SUMMARY OF MATERIAL MODIFICATIONS FOR THE AMERICAN AIRLINES, INC. HEALTH BENEFIT PLAN FOR CERTAIN LEGACY EMPLOYEES
EIN/PN: 13-1502798/501

EFFECTIVE OCTOBER 1, 2018

IMPORTANT NOTICE: THIS SUMMARY OF MATERIAL MODIFICATIONS APPLIES TO EMPLOYEE/RETIREE PARTICIPANTS AND THEIR COVERED DEPENDENTS WHO ARE ENROLLED IN THE AMERICAN AIRLINES, INC. HEALTH BENEFIT PLAN FOR CERTAIN LEGACY 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. 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, second level appeals for the Prescription Drug benefit will be conducted by the Claims Administrator.

Pages 94-100 are deleted and replaced in their entirety with the following:

Claims Procedures

Unless otherwise stated in this SPD, the following rules apply to both active employees and retirees. Generally, your provider will file your claim with the appropriate Claims Administrator. Under certain circumstances you must file your claim (e.g., for out-of-network claims or claims under Out-of-Area coverage). Once filed, all claims are subject to the following rules.

Time Frame for Initial Claim Determination

For **urgent care claims** *(see the "*Urgent Care Claims*" section of this SPD for a definition)* and **pre-service claims** (claims that require approval of the benefit before receiving medical care), the appropriate Claims Administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- 72 hours after receipt of an **urgent care claim** (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification); and
- 15 days after receipt of a **pre-service claim**.

For **post-service claims** (claims that are submitted for payment after receiving medical care), the appropriate Claims Administrator will notify you of an adverse benefit determination within 30 days after receipt of a claim. An adverse benefit determination is any denial, reduction or termination of a benefit or a failure to provide or make a payment, in whole or in part, for a benefit under the Plan.

For **urgent care claims**, if you fail to provide the appropriate Claims Administrator with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the appropriate Claims Administrator must notify you within 24 hours of receiving your claim of the specific information needed to complete the claim. You then have 48 hours to provide the information needed to process the claim. You will be notified of a determination no later than 48 hours after the earlier of:

- The appropriate Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

For **pre- and post-service claims**, a 15-day extension may be allowed to make a determination, provided that the appropriate Claims Administrator determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the appropriate Claims Administrator must notify you before the end of the first 15- or 30-day period of the reasons(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim.

If an extension is necessary for pre- and post-service claims due to your failure to submit necessary information, the applicable claim administrator's time frame for making a benefit determination is tolled or suspended from the date the appropriate Claims Administrator sends you an extension notification until the date you respond to the request for additional information.

In addition, if you or your authorized representative fails to follow the Plan's procedures for filing a pre-service claim, you or your authorized representative must be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification must be provided within five days (24 hours in the case of a failure to file a pre-service claim involving urgent care) following the Plan's knowledge of such failure. Notification may be oral, unless you or your authorized representative requests written notification. This paragraph only applies to a failure that is:

- A communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; or

- A communication that names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is required.

Urgent Care Claims

Urgent care claims are a special type of pre-service claim which, unless the special urgent care deadlines for response to a claim are followed, either:

- Could seriously jeopardize the patient's life, health or ability to regain maximum function;
- In the opinion of a physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested in the claim for benefits.

An individual acting on behalf of the Plan, applying the judgment of a prudent layperson with an average knowledge of health and medicine will determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.

Note that the Claims Administrators make the initial claims determination for all benefits. If the Claims Administrator denies the claim, the initial notice of denial of an urgent care claim may be provided orally, provided that written notification is provided to you within three days after the oral notification.

Concurrent Care Claims

There are two types of concurrent care claims: 1) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and 2) where an extension is requested beyond the initially-approved period of time or number of treatments. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours after receipt of your claim, provided your request is made at least 24 hours prior to the end of the approved course of treatment.

If your request for extended treatment is not made within 24 hours before the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim time frames described earlier. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend treatment is a non-urgent claim, your request will be considered a new claim and decided according to pre-service or post-service time frames, whichever applies.

Note: *Any reduction or termination of a course of treatment will be considered an adverse benefit determination, unless the reduction or termination of such course of treatment is the result of a Plan amendment or Plan termination.*

If You Receive an Adverse Benefit Determination

The appropriate Claims Administrator will provide you with a written notification of any adverse benefit determination, which will set forth:

- The specific reason(s) for the adverse benefit determination;
- References to the specific Plan provisions on which the benefit determination is based;
- A description of any additional material or information needed to process the claim and an explanation of why that material or information is necessary;
- A description of the Plan's appeal procedures and the time limits applicable to those procedures, including a statement of your right to bring a civil action under ER1SA after an appeal of an adverse benefit determination;
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination, or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the adverse determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- If the adverse benefit determination concerns a claim involving **urgent care**, a description of the expedited review process applicable to the claim.

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

If you receive an adverse benefit determination, you may ask for a review by contacting the appropriate Claims Administrator/Claims Fiduciary. You, or your authorized representative, have 180 days following the receipt of a notification of an adverse benefit determination within which to appeal the determination. A failure to file a request for review within 180 days will constitute a waiver of your right to request a review of the claim denial. *(For more details, see the "How to Contact Your Claims Administrator/Claims Fiduciary" section of this SPD)*

Note that the Claims Administrators determine the second level of appeal for all benefits.

You have the right to:

- Authorize a representative to act on your behalf, as long as such designation is in writing and submitted to the Claims Administrator. Submit written comments, documents, records and other information relating to the claim for benefits;
- Upon a request, and 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 benefits determination; and
  - 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;
- 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 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; and
- 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; and
  - 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.
- Ordinarily, a decision regarding your appeal will be reached within:
  - 72 hours after receipt of your request for review of an urgent care claim;
  - 15 days after receipt of your request for review of a pre-service claim; or
  - 30 days after receipt of your request for review of a post-service claim.

The notice of an adverse benefit determination on appeal, from the appropriate Claims Administrator/Claims Fiduciary, will contain all of the following information:

- The specific reason(s) for the adverse benefit determination;
- References to the specific Plan provisions on which the benefit determination is based;
- 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 your claim;

- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA;
- Any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse benefit determination; or a statement that a copy of this information will be provided free of charge to you upon request;
- If the adverse benefit determination was based on 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; and
- You may not bring a lawsuit to recover benefits under this Plan until you have exhausted all levels of appeals (2 levels) offered through the administrative process described in this Plan. No legal action to recover benefits under the Plan may be filed beyond three years after the date a final decision is made on your claim for benefits. The three-year statute of limitations on suits for all benefits shall apply in any forum where the Beneficiary may initiate such suit.

External Review

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the External Review Program. This program only applies if the adverse benefit determination is based on:

- Clinical reasons/medical judgment (medical judgment includes a decision based on medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, or a decision that a treatment is experimental or investigational).
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

This External Review Program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if Claims Administrator fails to respond to your appeal in accordance with applicable regulations.

If the above conditions are satisfied, you may request an independent review of the adverse benefit determination. Neither you nor the Claims Administrator will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. You or an authorized designated representative must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination. A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement.

The independent review will be performed by an independent review organization (IRO). The IRO has been contracted by the Claims Administrator and has no material affiliation or interest

with the Claims Administrator or American Airlines, Inc. The Claims Administrator will choose the IRO based on a rotating list of appropriately accredited IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO. Within applicable timeframes of the Claims Administrator's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by the Claims Administrator in making a decision on the case; and
- All other information or evidence that you or your Physician has already submitted to the Claims Administrator.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Claims Administrator will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes required by law. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claims Administrator with the reviewer's decision, and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan is required to provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

The following Claims Administrators do not have an External Review Program:

- MetLife Dental
- EyeMed

Your decision to seek External Review will not affect your rights to any other benefits under this Plan and nothing contained in this section will affect an employee's grievance rights under the collective bargaining agreement. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

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 BENEFIT PLAN FOR CERTAIN LEGACY EMPLOYEES EFFECTIVE OCTOBER 1, 2018 EIN/PN: 13-1502798/501