- The EBC, its delegated authority, due to their role in governing health plan matters, including rendering appeal decisions and other health plan administrative matters.
- Benefits Compliance and the EBC Appeals group personnel involved in receiving, researching and responding to health plan member appeals filed with the EBC.
- American Airlines Benefits Service Center personnel who assist with day-to-day health plan operations, including Vendor Relations personnel; employees involved in receiving, reviewing and processing Qualified Medical Child Support Orders and all call center personnel, case coordinators and support staff who assist employees by answering questions, researching issues and resolving health plan problems; Leave of Absence coordinators working with health plan enrollment issues and secretarial and support staff for the employees listed.

- Instructors who train American Airlines Benefits Service Center personnel, and thus have access to the call center systems.
- The Records Room personnel responsible for managing benefit plan record storage.
- Legal department employees, including Employment and Labor Attorneys, ERISA counsel, Litigation Attorneys and any other attorneys involved in health plan legal matters, and including paralegals and administrative assistants, and Legal Records Room personnel who manage record storage.
- American Airlines Benefits Service Center personnel responsible for financial management of the health plans, including the HR Controller; HR Delivery Operations personnel; health plan Benefits Analysts monitoring financial trends and their administrative assistants, secretarial and support staff.
- Financial Reporting Group employees involved in audits and financial reporting for the group health plans, and including the secretarial and support staff for these employees.
- Employee Relations personnel, but only those involved in grievance processes or mediation/arbitration processes.
- Internal Audit employees, but only for purposes of auditing administrative processes related to the group health plans, and including the secretarial and support staff for these employees.
- Benefits & Travel Technology personnel who maintain key human resource and benefits systems used to transmit, store or manage PHI, and including the secretarial and support staff for these employees.
- Information Technology Services (ITS) management personnel, including certain team leads and other designated personnel managing IT infrastructure for systems used by the People Department and Benefits, including administrative staff, key vendor managers and certain management personnel responsible for disaster recovery procedures.
- Privacy Compliance Council and HIPAA Subcommittee members, due to their role in understanding and investigating the flow of PHI for the Plan, in order to ensure compliance with HIPAA and other privacy rules.
- On a need-to-know basis, appropriate personnel employed by the employer Plan Sponsor as independent contractors who have executed Business Associate agreements with the Plan to provide other necessary administrative services to the Plan that include, but are not limited to:
 - Insurance agents retained to provide consulting services and obtain insurance quotes,
 - Actuaries retained to assess the Plan's ongoing funding obligations,
 - Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities,
 - Consulting firms engaged to design and administer Plan benefits,

- Financial accounting firms engaged to determine Plan costs, and
- Claims processing companies engaged to assist the Plan Administrator in the processing of claims made against the Plan.

Access to and use of PHI by such employees and other persons described above is restricted to administration functions for the Plan performed by the Company, including payment and health care operations.

The Company shall provide an effective mechanism for resolving any issues of non-compliance by such employees or persons.

Noncompliance Issues

If the persons described above do not comply with the requirements included in this portion of the Plan, the Plan Sponsor shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions for the individuals involved in the violation, which sanctions are included in the policy on sanctions for violation of the privacy policies and procedures. The Plan's Policy Regarding Sanctions for Violation of the HIPAA Privacy Policies and Procedures shall be followed along with the Group Health Plan's Policy and Procedure on Mitigation of Damages for Violative Disclosure of PHI in the event of any violation of the Plan's HIPAA Privacy Provisions in this Article.

Organized Health Care Arrangement

The Plan is part of an organized health care arrangement with the following other health plans maintained by American Airlines, Inc.

The American Airlines, Inc. Health & Welfare Plan for Active Employees with respect to the benefits and benefit options providing medical benefits, dental benefits, vision benefits, health care flexible spending accounts and the HMOs offered hereunder, the Supplemental Medical Plan for Employees of Participating American Airlines Group Subsidiaries, the Trans World Airlines, Inc. Retiree Health and Life Benefits Plan, the Group Life and Health Benefits Plan for Retirees of Participating American Airlines Group Subsidiaries and any other Group Health plan for which American serves as Plan Administrator.

The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement for the purposes described in the regulations and in the section entitled "[Notice of Privacy Rights – Health Care Records.](#)"

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of the Plan's benefits that relate to an individual to whom health care is provided. A disclosure for payment will be limited to the minimally necessary information unless the disclosure occurs in the form of the standard for the electronic transactions. An authorization is not required to permit a disclosure or use for payment unless the disclosure involves psychotherapy notes or the

use of the information for marketing. Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, co-insurance, deductibles and co-payments as determined for an individual's claim)
- Adjudication of health benefit claims (including appeals and other payment disputes)
- Establishing employee contributions
- Risk adjusting amounts due based on enrollee health status and demographic characteristics
- Billing, collection activities and related health care data processing
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance)
- Determining medical necessity, experimental or investigational treatment or other coverage reviews or reviews of appropriateness of care or justification of charges (including hospital bill audits)
- Processing utilization review, including precertification, preauthorization, concurrent review, retrospective review, care coordination or case management
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for such purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan)
- Obtaining reimbursements due to the Plan

Health Care Operations. A disclosure for Health Care Operations will be limited to the amount minimally necessary. Health Care Operations include, but are not limited to, the following activities:

- Quality assessment,
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions,
- Rating providers and plan performance, including accreditation, certification, licensing or credentialing activities,
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance),

- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies,
- Business management and general administrative activities of the Plan, including but not limited to:
- Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - Participant service, including the provision of data analyses for participants or the Plan Sponsors
 - Resolution of internal grievances, and
 - The sale, transfer, merger or consolidation of all or part of the Plan with another covered entity, or an entity that following such activity will become a covered entity, and due diligence related to such activity.

Treatment. Disclosures for treatment are not limited by the minimally necessary requirement if the disclosures are made to, or the requests are made by, a health care provider for the treatment of an individual. Treatment means the provision, coordination or management of health care and related services by one or more health care provider(s). Treatment includes:

- The coordination or management of health care by a health care provider and a third party,
- Consultation between health care providers about an individual patient, or
- The referral of a patient from one health care provider to another.

Limited Data Set. The Plan may disclose PHI in the form of a limited data set as provided in 45 CFR §164.514(e) provided that the disclosure is in accordance with such provisions.

Claims Procedures

For Health Care Flexible Spending Account and Dependent Care Flexible Spending Accounts

Time Frame for Initial Claim Determination

For claims under the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account, the Claim Administrator 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 Claim Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the Claim Administrator 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 Claim Administrator 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.

How to Appeal an Adverse Benefit Determination

American Airlines, Inc., as Plan Sponsor and Plan Administrator of the Plan, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the Claim Administrator or benefit vendor that rendered the adverse benefit determination. Second Level Appeals are conducted by the Employee Benefits Committee (EBC) or its delegate at American Airlines, Inc. (Appeals may be filed on adverse benefit determinations such as claim denial or reduction in benefits, eligibility/enrollment denial, partial payment or partial denial of benefits, rescission of coverage, application of a benefit penalty, or other such adverse benefit determinations.)

This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document.

First Level Appeal

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Claim Administrator. You or your authorized representative have 180 days, following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the Claim Administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination.

To file a First Level Appeal with the Claim Administrator, please complete an Application for First Level Appeal, and include with the Application all comments, documents, records, and other information relating to the denied/withheld benefit. (The [Application for First Level Appeal](#) provides information about what to include with your appeal).

The Claim Administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing:

- For Health Care Flexible Spending Account and Dependent Care Flexible Spending Account claims – within 30 days of receipt of your First Level Appeal.

Second Level Appeal

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal with the EBC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the EBC at American Airlines, Inc. You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal (with the EBC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the EBC, please complete an Application for Second Level Appeal, and include with the Application all comments, documents, records and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The [Application for Second Level Appeal](#) provides information about what to include with your appeal.)

The EBC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For Health Care Flexible Spending Account and Dependent Care Flexible Spending Account claims – within 30 days of receipt of your Second Level Appeal.

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plan 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 and a report from the Claim Administrator, 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.
- Receive from the Plan Administrator or Claim Administrator any new or additional rationale before the rationale is used to issue a final internal adverse determination, so as to allow you a reasonable opportunity to respond to the new rationale

- 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 or Claim 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.

When You are Deemed to Have Exhausted the Internal Claim and Appeal Process

If the Plan Administrator or Claim Administrator fails to comply with these aforementioned rules in processing your claim, you are deemed to have exhausted the claims and internal appeals process and you may pursue a civil action under ERISA §502(a). However, keep in mind that the claim and appeal process won't be deemed exhausted based on *de minimis* violations of law (as long as the Plan Administrator or Claim Administrator determines that the violation was for good cause, was committed in a good faith exchange of information between you, or was due to matters beyond the Plan Administrator's or Claim Administrator's control).

You may request from the Plan Administrator or Claim Administrator a written explanation of the violation, and such explanation must be provided to you within 10 days. This explanation should include a specific description of the bases, if any, for its assertion that the violation should not cause the internal claim and appeal process to be deemed exhausted.

If a court rejects your request for immediate review because it finds that the Plan Administrator or Claim Administrator met the standards for exception (*de minimis* violation, good cause, good faith exchange of information, or matters beyond its control), you still have the right to resubmit and pursue the internal appeal. The Plan Administrator or Claim Administrator will notify you of your opportunity to file the internal appeal of your claim. The 12-month claim filing limit will begin to run upon your receipt of the Plan Administrator's or Claim Administrator's notice.

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

This information about the administration of the Plan is provided in compliance with the Employee Retirement Income Security Act (“ERISA”) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your Plan.

Names of Plan

The names of the Plan described in this SPD is the American Airlines, Inc. Flexible Benefit Plan for Certain Legacy Employees

Types of Plan

The Flexible Benefit Plan offers eligible employees the opportunity to elect to pay the cost for certain qualified benefits provided by American Airlines on a pre-tax basis in lieu of cash compensation.

The HCFSA and DCFSA provide for participation in a Health Care Flexible Spending Account and/or Dependent Care Flexible Spending Account.

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 Alight Solutions including answering questions on behalf of American Airlines, Inc. They can be reached at: 1-800-860-6178

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.

Agent for Service of Legal Process

Vice President, Benefits
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.
Mail Drop 5126 – HDQ1
Fort Worth, TX 76155

Identification Numbers

The Employer Identification Number ("EIN") assigned by the Internal Revenue Service to American Airlines is 13-1502798. The Plan Number assigned to the Health Care Flexible Spending Account is 501.

Plan Year

The Plan year is January 1 through December 31.

Organizations Providing Administrative Services

Listed below are the names, addresses, phone numbers and websites of the organizations that provide administrative services. These services include administering claims and providing customer assistance.

Flexible Spending Account

Alight Solutions
Your Spending Account Services
P.O. Box 785040
Orlando, FL 32878-5040
Fax: 1-888-211-9900

COBRA

Alight Solutions
P.O. Box 1345
Carol Stream, IL 60132-1345
Phone: 1-888-860-6178
Fax: 1-847-554-1884

Plan Funding/Sources of Contributions

The spending accounts are funded by pre-tax and/or after-tax contributions made by employees who elect to participate in the Plan.

Plan Document

This document is intended to help you understand the main features of the Plan. It should not be considered a substitute for the Plan documents, which govern the operation of the Plan. If you have any questions about information not covered in this document, or if this document appears to conflict with the official Plan documents, the text of the official Plan documents will determine how questions will be resolved.

You can request a copy of the Plan documents by contacting:

Alight Solutions
P.O. Box 1345
Carol Stream, IL 60132-1345
Phone: 1-888-860-6178

Anti-Assignment of Benefits

You may not assign your legal rights or rights to any payments under this Plan. However, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by you or your dependents, but only as a convenience to you. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) you or your dependents under any circumstances.

Future of the Plan

American Airlines intends to continue the Plan indefinitely. However, American Airlines reserves the right to amend, modify, suspend or terminate the Plan, in whole or in part. Any such action would be taken in writing and maintained with the records of the Plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time.

If the Plan, or any part of the Plan, is terminated, you will receive the benefits due you to the extent funded or provided contractually under the terms defined in the Plan’s legal contracts.

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:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the Plan, including insurance contracts, 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 (“EBSA”).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual reports.

Continue Group Health Plan Coverage (Applicable to the Health Care Flexible Spending Account Only)

You can continue coverage under the HCFSA Plan for yourself, spouse or dependents if there is a loss of coverage under that Plan as a result of a qualified family or work status event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage 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 this 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, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a 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 medical child support order, you may file suit in a federal court.

If it should happen that the Plan's 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 Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

Not A Contract of Employment

Your eligibility or your right to benefits under the Plan should not be interpreted as a guarantee of employment. The Company's employment decisions are made without regard to the benefits to which you are entitled.

This SPD provides detailed information about the Plan and how it works. This SPD does not constitute an expressed or implied contract or guarantee of employment.