SUMMARY OF MATERIAL MODIFICATIONS FOR THE AMERICAN AIRLINES, INC. HEALTH AND WELFARE PLAN FOR ACTIVE EMPLOYEES
EIN/PN: 13-1502798/501

CERTAIN CHANGES EFFECTIVE OCTOBER 1, 2018; OTHER CHANGES EFFECTIVE NOVEMBER 1, 2018

IMPORTANT NOTICE: THIS SUMMARY OF MATERIAL MODIFICATIONS APPLIES TO EMPLOYEE PARTICIPANTS AND THEIR COVERED DEPENDENTS WHO ARE ENROLLED IN THE AMERICAN AIRLINES, INC. HEALTH AND WELFARE PLAN FOR ACTIVE EMPLOYEES (THE "PLAN"). IF YOU ARE NOT ENROLLED IN THIS PLAN, THIS SUMMARY OF MATERIAL MODIFICATIONS DOES NOT APPLY TO YOU, AND SHOULD NOT BE CONSTRUED TO MEAN YOU HAVE COVERAGE UNDER THIS PLAN.

Section 104 of the Employee Retirement Income Security Act of 1974 ("ERISA") directs the administrator of an ERISA-covered plan to furnish to participants (and beneficiaries receiving benefits under the plan) a summary of any material modifications to the plan (the "SMM") within 210 days following the end of the plan year in which the change was adopted. This summary describes certain changes to the Plan that are effective October 1, 2018, and other changes to the Plan that are effective November 1, 2018. This SMM modifies the 2018 Summary Plan Description (the "SPD"). You should keep this SMM with the SPD you previously received for future reference.

These changes reflect that effective October 1, 2018, Urgent Appeals and Second Level Appeals for the Medical benefits that are administered by United Healthcare and the Prescription Drug benefits that are administered by Express Scripts will be conducted by the Network/Claim Administrators, rather than the Employee Benefits Committee of American Airlines, Inc. Effective November 1, 2018, Urgent Appeals and Second Level Appeals for the Medical benefits that are administered by Blue Cross and Blue Shield of Texas will be conducted by the Network/Claim Administrator, rather than the the Employee Benefits Committee of American Airlines, Inc.

Claims Procedures

Pages 272 – 280 are deleted and replaced in their entirety with the following:

Appealing a Denial

Unless otherwise provided in the applicable insurance policy/evidence of coverage, you must file your appeal within the deadlines set forth below.

Important Information about Health Care Provider's Appeals

Health care providers, whether in-Network or out-of-Network, may not pursue appeals on your behalf, unless you designate your provider as your authorized representative. The Plan prohibits the assignment of any benefit or any legal claim or cause of action (whether known or unknown). (See "Anti-Assignment of Benefits" in the Plan Administration chapter.)

Appealing an Enrollment or Eligibility Status Decision

American Airlines, Inc. or its delegate will determine enrollment and eligibility appeals under the same appeals process and time frames as the underlying benefit you are seeking to enroll in, as described below. American Airlines, Inc. reserves the right to change its process for determining enrollment and eligibility appeals at any time and without prior notice.

Procedures for Appealing an Adverse Benefit Determination

American Airlines, Inc., as Plan Sponsor and Plan Administrator of the Plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the Network/Claim Administrator or benefit vendor that rendered the adverse benefit determination. Second Level Appeals are also conducted by the Network/Claim Administrator, except for the Dental Benefit, Pilot STD, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account. Second level appeals for those benefits 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. The one exception to this mandatory two-tiered process is an appeal for an Urgent Care claim – for Urgent Care claim appeals, only Second Level Appeals are required – no First Level Appeals are necessary. Employees must use both levels of appeal (or the Second Level Appeal for Urgent Care claims) and must exhaust all administrative remedies to resolve any claim issues.

With respect to adverse benefit determinations made on fully insured benefits, the appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The insurers and HMOs make the final appeal determinations for their respective insured coverages/benefits. Each insurer or HMO has its own appeal process, and you should contact the respective insurer or HMO for information on how to file an appeal (see "HMO Contact Information" in the *Health Maintenance Organizations (HMOs)* section.) For purposes of this paragraph, "full-insured benefits" include the following:

- Employee Term Life Insurance

- Spouse and/or Child Term Life Insurance
- Voluntary Life Insurance
- Accidental Death & Dismemberment Insurance (employee, Spouse, Child, VPAI and all Company-provided Accident Insurance Benefits)
- Vision Insurance
- HMOs
- Long-Term Care Insurance

First Level Appeal

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Network/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 Network/Claim Administrator) within this time frame, you waive your right to file the First and Second Level Appeals of the determination. For Urgent Care claims, only Second Level Appeals are required – First Level Appeals are not necessary.

Information about filing a First Level Appeal can be found here.

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

- For pre-service claims – within 15 days of receipt of your First Level Appeal
- For post-service claims – within 30 days of receipt of your First Level Appeal
- For Urgent Care claims – within 72 hours of receipt of your First Level Appeal
- For Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account claims – within 30 days of receipt of your First Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If the Network/Claim Administrator requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (the Network/Claim Administrator will notify you if this additional time period is needed to complete a full and fair review of your case). For disability claims, this process may also be referred to as a "Second Level Review."
- For all other claims for all benefits other than Medical, Dental, Vision, Long-Term Care, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Limited Purpose Flexible Spending Account, or Disability, within 60 days of receipt of your First Level Appeal, if the Network/Claim Administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your First Level Appeal (the Network/Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

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 Network/Claim Administrator (or the EBC, for a Second Level Appeal for the Dental Benefit, Pilot STD, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account).

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the Network/Claim Administrator (or the EBC, for a Second Level Appeal for the Dental Benefit, Pilot STD, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account). 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 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 Network/Claim Administrator or the EBC (for the Dental Benefit, Pilot STD, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account), 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. Information about filing a second level appeal can be found here.

The Network/Claim Administrator (or the EBC for the Dental Benefit, Pilot STD, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account) will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within 15 days of receipt of your Second Level Appeal
- For post-service claims, within the 30 days of receipt of your Second Level Appeal
- For Urgent Care claims, within the 72-hour time period allotted for completion of both levels of appeal
- For Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account claims – within 30 days of receipt of your Second Level Appeal
- For disability claims, within 45 days of receipt of your First Level Appeal. If the Network/Claim Administrator requires additional time to obtain information needed to evaluate your Second Level Appeal for disability, it may have an additional 45 days to complete your Second Level Appeal (the Network/Claim Administrator will notify you if this additional time period is needed to complete a full and fair review of your case).
- For all other claims for all benefits other than Medical, Dental, Vision, Long-Term Care, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Limited Purpose Flexible Spending Account, or Disability, within 60 days of receipt of your Second Level Appeal, if the Network/Claim Administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 days to complete your Second Level

Appeal (the Network/Claim Administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon its receipt your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the Network/Claim Administrator or the EBC (for the Dental Benefit, Pilot STD, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account).

Note for the Dental Benefit, Pilot STD, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, and Limited Purpose Flexible Spending Account: 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 Network/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 Network/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 Network/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
- In the case of a claim for Urgent Care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
    - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method

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 (for appeals for all benefits except for those benefits listed under "All Other Claims").
- 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 (for appeals for all benefits except for those benefits listed under "All Other Claims"). 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.
- If the adverse benefit determination concerns a claim involving Urgent Care, a description of the expedited review process applicable to the claim

- 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.
- Date of service, the health care Provider, the claim amount (for Medical claims)
- The denial code and correspondent meaning (for Medical claims);
- A statement advising that you may request the diagnosis and treatment codes applicable to the claim, and the meanings of those codes (your request for these codes will not be considered a request for external review, and will not trigger the start of external review) (for Medical claims)
- A description of the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for Medical claims);
- A description of the external review process, if applicable (for Medical claims); and
- A statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for Medical claims).

When You are Deemed to Have Exhausted the Plan Administrator or Network/Claim Administrator Claim and Appeal Process

If the Plan Administrator or Network/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 initiate a request for external review (for Medical claims), you may pursue a civil action under ERISA §502(a), or you may pursue civil action under state law if the adverse benefit determination involved a fully-insured benefit. 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 Network/Claim Administrator 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 Network/Claim Administrator's control).

You may request from the Plan Administrator or Network/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 an external reviewer (for Medical claims) or court rejects your request for immediate review because it finds that the Plan Administrator or Network/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 Network/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 Network/Claim Administrator's notice.

If your claim is filed under one of the Plan's fully-insured benefits (an HMO, for example), contact the insurer for information on the State process for immediate review.

The External Review Process

After you have exhausted (of have been deemed to have exhausted) your internal appeal rights under the benefit plan(s), you have the right to request an external review of your adverse benefit determination. This external review process is defined by federal law—and American Airlines, Inc.-sponsored, non-grandfathered Medical Benefit Options will comply with the requirements of this external review process.

The external review process is applicable to adverse benefit determinations made under group health plans, in which the adverse benefit determination involved a medical judgment—such as:

- adverse determinations based on lack of Medical Necessity
- adverse determinations based on the assertion that the service or supply at issue was determined to be Experimental, Investigational, or Unproven in nature
- adverse determinations based on the assertion that the service or supply was cosmetic in nature
- adverse determinations based on appropriateness or type of care, appropriateness of place of care, manner of care, level of care, or whether Provider Network status could have affected availability or efficacy of treatment
- adverse determinations based on the determination of whether care constituted "emergency care", "Urgent Care"
- adverse determination based on a plan exclusion or limitation of coverage for a particular treatment in the presence of certain medical conditions
- adverse determination based on the determination of whether care was "preventive" in nature and the care was not referenced by the US Preventive Care Task Force, the Advisory Committee on Immunization Practices, or the Centers for Disease Control
- adverse determination that brings into question if the benefit plan is complying with the non-quantitative treatment limitations in the Mental Health Parity and Addiction Equity Act (such as methods and limitations on medical management)

Your external review will be conducted by an independent review organization not affiliated with the Plan. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination.

An external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

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.

Administrative Information

The section titled "The Plan Administrator for Urgent and Second Level Claims Appeals" on page 283 is deleted and replaced in its entirety as follows:

The Plan Administrator for Second Level Claim Appeals for the Dental Benefit, Pilot STD, HCFSA, DCFSA, and LPFSA

Employee Benefits Committee (EBC)

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

For More Information

The last row on page 315 is deleted and replaced in its entirety as follows:

Appeals (Second Level Appeals for the Dental Benefit, Pilot STD, HCFSA, DCFSA, and LPFSA)	Employee Benefits Committee American Airlines MD 5134-HDQ1 P.O. Box 619616 DFW Airport, TX 75261-9616 ICS or 1-817-967-1412

For Additional Information

To request additional information regarding this summary, please contact American Airlines Benefit Service Center at 1-888-860-6178.

END OF SUMMARY OF MATERIAL MODIFICATIONS FOR THE AMERICAN AIRLINES, INC. HEALTH AND WELFARE PLAN FOR ACTIVE EMPLOYEES EFFECTIVE OCTOBER 1, 2018 EIN/PN: 13-1502798/501