SUMMARIES OF MATERIAL MODIFICATIONS FOR THE US AIRWAYS, INC. HEALTH BENEFIT PLAN EFFECTIVE JANUARY 1, 2015, JANUARY 1, 2016, AND JANUARY 1, 2017

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SUMMARY OF MATERIAL MODIFICATIONS FOR THE
US AIRWAYS, INC. HEALTH BENEFIT PLAN
EIN/PN: 53-0218143/501

EFFECTIVE JANUARY 1, 2015

IMPORTANT NOTICE: THIS SUMMARY OF MATERIAL MODIFICATIONS APPLIES TO EMPLOYEE/RETIREE PARTICIPANTS AND THEIR COVERED DEPENDENTS WHO ARE ENROLLED IN THIS HEALTH BENEFIT PLAN. IF YOU ARE NOT ENROLLED IN THIS HEALTH BENEFIT PLAN, THIS HEALTH PLAN 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 US Airways, Inc. Health Benefit Plan (the "Plan") that were effective January 1, 2015. This SMM, along with the 2014 SMM provided to you previously, modifies the Summary Plan Description (the "SPD"), restated as of January 1, 2013. You should keep this SMM with the SPD and other SMMs you previously received for future reference.

The following changes to the SPD are **effective January 1, 2015**, unless otherwise indicated:

ABOUT YOUR PARTICIPATION – ACTIVE EMPLOYEES (SPD, Pages 1-14)

ELIGIBILITY FOR YOU (SPD, Page 1):

Replace the first bullet with the following:

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

- An active, full-time or part-time employee of US Airways, Inc. with a work base in the United States, but excluding (i) all active US Airways Pilots, (ii) all active US Airways Officers, Management/Specialists, and Support Staff; and (iii) any temporary, on-call or seasonal employees; or

MAKING CHANGES DURING THE YEAR DUE TO A CHANGE IN STATUS (SPD, Page 8)

The following sentence shall be added to the beginning of this section:

NOTE: Throughout this document, the terms "change in status events" and "Life Events" share the same meaning and are used interchangeably.

MAKING CHANGES DURING THE YEAR DUE TO A CHANGE IN STATUS (SPD, Page 9)

A 10th bullet will be added to the end of this Section as follows:

- Eligibility for Tricare (federal coverage for employees who served in the military). If you, your Spouse (or your domestic partner) or Dependent becomes eligible for Tricare, you may voluntarily waive participation in this Plan.

AN OVERVIEW OF CHANGE IN STATUS EVENTS (SPD, Page 9)

The following language is added to the end of the first paragraph in this Section:

- You must register your Change In Status Event within 31 days of the date the event occurred, and
- You must submit documentation/proof of eligibility within 31 days of the date you are requested to submit documentation by the American Airlines Benefits Service Center. For example: You marry on 5/01/15. In order for your Spouse to gain coverage, you must request that your Spouse be added to your health coverage by 6/02/15. Then you must submit proof of your spouse's eligibility by 7/03/2015.

AN OVERVIEW OF CHANGE IN STATUS EVENTS (SPD, Page 9)

The existing "Changes In Status" chart is hereby deleted and replaced by the following chart:

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.**
Your Spouse or Eligible Dependent Child dies	**Medical, Dental, and Vision:** • You lose a Spouse/ Eligible Dependent Child: Stop coverage for your lost Spouse/ Eligible Dependent Child (dependent coverage may be subject to QMCSO). Start coverage for yourself or your Eligible Dependent Child if the loss of your Spouse results in loss of eligibility under your Spouse's plan • You gain a Spouse/Eligible Dependent Child: Start coverage for yourself, your Spouse, and/or your
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) • **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**	

If You Experience the Following Life Event…	Then, You May be Able to…
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.**	Eligible Dependent Child. Stop coverage for yourself and/or your Eligible Dependent Child if you gain coverage under new Spouse's plan. • Change in your, your Spouse's or your Eligible Dependent Child's employment: If you/your Spouse or your Eligible Dependent Child gain eligibility under the other employer's plan, you can drop yourself, your Spouse, and/or your Eligible Dependent Child. If you/your Spouse or your Eligible Dependent Child lose eligibility or employer contribution under the other employer's plan, you can add yourself, your Spouse, and/or your Eligible Dependent Child. • If you change Medical Benefit Options, your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO. **Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):** • Start/Stop coverage for yourself only. If you enroll for the first time, coverage is for a duration of 2 years **Company-provided Short-Term Disability (for OMSSS):** • No changes allowed **Voluntary Term Life Insurance:** • Increase/Decrease your coverage (for increase, you must provide Proof of Good Health) **Spouse Term Life Insurance:** • Start/Stop coverage **Child Term Life Insurance:** • Start/Stop coverage
You get legally married (including common law marriage), divorced or legally separated	
Change in your employment with an employer other than the Company **OR** **Change in Spouse's/ Eligible Dependent Child's employment or other health coverage** **OR** **Your Spouse's Eligible Dependent Child's employer no longer contributes toward health coverage** **OR** **Your Spouse's Eligible Dependent Child's employer no longer covers employees in your Spouse's/Eligible Dependent Child's position**	

If You Experience the Following Life Event…	Then, You May be Able to…
	AD&D/VPAI Insurance: • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself **Spouse AD&D Insurance:** • Start/Stop coverage for eligible Spouse/ • Increase/Decrease for eligible Spouse **Child AD&D Insurance:** • Start/Stop coverage • Increase/Decrease coverage **Health Flexible Spending Accounts:** • If you lose a Spouse/Eligible Dependent Child: Stop/Decrease contributions • If you gain a Spouse/Eligible Dependent Child: Start/Increase contributions (if incentives or contributions have been deposited to an HSA, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision, regardless of the plan selection) • 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 **Dependent Care Flexible Spending Account:** • Increase/Decrease contributions

If You Experience the Following Life Event…	Then, You May be Able to…
Your covered Eligible Dependent Child no longer meets the Plan's eligibility requirement, i.e.: • **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**	**Medical, Dental, and Vision:** • Stop coverage for your Eligible Dependent Child (dependent coverage may be subject to QMCSO). • You may change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO. **Optional Short-Term Disability (for FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):** • No changes allowed **Company-provided Short-Term Disability (for OMSSS):** • No changes allowed **Voluntary Term Life Insurance:** • Increase/Decrease your existing coverage (for increase, you must provide Proof of Good Health) **Spouse Term Life Insurance:** • Start or stop coverage. **Child Term Life Insurance t:** • Start or stop coverage. **AD&D/VPAI Insurance:** • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself **Spouse AD&D Insurance:** • Start/Stop coverage for eligible Spouse **Child AD&D Insurance:** • Start/Stop coverage **Health Flexible Spending Accounts:** • Stop/Decrease contributions • Cannot reduce to an amount less than what has already been deducted or

If You Experience the Following Life Event…	Then, You May be Able to…
	paid **Additionally:** • Contact American Airlines Benefits Service Center to advise that a COBRA packet should be sent to the now-ineligible Dependent's address.
Your dependent Child attains age 13 or he or she or no longer requires Dependent Day Care **OR** **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.**	**Dependent Care Flexible Spending Account:** • Reduce/Stop Dependent Care Flexible Spending Account contributions. • No other changes to benefits are allowed
Your benefit coverages are significantly improved, lowered or lessened by the Company **(Plan Administrator/Sponsor will determine whether or not a change is "significant")** **OR** **Your contribution amount is significantly increased or decreased by the Company** **(Plan Administrator/Sponsor will determine whether or not a change is "significant")**	**Make changes to the applicable Benefit Options:** • 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.
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	**Medical, Dental, and Vision:** • Start coverage for yourself • Start coverage for your Eligible Dependent Child named in the QMCSO • If required by the terms of the QMCSO, you must change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO • You can start Dental/vision coverage for yourself and/or your Eligible

If You Experience the Following Life Event…	Then, You May be Able to…
	Dependent Child ONLY if the QMCSO specifically orders it. **Health Flexible Spending Accounts:** • Start/Increase as long as it is not within 60 days of the end of the Plan Year
You, your Spouse, or your Eligible Dependent Child enroll in Medicare or Medicaid or CHIP coverage	**Medical, Dental, and Vision:** • Stop coverage for the affected Spouse or Eligible Dependent Child.
You, your Spouse, or your Eligible Dependent Child lose Medicare, Medicaid or CHIP coverage	**Medical, Dental, and Vision:** • Start coverage for yourself and the affected Spouse or Eligible Dependent Child
You, your Spouse, or your Eligible Dependent Child become eligible for a state premium assistance program	**Medical, Dental, and Vision:** • Start coverage for yourself and the affected Spouse or Eligible Dependent Child. • If you're adding a Spouse or Eligible Dependent Child, you can change your Medical Benefit Option. If you change, your Deductible and Out-of-Pocket amounts will transfer to your newly elected Medical Benefit Option.
You, your Spouse or your Eligible Dependent Child become eligible for/lose eligibility for and become enrolled/disenrolled in government-sponsored Tricare coverage	**Medical:** • Start coverage for yourself if you lose eligibility • Stop coverage for yourself if you gain eligibility • Start coverage for your Spouse if he/she loses eligibility • Stop coverage for your Spouse if he/she gains eligibility • Start coverage for your Eligible Dependent Child if he/she loses eligibility • Start coverage for your Eligible

If You Experience the Following Life Event…	Then, You May be Able to…
	Dependent Child if he/she gains eligibility
You move to a new home address: • **Update both your permanent AND alternate addresses on the Update MY Information page of Jetnet. US Airways, Inc. employees should update their legal payroll address and benefits address on MyHR: http://wings.usairways.com/uswings/human_resources/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** • **Contact other organizations such as the American Credit Union and C.R. Smith Museum directly to update your contact information.** • **Provide your new address and current emergency contact numbers to your manager/supervisor, as well.** • **If you are enrolled in the STANDARD, VALUE or CORE Medical Benefit Option and you move to a location where the STANDARD, VALUE or CORE Medical Benefit Option is available, you will stay enrolled in STANDARD, VALUE or CORE Medical Benefit Option. If you were enrolled in an HMO that is not offered in your new location, you may elect a self-funded Medical Benefit Option or an HMO if it exists in your new location.** • **If a STANDARD, VALUE or CORE Medical Benefit Option Network is not available, you must choose another Medical Benefit Option (OUT-OF-AREA), or you may waive coverage if you have other coverage (such as your Spouse's employer-sponsored plan).** • **Contact American Airlines Benefits Service Center and a representative will assist you with your election. If you are**	**Medical, Dental, and Vision:** • You may change Medical Benefit Options if your existing Medical Benefit Option is unavailable in your new location, or if your new location offers a new Medical Benefit Option not available in your old location. • No changes allowed for Dental and/or Vision Benefit Options. **Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):** • Start coverage for yourself only if you had no access to this coverage in your prior state • Stop coverage for yourself if your new state prohibits OSTD coverage **Company-provided Short-Term Disability (for OMSSS):** • No changes allowed **Voluntary Term Life Insurance:** • No changes allowed **Spouse Term Life:** • No changes allowed **Child Term Life:** • No changes allowed **AD&D/VPAI Insurance:** • No changes allowed **Spouse AD&D/VPAI:** • No changes allowed **Child AD&D/VPAI:** • No changes allowed **Flexible Spending Accounts:** • No changes allowed

If You Experience the Following Life Event…	Then, You May be Able to…
enrolled in an HMO or in the STANDARD, VALUE or CORE Medical Benefit Option and you do not process your relocation Life Event within 31 days of your move, you will stay in your selected Medical Benefit Option. If your selected Medical Benefit Option is not available, you will automatically be enrolled in the default Medical Benefit Option, which is CORE. **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.**	
You become disabled	Notify: Your manager/supervisor can download a Disability Claim Form. Complete and submit: Your claim for disability benefits.
You start an unpaid leave of absence	**Access the American Airlines Benefits Service Center to register your "Going on Leave of Absence" Life Event and update your benefit elections. A confirmation statement showing your choices, the monthly cost of benefits, etc. will display.** **Your cost depends on: The type of leave you are taking** **Medical, Dental, and Vision:** • Stop coverage • Stop Spouse coverage • Stop Eligible Dependent Child coverage **Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):** • Stop coverage **Company-provided Short-Term Disability (OMSSS):** • No changes allowed **Voluntary Term Life Insurance:**

If You Experience the Following Life Event…	Then, You May be Able to…
	• Stop coverage **Spouse Term Life:** • Stop coverage **Child Term Life:** • Stop coverage **AD&D/VPAI Insurance Benefit:** • Stop coverage **Spouse AD&D/VPAI:** • Stop coverage **Child AD&D/VPAI:** • Stop coverage **Flexible Spending Accounts:** • Stop/Decrease Health FSA contributions • Stop/Decrease Dependent Care FSA contributions • Cannot reduce any FSA to amount lower than what has been deducted or paid
You return from an unpaid leave of absence	**If you did not continue payment of your benefits during your leave and wish to reactivate your benefits upon your return to work, you may do so; however, you will be required to provide Proof of Good Health for certain benefits (e.g., Voluntary Term Life Insurance, Short Term Disability, etc.)** **Go to the American Airlines Benefits Service Center, register your "Return to Work" Life Event and make selections or changes to your benefits. If you return within 30 days, you will be placed back in the elections you were in prior to your leave unless you experience another change in status event.** **Medical, Dental, and Vision:** • Resume/Start coverage for yourself • Start coverage for your Spouse • Start coverage for your Eligible

If You Experience the Following Life Event…	Then, You May be Able to…
	Dependent Child **Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):** • Start/Resume coverage for yourself; Proof of Good Health is required **Company-provided Short-Term Disability (OMSSS):** • No changes allowed **Voluntary Term Life Insurance:** • Start/Resume coverage for yourself; Proof of Good Health is required • Increase/Decrease coverage for yourself; for increase, Proof of Good Health is required **Spouse Term Life Insurance:** • Start/Resume coverage; Proof of Good Health is required • Increase/Decrease coverage; for increase, Proof of Good Health is required **Child Term Life Insurance:** • Start/Resume coverage **AD&D/VPAI Insurance:** • Start/Resume coverage for yourself • Stop/Decrease coverage for yourself **Spouse AD&D/VPAI Insurance:** • Start/Stop coverage • Increase/Decrease coverage **Child AD&D/VPAI Insurance:** • Start/Stop coverage **Flexible Spending Accounts:** • Start/Increase contributions • Stop/Decrease contributions • Special rules apply to the Health FSAs if your leave was FMLA leave ○ You can resume contributions without making up

If You Experience the Following Life Event…	Then, You May be Able to…
	contributions you missed (coverage will be correspondingly reduced), or ○ You can resume contributions plus make up contributions you missed (coverage will resume at the level you elected).
You change from part-time to full-time employment or full-time to part-time employment	**Optional Short-Term Disability Insurance (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):** • Start coverage for yourself; Proof of Good Health is required • Minimum duration of enrollment is 2 years **Company-provided Short-Term Disability (OMSSS):** • No changes allowed **Voluntary Term Life Insurance:** • Start/Resume coverage for yourself; Proof of Good Health is required • Stop coverage for yourself • Increase/Decrease coverage for yourself; for increase, Proof of Good Health is required **Spouse Term Life Insurance:** • Start/Resume coverage; Proof of Good Health is required • Stop coverage **Child Term Life Insurance:** • Start/Resume coverage • Stop coverage **AD&D/VPAI Insurance:** • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself **Spouse AD&D/VPAI Insurance:** • Start/Stop coverage • Increase/Decrease coverage

If You Experience the Following Life Event…	Then, You May be Able to…
	Child AD&D/VPAI Insurance: • Start/Stop coverage **Flexible Spending Accounts:** • 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 Coverage Ends" in the General Enrollment 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	**Medical, Dental, and Vision:** • Changes are allowed only to the extent that the change in workgroup affects benefit eligibility • Start/Stop coverage for yourself, your Spouse and/or your Eligible Dependent Child (dependent coverage may be subject to QMCSO). • You may change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option. • Contact your HMO for eligibility – eligibility is determined by the HMO. **Optional Short-Term Disability (FA, TWU, Employees represented by the Communications Workers of America, AFL-CIO, CLC, IBT):** • Start/Stop coverage for yourself only. If you enroll for the first time,

If You Experience the Following Life Event…	Then, You May be Able to…
	coverage is for a duration of 2 years. **Company-provided Short-Term Disability (for OMSSS):** • No changes allowed **Voluntary Term Life Insurance:** • Increase/Decrease your coverage with Proof of Good Health **Spouse Term Life Insurance:** • Start/Stop coverage **Child Term Life Insurance:** • Start/Stop coverage **AD&D/VPAI Insurance:** • Start/Stop coverage for yourself • Increase/Decrease coverage for yourself **Spouse AD&D Insurance:** • Start/Stop coverage for eligible Spouse • Increase/Decrease for eligible Spouse **Child AD&D Insurance:** • Start/Stop coverage **Health Flexible Spending Accounts:** • 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 (if incentives or contributions have been deposited to an HSA, you will be deemed to have enrolled in a Limited Purpose Flexible Spending Account (LPFSA), which can only be used for dental and vision, regardless of the plan selection) • Cannot reduce to an amount less than what has already been deducted or paid **Dependent Care Flexible Spending**

If You Experience the Following Life Event…	Then, You May be Able to…
	Account: • Increase/Decrease contributions
You, your Spouse, and/or your Eligible Dependent Child declined the Company's medical coverage because you or they had coverage elsewhere (external to the Company), and any of the following events occur: • **Loss of eligibility for other coverage due to legal separation, divorce, death, termination of employment, reduced work hours (this does not include failure to pay timely contributions, voluntary disenrollment, or termination for cause)** • **Employer contributions for the other coverage stopped** • **Other coverage was COBRA and the maximum COBRA coverage period ended** • **Exhaustion of the other coverage's lifetime maximum benefit** • **Other employer-sponsored coverage is no longer offered** • **Other coverage (including HMO, other group health plan or arrangement) ends because you and/or your Eligible Dependents no longer reside, live, or work in its service area** •	**Medical Coverage:** • Start coverage for yourself o Note that you must enroll in the coverage in order to elect coverage for your Spouse and/or Eligible Dependent Child. • Start coverage for your affected Spouse • Start coverage for your affected Eligible Dependent Child • You may change Medical Benefit Options; your Deductible and Out-of-Pocket Maximum will carry over to your new Medical Benefit Option.
The cost of dependent care changes (only if the change is imposed by a dependent care provider who is not your relative)	**Dependent Care Flexible Spending Account:** • Increase/decrease contributions

YOUR MEDICAL OPTIONS (SPD, Pages 15-37)

WELLNESS PROGRAM (SPD, Page 15)

Replace this section in its entirety with the following:

- Healthmatters is a wellness program that is provided free of charge for certain employees of US Airways, Inc., and American Airlines, Inc., including all US Airways, Inc. employees (and their spouses/domestic partners) who are currently enrolled in the Plan, and participation is voluntary.

- Covered employees and covered spouses and domestic partners may earn wellness incentives by participating in selected programs (up to $250 for employee and an additional $250 for a covered spouse, if applicable). Those incentive amounts are deposited into an HUSA if you are enrolled in PPO 100/90/80 medical plans. Once deposited into your account, these rewards can be used to pay for eligible health care expenses (medical, dental, vision, prescription medications) not paid by your health plan.
- An HUSA is a health spending account, made accessible to you when you enroll in the Plan and earn Healthmatters rewards. Retirees are eligible to participate in Healthmatters program but they will not be able to earn rewards.
- See my.aa.com/wellness for more information.

YOUR MEDICAL OPTIONS (PPO MEDICAL OPTIONS): WHEN YOU SEE OUT-OF-NETWORK PROVIDERS (SPD, Page 16):

The following statement is added to the end of the first paragraph:

You can review more information about how R&C is determined in the Glossary, under "Reasonable and Customary Charges".

YOUR MEDICAL OPTIONS: WHEN YOU SEE OUT-OF-NETWORK PROVIDERS (SPD, Page 26):

The following statement is added to the end of the first paragraph:

You can review more information about how R&C is determined in the Glossary, under "Reasonable and Customary Charges".

MEDICAL SERVICES COVERED UNDER THE PLAN (see SMM dated January 1, 2014): **GENDER REASSIGNMENT BENEFIT (GRB))**

All references to the $75,000 maximum benefit limit for the GRB are eliminated. However, the $10,000 maximum reimbursement limit for travel expenses remains in force.

MEDICAL SERVICES NOT COVERED UNDER THE PLAN (SPD, Page 34):

The following statement is added as the 17th bullet of the listing of excluded expenses:

Prescription medications prescribed or consumed in dosage, quantity, or for condition(s) not approved by the US Food and Drug Administration, and prescription medications used in a manner, quantity, dosage, or route of administration not approved by the US Food and Drug Administration for such medication.

RETIREE HEALTH COVERAGE: (SPD, Page 68)

ELIGIBILITY FOR YOU (SPD, Page 68)

The third bullet is changed to read as follows:

- You have at least ten (10) years of service with US Airways, unless otherwise specified in your collective bargaining agreement.

GLOSSARY (SPD, Page 100)

—REASONABLE AND CUSTOMARY CHARGES (R&C CHARGES) (SPD, Page 103)

The following language shall be added to the definition of Reasonable and Customary Charges:

Effective March 1, 2015, the reasonable and customary (R&C) amount is the maximum amount that the Plan will consider as an eligible expense for medical or dental services and supplies. For purposes of the Plan, "reasonable and customary" shall be equivalent with the terms "usual and customary", "usual and prevailing", and "usual, reasonable and customary". The primary factors considered when determining if a charge is within the reasonable and customary fee limits are:

- The range and complexity of the services provided
- The typical charges in the geographic area where the service or supply is rendered/provided and other geographic areas with similar medical cost experience

The Plan Administrator utilizes a database of charge information about healthcare procedures and services, and this database is reviewed, managed, and monitored by FairHealth. Information about FairHealth and its work on this database is available at www.fairhealthus.org.

Information from this FairHealth database is utilized by US Airways' medical administrators in determining the eligible expense for medical or dental services and supplies provided by non-participating and out-of-network providers (FairHealth data for out-of-network expenses are used at the 90th percentile to determine eligible expenses).

Reasonable and customary fee limits can also be impacted by the number of services or procedures you receive during one medical treatment. Under the Plan, when reviewing a claim for reasonable and customary fee determination, the Claims Administrator looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (often referred to as "coding fragmentation" or "unbundling") usually results in higher physician's charges that if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually.

PLAN ADMINISTRATION: REQUIRED BENEFIT NOTICES

Immediately following the Plan Administration section, the Required Benefit Notices are added, as follows:

Statement of Rights Under the Newborns' and Mother's Health Protection Act

Group Health Plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider (e.g., your physician, nurse midwife, or physician assistant), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

Statement of Rights Under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See the Schedule of Benefits.
If you would like more information on WHCRA benefits, call your Plan Administrator.

YOUR CONTACT FOR PLAN AND BENEFIT INFORMATION (THIS IS REFERENCED THROUGHOUT THE SPD):

Benefits US Customer Service will now be referenced as American Airlines Benefit Service Center. The same phone number (1-888-860-6178) will apply.

You may utilize the following websites for benefit information:

http://wings.usairways.com.
http://my.aa.com/en/home

For Additional Information

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

END OF SUMMARY OF MATERIAL MODIFICATIONS FOR THE US AIRWAYS, INC. HEALTH BENEFIT PLAN EFFECTIVE JANUARY 1, 2015 EIN/PN: 53-0218143/501

SUMMARY OF MATERIAL MODIFICATIONS FOR THE US AIRWAYS, INC. HEALTH BENEFIT PLAN EIN/PN: 53-0218143/501

EFFECTIVE JANUARY 1, 2016

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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 US Airways, Inc. Health Benefit Plan (the "Plan") that were effective January 1, 2016. This SMM, along with the 2014 SMM and 2015 SMM provided to you, modifies the Summary Plan Description (the "SPD"), restated as of January 1, 2013. You should keep this SMM with the SPD and other SMMs you previously received for future reference.

The following changes to the SPD are **effective January 1, 2016**, unless otherwise indicated:

Effective January 1, 2016, replace the Plan name throughout the document with "American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees."

ABOUT YOUR PARTICIPATION – ACTIVE EMPLOYEES (SPD, Pages 1-14)

ELIGIBILITY FOR YOU (SPD, Page 1):

Effective January 1, 2016, replace the first bullet with the following:

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

- An active, full-time or part-time employee of on U.S. payroll of American Airlines, Inc. who is in one of the following categories: (i) mechanics and related fleet service and maintenance employees of American Airlines, Inc. who were employed by US Airways, Inc. immediately prior to December 30, 2015 and are represented by the Transport Workers Union ("TWU") or the International Association of Machinists and Aerospace Workers ("IAM"), and (ii) passenger service employees of American Airlines, Inc. who were employed by US Airways, Inc. immediately prior to December 30, 2015 and are

represented by the Communications Workers of America and the International Brotherhood of Teamsters ("CWA-IBT").

YOUR MEDICAL OPTIONS (SPD, Pages 15-37)

WELLNESS PROGRAM (SPD, Page 15)

Effective January 1, 2016, WebMD will replace Active Health as the third party administrator for the wellness program. In addition, effective January 1, 2016, employees' wellness incentive amounts will be deposited into an HRA (health reimbursement account), rather than an HUSA. As a result, effective January 1, 2016, this section shall be replaced in its entirety with the following:

- WebMD is a wellness program that is provided free of charge for certain employees (and their spouses/domestic partners) who are currently enrolled in the Plan, and participation is voluntary.
- Covered employees and covered spouses and domestic partners may earn wellness incentives by participating in selected programs (up to $250 for employee and an additional $250 for a covered spouse, if applicable). Beginning on January 1, 2016, those incentive amounts are deposited into an HRA if you are enrolled in PPO 100/90/80 medical plans. Once deposited into your account, these rewards can be used to pay for eligible health care expenses (medical, dental, vision, prescription medications) not paid by your health plan.
- An HRA is a health reimbrusement account, made accessible to you when you enroll in the Plan and earn wellness rewards. Retirees are eligible to participate in the WebMD program but they will not be able to earn rewards.
- Any earned but unused wellness incentives that were earned and deposited into your 2015 HUSA account will be deposited in your 2016 HRA.
- See www.webmdhealth.com/AmericanAirlines for more information.

SCHEDULE OF PPO PLAN BENEFITS (SPD, Page 17)

Effective January 1, 2016, the following row is inserted after the row titled "Doctor's Office Visits":

Schedule of PPO Plan Benefits						
	PPO 80/60		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Office Services						
Telehealth	$30 co-pay for Telehealth visit	Not covered	$30 co-pay for Telehealth visit	Not covered	$30 co-pay for Telehealth visit	Not covered

Effective June 1, 2016, the row titled "Telehealth" is replaced in its entirety with the following:

Schedule of PPO Plan Benefits						
	PPO 80/60		**PPO 90/70**		**PPO 100/80**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Medical Office Services						
Telehealth	$20 co-pay for Telehealth visit	Not covered	$20 co-pay for Telehealth visit	Not covered	$20 co-pay for Telehealth visit	Not covered

SCHEDULE OF PPO PLAN BENEFITS (SPD, Page 24)

Effective January 1, 2016, in the second row, the description of Chiropractic Care is replaced in its entirety with the following:

Chiropractic Care (20-visit maximum per year; visits beyond the per year maximum are covered if medically necessary). Visits above 20 per year subject to ongoing medical necessity review.

SCHEDULE OF OUT-OF-AREA PROGRAM BENEFITS (SPD, Page 17)

Effective January 1, 2016, the following row is inserted after the row titled "Doctor's Office Visits":

Schedule of Out-of-Area Program Benefits			
	OOA 80	**OOA 90**	**OOA 100**
Medical Office Services			
Telehealth	$30 co-pay for Telehealth visit	$30 co-pay for Telehealth visit	$30 co-pay for Telehealth visit

Effective June 1, 2016, the row titled "Telehealth" is replaced in its entirety with the following:

Schedule of Out-of-Area Program Benefits			
	OOA 80	**OOA 90**	**OOA 100**
[redacted]			
Telehealth	$20 co-pay for Telehealth visit	$20 co-pay for Telehealth visit	$20 co-pay for Telehealth visit

MEDICAL SERVICES COVERED UNDER THE PLAN (see SMM dated January 1, 2014): **GENDER REASSIGNMENT BENEFIT (GRB))**

Effective January 1, 2016, the second paragraph of this section is replaced in its entirety as follows:

This benefit is available to active employees, retirees, spouses, Company-recognized Domestic Partners, and eligible dependent children age 18 and over.

MEDICAL SERVICES COVERED UNDER THE PLAN (SPD, Page 33)

Effective January 1, 2016, the following paragraphs shall be added:

Cochlear implants:
Cochlear implants are covered In-Network and Out-of-Network.

Colonoscopy:

- In-Network: The first Colonoscopy and all related ancillary services per calendar year will be covered in full regardless of diagnosis billed. Ancillary services to the first colonoscopy seven (7) days after will also be covered in full, with no copay. All subsequent procedures will be covered in full after a copay ($25 copay for Primary Care Doctors; $40 co-pay for Specialists).
- Out-of-Network: Out-of-Network, deductible and coinsurance apply.
- This section applies to both facility and professional charges.

Diagnostic mammograms

- In-Network: Subject to a $25 co-pay, regardless of whether it is performed in an office setting or in a facility. If it is performed in an office setting, a $25 co-pay is charged for the office visit during which the mammogram is performed, but no additional co-pay is charged for the mammogram.
- Out-of-Network: The deductible applies, then out-of-network Reasonable & Customary co-insurance applies.
- A maximum of two mammograms per year are covered (combined In-Network and Out-of-Network) for any reason. After the two mammograms, an unlimited number are covered if medically necessary.

Repetitive Transcranial Magnetic Stimulation (RTMS):
Claims for RTMS will be referred for further review. RTMS is unproven and not medically necessary for treating all medical conditions.

Routine colon cancer screenings, fecal occult blood test, barium enema and sigmoidoscopies:
These procedures are covered in full In-Network, with no copay. Out-of-network, they are subject to coinsurance after the deductible.

Routine bone density (with or without an office visit):
Routine bone density is covered in full with no copay when conducted by an In-Network provider.

Routine hearing screening (performed with wellness exam):
Routine hearing screening is covered in full, with no copay, when performed as part of a wellness exam.

Telehealth:
The Plan will cover telehealth consultations for medical benefits for participants enrolled in one of the self-funded benefit options. These medical benefits are offered by Doctor on Demand, a telehealth service offering video medical visits through a secure mobile app. Doctor on Demand's contracted providers can diagnose, treat and write prescriptions for a wide range of non-emergency medical issues. The Plan has contracted with Doctor on Demand to include these medical providers as network providers. The Doctor on Demand service is available 24 hours a day, seven days a week by computer, tablet or smartphone. These medical services may not be available everywhere due to state law restrictions; check with Doctor on Demand for a list of states where medical services are not available. Doctor on Demand cannot provide treatment for chronic conditions like diabetes, or medical emergencies like chest pain or severe burns. The Plan has contracted with Doctor on Demand for medical benefits only.

Services provided through Doctor on Demand providers are subsidized by the Plan, but you will be responsible for some of the cost. Telehealth benefits under the PPO and OOA options will be treated like any other office visit. For more information about services and technological requirements, visit Doctor on Demand online at doctorondemand.com or call 800-997-6196.

Treatment and Observation rooms:
Treatment and observation rooms are not subject to an emergency room co-pay if an emergency room visit is not billed. They will be covered at 80% coinsurance after deductible (In-Network) and 60% coinsurance after deductible (Out-of-Network). If an emergency room visit is billed, then an emergency room co-pay will apply.

MEDICAL SERVICES NOT COVERED UNDER THE PLAN (SPD, Page 34):

Effective January 1, 2016, the following statement is added as the final bullet of the section:

- Routine hearing examinations.

Effective January 1, 2016, the following exclusion is removed:

- Services and supplies related to routine foot care; except for procedures associated with diabetic treatment;

MEDICAL SERVICES NOT COVERED UNDER THE PLAN (SPD, page 35):

Effective January 1, 2016, the following replaces the 23rd bullet: "Travel whether or not recommended by a physician, except in connection with medically necessary travel for an organ transplant, cancer treatment, congenital heart disease treatment, bariatric surgery, or gender reassignment surgery, subject to and only if approved in accordance with the Travel and Lodging Reimbursement Guidelines."

MENTAL HEALTH AND CHEMICAL DEPNEDENCY BENEFIT LIMITATIONS AND EXCLUSIONS (SPD, page 48):

Effective January 1, 2016, the following is removed from the 11th bullet: biofeedback

HOW TO CONTACT YOUR CLAIMS ADMINISTRATORS/CLAIMS FIDUCIARIES (SPD, Page 91)

Effective January 1, 2016, replace the Anthem contact information with the following:

Blue Cross Blue Shield of Texas (medical benefits and mental health and chemical dependency benefits, for employees who have BCBSTX as their medical claims administrator, effective 1/1/16)	1-877-235-9258	www.bcbstx.com/americanairlines

Effective January 1, 2016, replace the CVS Caremark contact information with the following:

Express Scripts (ESI) (prescription drug benefits)	1-800-988-4125	www.express-scripts.com/americanairlines OR www.express-scripts.com

Effective January 1, 2016, replace United Behavioral Health's contact information with the following:

OptumHealth Behavioral Solutions (mental health and chemical	1-800-363-7190	www.liveandworkwell.com (Access code US Airways)

dependency benefits, except for employees who have BCBSTX as their medical claims administrator)		

Effective January 1, 2016, replace Superior Vision's contact information with the following:

EyeMed (vision benefits)	1-844-714-5678	www.eyemedvisioncare.com/american

PLAN ADMINISTRATION (SPD, Pages 92-93)

PLAN SPONSOR

Effective January 1, 2016, replace the name, address, and telephone number of the Plan sponsor with the following:

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

Effective January 1, 2016, replace the name, address, and telephone number of the Plan Administrator with the following:

American Airlines, Inc., or its authorized delegate

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

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

AGENT FOR SERVICE OF LEGAL PROCESS

Effective January 1, 2016, replace the name, address, and telephone number of the agent for service of legal process with the following:

Managing Director, Health and Wellness
American Airlines, Inc.

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

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

IDENTIFICATION NUMBERS

Effective January 1, 2016, replace the Employer Identification Number (EIN) with the following: 13-1502798.

ORGANIZATIONS PROVIDING ADMINISTRATIVE SERVICES UNDER THE PLAN (SPD, Page 93)

Effective January 1, 2016, replace Anthem's contact information with the following:

Medical	United HealthCare P.O. Box 30555 Salt Lake City, UT 84130-0555 1-800-955-8095 Website: americanairlines.welcometouhc.com/ Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266 0044 1 877 235 9258 Website: www.bcbstx.com/americanairlines

Effective January 1, 2016, replace the CVS Caremark contact information with the following:

Prescription Drugs	Mail Order Pharmacy Service: Express Scripts P.O. Box 3938 Spokane, WA 99220-3938 1-800-988-4125

	Website: www.express-scripts.com/americanairlines Prescriptions – Prior Authorization: Express Scripts 8111 Royal Ridge Parkway, Suite 101 Irving, TX 75063 1-800-988-4125 Website: www.express-scripts.com/americanairlines Filing Retail Prescription Claims: Express Scripts P.O. Box 2160 Lee's Summit, MO 64063-2160 1-800-988-4125 Website: www.express-scripts.com/americanairlines

Effective January 1, 2016, replace Quest Diagnostics, Inc.'s contact information with the following:

Wellness	WebMD www.webmdhealth.com/AmericanAirlines

Effective January 1, 2016, replace Superior Vision's contact information with the following:

Vision Care	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 1-844-714-5678 www.eyemedvisioncare.com/american

GLOSSARY (SPD, Page 100)

---COMPANY

Effective January 1, 2016, the definition of "Company" is replaced in its entirety with the following:

American Airlines, Inc.

For Additional Information

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

END OF SUMMARY OF MATERIAL MODIFICATIONS FOR THE US AIRWAYS, INC. HEALTH BENEFIT PLAN EFFECTIVE JANUARY 1, 2016 EIN/PN: 53-0218143/501

SUMMARY OF MATERIAL MODIFICATIONS FOR THE AMERICAN AIRLINES, INC. HEALTH BENEFIT PLAN FOR CERTAIN LEGACY EMPLOYEES

EIN/PN: 53-0218143/501

EFFECTIVE JANUARY 1, 2017

IMPORTANT NOTICE: THIS SUMMARY OF MATERIAL MODIFICATIONS APPLIES TO EMPLOYEE/RETIREE PARTICIPANTS AND THEIR COVERED DEPENDENTS WHO ARE ENROLLED IN THIS HEALTH BENEFIT PLAN. IF YOU ARE NOT ENROLLED IN THIS HEALTH BENEFIT PLAN, THIS HEALTH PLAN 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 American Airlines, Inc. Health Benefit Plan for Certain Legacy Employees (the "Plan") that are effective January 1, 2017. This SMM, along with the 2014 SMM, 2015 SMM, and 2016 SMM provided to you, modifies the Summary Plan Description (the "SPD"), restated as of January 1, 2013. You should keep this SMM with the SPD and other SMMs you previously received for future reference.

The following changes to the SPD are **effective January 1, 2017**, unless otherwise indicated:

ABOUT YOUR PARTICIPATION – ACTIVE EMPLOYEES (SPD, Pages 1-14)

ELIGIBILITY FOR YOU (SPD, Page 1):

Effective January 1, 2017, replace the first bullet with the following:

You are eligible to participate in the 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 US Airways, Inc. and the IAM.

- All active, full-time or part time employees of American Airlines, Inc. in the flight simulator engineer and flight crew training instructor groups who were covered by collective bargaining agreements entered into between US Airways, Inc. and the TWU.

ELIGIBILITY FOR YOUR DEPENDENTS; DOMESTIC PARTNERS (SPD, Pages 2-5)

Effective January 1, 2017, Domestic Partners and their children are no longer eligible Dependents under the Plan, and all references to Domestic Partners and their children are hereby removed from this SPD.

MEDICAL SERVICES COVERED UNDER THE PLAN (SPD, Page 33)

Effective January 1, 2017, the following paragraphs shall be added:

Clinical Trials: Routine patient costs otherwise covered by the Plan that are associated with participation in phases I-IV of Approved Clinical Trials (i.e., clinical trials that are federally funded and certain drug trials) to treat cancer or other Life-Threatening Conditions, as determined by the Third Party Administrator and as required by law. These costs will be subject to the Plan's otherwise applicable deductibles and limitations and do not include items that are provided for data collection or services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis or otherwise payable or reimbursable by another party.

Mammograms (including 3-D mammograms) (diagnostic - required as part of a work-up for symptoms or a medical condition): Diagnostic mammograms are covered, regardless of age, under all Medical Benefit Options both In-Network and Out-of-Network.

Mammograms (including 3-D mammograms) (routine screening or preventive)**:** I n-Network, routine screening mammograms are covered under all Medical Benefit Options at 100%, as described in the U.S. Preventive Services Task Force A or B recommendations. Please click here to view those recommendations:
https://www.uspreventiveservicestaskforce.org/BrowseRec/Index

ADDITIONAL RULES THAT APPLY TO THE PLAN: (SPD, Page 74)

SUBROGATION AND REIMBURSEMENT (SPD, Page 74)

Effective January 1, 2017, this section is replaced in its entirety with the following:

The Plan has a right to subrogation and reimbursement. By enrolling in the Plan and applying for benefits from the Plan, you and your covered dependents (including minor dependents) agree and acknowledge that benefits are not payable to or on behalf of a covered person or dependent when the injury or illness occurs through an act or omission of another person, party, or entity, and any such payments made or advanced by the Plan are subject to the following terms and conditions:

Subrogation applies when the Plan has paid benefits on your behalf for a sickness or injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue

against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. The Plan has the right to subrogate 100% of the benefits paid or to be paid on your behalf.

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You further agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable.
    - Providing any relevant information requested by the Plan.
    - Signing and/or delivering such documents as the Plan or the Plan's agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.

- Complying with the terms of this section.

Your failure to cooperate with us is considered a breach of contract. As such, the Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or set off from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with us. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- By accepting benefits from this Plan, you agree that the Plan has established an equitable lien by agreement and has a first priority right to receive payment on any claim against a third party before you receive payment from that third party, whether obtained by judgment, award, settlement, or otherwise. The Plan has the right to 100% reimbursement in a lump sum and has the right to recover interest on the amount paid by the Plan because of the actions of a third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

- The Plan's lien exists at the time the Plan pays benefits, and if you or your covered dependents file a petition for bankruptcy, you and your covered dependents agree that the Plan's line existed prior to the creation of the bankruptcy estate.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and the Plan is not responsible for your attorney's fees, expenses and costs. The Plan is not subject to any state laws or equitable doctrines, including but not limited to the so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine," which would purport to require the Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable doctrine or state law shall limit or defeat the Plan's subrogation and reimbursement rights.

- If this Section applies, the Plan will not cover either the reasonable value of the services to treat such an injury, sickness or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By accepting benefits from this Plan, you and your covered dependents automatically assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury, including another group health plan, insurer or individual. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; and filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval, or approval from the Plan's authorized or designated agent for subrogation-and-reimbursement recoveries.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a dependent Child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

- If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

The Plan and all individuals and entities administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

COORDINATION OF BENEFITS IF YOU ARE COVERED BY MORE THAN ONE PLAN (SPD, Page 77)

Effective January 1, 2017, this section is replaced in its entirety with the following:

This section explains how the Plan coordinates coverage between the Plan and any other benefits/plans that provide coverage for you or your Eligible Dependents.

If you or any other covered dependents have primary coverage (see "Which Plan Is Primary" in this section) under any other group medical or group dental benefits/plans, your Company-sponsored Medical, Dental and Vision Insurance will coordinate to avoid duplication of payment for the same expenses. The benefit program will take into account all payments you have received under any other benefits/plans, and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical, Dental and Vision Insurance were your only coverage.

For example, if your dependent is covered by another benefit/plan and the Plan is his or her secondary coverage, the Plan pays only up to the maximum benefit amount payable under the Plan, and only after the primary benefit/plan has paid.

The maximum benefit payable depends on whether the In-Network or Out-of-Network Providers are used. When this Plan is secondary, the Eligible Expense is the primary plan's allowable expense (for primary plans with Provider Networks, this will be the Network allowable expense; for primary plans that base their reimbursement on reasonable and customary or usual and prevailing charges, the allowable expense is the Maximum Out-of-Network Charge ("MOC")). If both the primary plan and this Plan do not have a Network allowable expense, the Eligible Expense will be the greater of the two plans' reasonable and customary or usual and prevailing charges. The maximum combined payment you can receive from all plans may be less than 100% of the total Eligible Expense.

If you or your dependent is hospitalized when coverage begins, your prior coverage is responsible for payment of medical services until you are released from the hospital. If you have no prior coverage, the benefit program will pay benefits only for the portion of the hospital stay occurring after you became eligible for coverage under the benefit program.

If you or your dependent is hospitalized when your benefit program for coverage changes from one Medical Benefit Option to another, your prior coverage is responsible for payment of Eligible Expenses until you or your dependent is released from the hospital.

The Plan's coordination of benefits rules apply regardless of whether a claim is made under the other plan. If a claims is not made, benefits under the Plan may be delayed or denied until an explanation of benefits is issued showing a claim made with the primary plan.

The Plan will not coordinate as a secondary payer for any copays you pay with respect to another plan or with respect to prescription drug claims (except where the other plan is Medicare).

If you reside in a state where automobile no-fault coverage, personal injury protection coverage or medical payment coverage is mandatory, that coverage is primary and the Plan takes secondary status. The Plan will reduce benefits for an amount equal to, but not less than, the state's mandatory minimum requirement.

The Plan has first priority with respect to its right to reduction, reimbursement and subrogation.

The Plan will not coordinate benefits with an HMO or similar managed care plan where you only pay a copayment or fixed dollar amount.

Other Plans

The term "other group medical benefit/plan" or "other group dental benefit/plan" or "other group vision insurance benefit/plan" in this section includes any of the following:

- Group insurance or other coverage for a group of individuals, including coverage under another employer-sponsored benefit plan or student coverage through an educational facility, organization, or institution
- Coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefit organization plans
- Government or tax-supported programs, including Medicare or Medicaid
- Property or homeowner's insurance or no-fault motor vehicle coverage
- Any other individual or association insurance policies that are group or individual rated

Which Plan Is Primary

When a person is covered by more than one plan, one plan is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid. Proof of other coverage will be required from time to time.

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.
- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee
- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under Medical, Dental and Vision Insurance Benefits and Medicare are paid according to federal regulations. In case of a conflict between Medical, Dental and Vision Insurance Benefits provisions and federal law, federal law prevails.
- The Plan is always secondary to any motor vehicle policy that may be available to you, including personal injury protection (PIP coverage) or no-fault coverage. If the Plan pays benefits as a result of injuries or illnesses resulting from the acts of another party, the Plan has a right of reimbursement or subrogation as to the benefits paid. Please see the Plan's Subrogation and Reimbursement provision.
- If the coordination of benefits is on behalf of a covered Child:
    - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise.
- For a stepchild or Special Dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the other plan has a gender rule, that plan determines which plan is primary.

Coordination with Medicare

If you (or one of your dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare benefits for Prescription drug benefits), American Airlines, Inc. is the primary payer if:

- You are currently working for American Airlines, Inc.

- You become eligible for Medicare due to your (or your dependent) having end-stage renal disease, but only for the first 30 months of Medicare entitlement due to end-stage renal disease.

- You become eligible for Medicare due to becoming eligible for Social Security Disability and your coverage under this Plan is due to the current employment status of the employee. (For this purpose, you will only be considered to have current employment status during first six months in which you receive Company paid disability benefits that are subject to FICA tax. Generally, Medicare does not begin to pay benefits until after this period ends.)

If you (or one of your dependents) are eligible for Medicare benefits, including Medicare Part D (Medicare benefits for Prescription drug benefits), the American Airlines, Inc. plan pays secondary if:

- You (or your dependent) are covered by Medicare, do not have end-stage renal disease, and you are not currently working for American Airlines, Inc. or deemed to have coverage because of current employment status.

- You become eligible for Medicare due to you (or your dependent) having end-stage renal disease, but only after the first 30 months of Medicare entitlement due to end-stage renal disease is exhausted.

If you (or your dependent) are over age 65 and the American Airlines, Inc. plan would otherwise be the primary payer because you are still working, you or your dependent may elect Medicare as the primary payer of benefits. If you do, benefits under the American Airlines, Inc. plan will terminate.

Benefits for Disabled Individuals

If you stop working for American Airlines, Inc. because of a disability and you are eligible for Social Security Disability Benefits, or if you retire before age 65 and subsequently become disabled and you are eligible for Social Security Disability Benefits, you must apply for Medicare Parts A, B and D, or Parts C and D, whichever is applicable. Medicare Part A provides inpatient hospitalization benefits, Medicare Part B provides outpatient medical benefits, such as doctor's office visits and Medicare Part D provides prescription drug benefits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the American Airlines, Inc. plan, the American Airlines, Inc. plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the American Airlines, Inc. plan considers eligible, the American Airlines, Inc. plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any.

When Medicare is the primary payer, no benefits will be payable under the American Airlines, Inc. plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or

submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

GLOSSARY (SPD, Page 100)

Effective January 1, 2016, definition of "Approved Clinical Trial" and "Life-Threatening Condition" are added as follows:

Approved Clinical Trial: A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and meets any of the following three conditions:

- (1) *Federally funded trials*. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  (a) The National Institutes of Health.
  (b) The Centers for Disease Control and Prevention.
  (c) The Agency for Health Care Research and Quality.
  (d) The Centers for Medicare & Medicaid Services.
  (e) Cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
  (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  (g) Any of the following if certain conditions are met:
    - The Department of Veterans Affairs.
    - The Department of Defense.
    - The Department of Energy.

  The conditions for this clause (g) are that the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines: to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- (2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

- (3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Life-Threatening Condition: Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

PLAN ADMINISTRATION: REQUIRED BENEFIT NOTICES

Immediately following the Plan Administration section, the Required Benefit Notices are added, as follows:

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP)

Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**NEVADA – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/ http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
RHODE ISLAND – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://chipofvirginia.org/ CHIP Phone: 1-855-242-8282
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publication

	s/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

For Additional Information

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

END OF SUMMARY OF MATERIAL MODIFICATIONS FOR THE AMERICAN AIRLINES, INC. HEALTH BENEFIT PLAN FOR CERTAIN LEGACY EMPLOYEES EFFECTIVE JANUARY 1, 2017 EIN/PN: 13-1502798