# AMERICAN AIRLINES, INC.
# CAFETERIA PLAN

Amended and Restated Effective January 1, 2025

# AMERICAN AIRLINES, INC.
# CAFETERIA PLAN
# TABLE OF CONTENTS

## ARTICLE I
PURPOSE

1.01 Purpose of Plan. The Company has established the Plan as hereinafter set forth to provide its Employees with the ability to purchase certain employee benefits on a pre-tax basis through salary reduction. Specifically, the Plan allows an Eligible Employee to pay for his or her share of premiums and contributions under the Premium Payment Arrangement on a pre-tax, salary reduction basis. In addition, the Plan allows an Eligible Employee to contribute on a pre-tax, salary reduction basis to accounts for reimbursement of certain medical and dependent care expenses under the respective Health Care FSA and Dependent Care FSA. Only Employees may participate in the Plan, and the provisions described in the Plan shall apply uniformly to all participants.

1.02 Qualification. This Plan is intended to qualify as a "cafeteria plan" within the meaning of Code section 125 such that salary reductions under the Premium Payment Arrangement, the Health Care Flexible Spending Account, the Limited Purpose Flexible Spending Account, the Health Savings Account, and the Dependent Care Flexible Spending Account will be eligible for exclusion from Participants' taxable income. It is intended that the Health Care FSA and Limited Purpose FSA Benefit Options meet the requirements of ERISA, operate in accordance with the rules under Code section 125, and each qualify as an "accident and health plan" within the meaning of Code section 105(e) such that reimbursements will be eligible for exclusion from Participants' taxable income under Code section 105(b). It is intended that the Dependent Care Flexible Spending Account qualify as a dependent care assistance program within the meaning of Code section 129 such that reimbursements will be eligible for exclusion from Participants' taxable income under Code section 129(a). It is intended that the Health Savings Account satisfy the requirements under Code section 223 such

that reimbursements will be eligible for exclusion from Participants' taxable income, subject to the limitations in Code section 223. To the extent that a provision of this Plan relates to a requirement of the Code or ERISA, it must be interpreted to impose such requirement, but only to the extent required by law, unless the terms of the provision expressly provide otherwise.

1.03 Restatement of the Plan. This Plan is an amendment and restatement of the Prior Plan, which was effective January 1, 2016.

1.04 Definitions and Interpretation. The capitalized words and phrases used throughout the Plan have the meanings set forth in Article II. The Plan is to be interpreted in accordance with the principals set forth in Article III.

1.05 Rights of Employees Not Expanded. Neither the Plan, nor the action of an Employer in establishing or continuing the Plan, nor participation in the Plan may be construed as giving any person the right to be employed by or remain employed with an Employer or, except as provided in the Plan, the right to any payment or benefit.

1.06 Application of ERISA. The Health Care FSA and Limited Purpose FSA portions of the Plan are each an "employee welfare benefit plan" within the meaning of ERISA section 3(1). Certain requirements of ERISA, including the fiduciary responsibility provisions, apply to the Health Care FSA and Limited Purpose FSA, as referenced in Articles XI and XII. The Premium Payment Arrangement, the Dependent Care FSA and the Health Savings Account portions of the Plan are not subject to the requirements of ERISA, and the Plan shall not be interpreted as applying the requirements of ERISA to such portions of the Plan.

1.07 Unfunded Plan. The Plan is an unfunded plan without a trust or any other separate funding vehicle. Although Plan bookkeeping accounts are maintained, including for amounts attributable to Employee pre-tax salary reduction elections, all Plan benefits are paid

from the general assets of the Employer. Notwithstanding the preceding sentence, the Health Savings Account that the Participant maintains is a funded arrangement, with a custodial account, in accordance with Code section 223.

## ARTICLE II
## DEFINITIONS

Whenever used in the Plan, the following terms, when capitalized, shall have the respective meanings indicated, unless otherwise expressly provided herein.

2.01 "Accidental Death and Dismemberment Benefits" means the accidental death and dismemberment insurance benefits provided to Participants by the Employer as described in the summary plan description entitled "American Airlines, Inc. Health and Welfare Plan for Active Employees."

2.02 "Affiliated Employer" means the Company and any corporation which is a member of a controlled group of corporations (as defined in Code section 414(b)) which includes the Company; any trade or business (whether or not incorporated) which is under common control (as defined in Code section 414(c)) with the Company; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code section 414(m)) which includes the Company; and any other entity required to be aggregated with the Company pursuant to Treasury regulations under Code section 414(o).

2.03 "Benefit Option" means any of the following benefits which Eligible Employees can elect and pay for with pre-tax salary reduction contributions: the Medical Benefit, the Dental Benefit, the Vision Benefit, the Accidental Death and Dismemberment Benefit, the Health Care Flexible Spending Account, and the Dependent Care Flexible Spending Account.

2.04 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.05 "Company" means American Airlines, Inc. and any successor thereto.

2.06 "Dental Benefit" means the stand-alone dental benefit offered to Participants by the Employer, as described in the summary plan description entitled "American Airlines, Inc. Health and Welfare Plan for Active Employees."

2.07 "Dependent" means a beneficiary of a Participant as designated or determined under the terms of a Benefit Option, as described in the applicable summary plan description.

2.08 "Dependent Care Account" means the individual account established under the Plan in the name of each Participant for the purpose of accounting for credits and for benefits for Qualifying Dependent Care Expenses paid for or on behalf of the Participant.

2.09 "Dependent Care Flexible Spending Account" or "Dependent Care FSA" means the Employer's Dependent Care Flexible Spending Account as described in Article VI and in the summary plan description entitled "American Airlines, Inc. Health and Welfare Plan for Active Employees."

2.10 "Effective Date" means January 1, 2025.

2.11 "Election" means the elections a Participant makes for the Plan Year in his or her Election and Pay Reduction Arrangement.

2.12 "Election and Pay Reduction Arrangement" means the arrangement through which the Employer allows each Eligible Employee to elect benefits under the Plan and specify salary reduction amounts. This election and pay reduction arrangement may be undertaken through electronic means.

2.13 "Eligible Employee" means an Employee who satisfies the requirements of Section 3.01.

2.14 "Employee" means a common law employee of the Employer on its U.S. payroll. For any and all purposes under this Plan, "Employee" shall not include a person otherwise designated by the Employer at the time of hire as not eligible to participate in the Plan or receive benefits under the Plan, even if such ineligible person is subsequently determined to be an "employee" by any government or judicial authority.

2.15 "Employer" means the Company.

2.16 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

2.17 "Fiduciary" means a person who has discretionary authority over the administration of the Health Care FSA within the meaning of ERISA section 3(21).

2.18 "FMLA Leave" means leave under the Family and Medical Leave Act of 1993, as amended from time to time.

2.19 "Grace Period" means the 2 ½ month period immediately following the end of the Plan Year.

2.20 "Health Care Account" means an account established under the Plan in the name of each Participant for the purpose of accounting for credits and for benefits for Qualifying Medical Expenses paid for or on behalf of the Participant.

2.21 "Health Care Flexible Spending Account" or "Health Care FSA" means the Employer's Health Care Flexible Spending Account as described in Article V and in the summary plan description entitled "American Airlines, Inc. Health and Welfare Plan for Active Employees."

2.22 "High-Deductible Health Plan" means the high-deductible health plan offered by the Company as a Medical Benefit Option that is intended to qualify as a high-deductible health plan under Code section 223(c)(2), as described in summary plan description entitled "American Airlines, Inc. Health and Welfare Plan for Active Employees."

2.23 "Highly Compensated Employee" means an Employee who:

(a) performs services for the Employer during the determination year; and

(b) for the look-back year received compensation (as defined in Code section 415(c)(3), including elective deferrals as defined in Code section 402(g) and amounts excludible

from salary under Code sections 125, 132(f)(4), or 457) in excess of $160,000 (for 2025), as adjusted to reflect cost-of-living increases; and

(c) was a Participant of the top 20% of Employees during the look-back year when ranked on the basis of compensation received during the year.

For purposes of this definition of Highly Compensated Employee, the "determination year" is the Plan Year, and the "look-back year" is the 12-month period immediately preceding the determination year.

2.24 "Highly Compensated Individual" means, with respect to Code section 125, a Participant who is (a) an officer, (b) a Highly Compensated Employee, (c) a more-than-5 percent owner, or (d) a Spouse or Dependent of an individual described in (a), (b) or (c) above. With respect to Code section 105(h), Highly Compensated Individual means an individual who is (1) one of the five highest paid officers, (2) a more-than-10% owners of the employer's stock, or (3) among the highest paid 25% of all Employees.

2.25 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

2.26 "HSA or Health Savings Account" means an individual trust or custodial account established under Code section 223 by an Employee with a trustee/custodian that has contracted with the Employer to receive pre-tax salary reduction contributions. Although funded by salary reduction under this Plan, the HSA is not part of or intended to be part of an ERISA-covered benefit plan.

2.27 "HSA Benefits" has the meaning described in Section 8.01.

2.28 "HSA-Eligible Individual" means an Eligible Employee who satisfies the requirements to contribute to an HSA under Code section 223 and who has elected qualifying

High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

2.29 "Key Employee" means any person who is a key employee as defined in Section 416(i)(1) of the Code.

2.30 "Limited Purpose Flexible Spending Account" or "Limited purpose FSA" means the Employer's Limited Purpose Flexible Spending Account as described in Article V and in the summary plan description entitled "American Airlines, Inc. Health and Welfare Plan for Active Employees."

2.31 "Medical Benefit" means the medical benefit provided to Participants by the Employer as described in the Plan documents/summary plan descriptions entitled "American Airlines, Inc. Health and Welfare Plan for Active Employees," "American Airlines, Inc. PPO Plan," "American Airlines, Inc. Plus Plan," and "American Airlines, Inc. DFW Connected Care Plan."

2.32 "Named Fiduciary" means a named fiduciary within the meaning of ERISA section 402(a)(2).

2.33 "Participant" means any Employee who participates in the Plan in accordance with Article III.

2.34 "Part-Time Employee" means an Employee who works, or is expected to work on a regular basis, less than 30 hours a week and is designated as a part-time Employee on the Employer's personnel records.

2.35 "Plan" means the American Airlines, Inc. Cafeteria Plan, as set forth herein, as amended from time to time thereafter.

2.36 "Plan Administrator" means the Employee Benefits Committee, or other

individual(s) or corporations to which the Employer delegates purely administrative functions otherwise exercisable by the Employer as plan sponsor.

2.37 "Plan Year" means a twelve (12) consecutive month period beginning January 1 and ending on December 31.

2.38 "Premium Payment Arrangement" means the Employer's Premium Payment Arrangement described in Article IV, which allows each Participant to pay for his or her share of the contribution or premium for the Medical Benefit, the Dental Benefit, the Vision Benefit, and the Accidental Death and Dismemberment Benefit, on a pre-tax basis.

2.39 "Prior Plan" means a predecessor plan that was in existence and effective prior to this amendment and restatement.

2.40 "Qualifying Dependent Care Expenses" means expenses that are eligible to be reimbursed from the Dependent Care FSA, as described in Section 6.06.

2.41 "Qualifying Medical Expenses" means expenses that are eligible to be reimbursed from the Health Care FSA or Limited Purpose FSA, as described in Section 5.07.

2.42 "Spouse" means an individual who is lawfully married to a Participant as recognized by the state, possession, or territory of the U.S. in which the marriage is entered into, regardless of domicile, and who is not legally separated. Notwithstanding any language to the contrary, for purposes of the Dependent Care FSA, the term "Spouse" does not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence separate from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

2.43 "Vision Benefit" means the stand-alone vision benefit offered to Participants by the Employer, as described in the summary plan description entitled "American Airlines, Inc. Health and Welfare Plan for Active Employees."

## ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.01 Eligibility.

(a) Eligibility Requirements. An Eligible Employee is an active full-time or part-time Employee who satisfies any conditions described in the summary plan description applicable to a particular Benefit Option, and who is not:

(1) Any Employee represented in collective bargaining by a labor organization whose collective bargaining agreement does not provide for participation in the Plan;

(2) A leased Employee, as defined in Code section 414(n) Code; or

(3) An independent contractor, consultant or other persons otherwise designated by the Employer at the time of hire as not on the payroll or not eligible to participate in or receive benefits under the Plan.

(b) Effective Date of Participation. An Employee shall be eligible to participate in the Plan on the first day of the month on or immediately following the date in which such Employee satisfies the conditions for eligibility specified in Section 3.01(a) and any conditions described in the summary plan description applicable to a particular Benefit Option.

3.02 Election to Participate.

(a) If Eligibility Requirements Satisfied Before First Day of Plan Year. An Employee who is an Eligible Employee before the first day of a Plan Year may become a Participant in the Plan for that Plan Year by entering into an Election and Pay Reduction Arrangement with the Employer before the first day of the Plan Year for which it will be effective.

(b) If Eligibility Requirements Satisfied After First Day of Plan Year. An individual who does not become an Eligible Employee until after the first day of a Plan Year may enter into an Election and Pay Reduction Arrangement with the Employer during the 31-day period following the first day on which he or she becomes an Eligible Employee.

3.03 Cessation of Participation. A Participant shall cease to be a Participant as of the earliest of:

(a) the date on which the Plan terminates;

(b) the end of the Plan Year if the Participant: (i) does not make an election to receive benefits under the Health Care FSA or Dependent Care FSA, and (ii) waives coverage under all other Benefit Options for the next Plan Year;

(c) the date on which the Participant's election and compensation reduction agreement expires or is terminated under the Plan;

(d) the date on which the Participant revokes coverage pursuant to the Family and Medical Leave Act;

(e) the date on which the Participant terminates employment with the Employer;

(f) the date on which the Participant ceases to be an Eligible Employee;

(g) the date on which the Participant fails to make the required contributions for coverage; or

(h) the date on which the Participant dies.

3.04 Reinstatement During Plan Year. Except as provided in Section 7.08, if a Participant's coverage under the Plan is canceled during the Plan Year because of termination of employment, leave of absence, or ineligibility for benefits, and that individual resumes

employment with the status as an Eligible Employee during the same Plan Year, he or she may elect to reinstate coverage during that Plan Year on a prospective basis, but only in accordance with his monthly Premium Payment Arrangement Election, and his annual Health Care FSA and Dependent Care FSA Elections, under his Election and Pay Reduction Arrangement as in effect before cancellation of coverage.

3.05 Continuation of Coverage. Pursuant to Code section 4980B, any qualified beneficiary (as defined in Code section 4980B(g)(1)), who would lose coverage under the Health Care FSA as a result of a qualifying event (as defined in Code section 4980B(f)(3)) can elect, within a stated election period, continuation of coverage of benefits previously received under the Health Care FSA. If a qualified beneficiary timely elects continuation coverage, the benefits elected will be available for the time period prescribed by law (*i.e.*, the end of the Plan Year). In addition, the Plan allows qualified beneficiaries to carryover up to an amount equal to 20 percent of the maximum salary reduction contribution under Code section 125(i) for that Plan Year remaining in the qualified beneficiary's Health Care FSA or Limited Purpose FSA as of the end of the calendar year in which the individual became eligible for continuation of coverage. Such carryover amount may be used to pay or reimburse medical expenses incurred during the maximum duration of COBRA continuation period (*i.e.* 18, 29, or 36 months, as applicable). Any unused amount of more than an amount equal to 20 percent of the maximum salary reduction contribution under Code section 125(i) for that Plan Year remaining in the qualified beneficiary's Health Care FSA or Limited Purpose FSA at the end of the calendar year in which the individual became eligible for continuation of coverage will be forfeited.

3.06 Absence from Employment Due to Military Service. If an Eligible Employee is absent from employment due to qualifying military service, coverage and benefits will be

provided in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

## ARTICLE IV
PREMIUM PAYMENT ARRANGEMENT

4.01 Generally. Eligible Employees may choose to participate in the Premium Payment Arrangement. The purpose of the Premium Payment Arrangement is to allow Eligible Employees to purchase coverage or make contributions to coverage on a pre-tax basis by paying for Qualifying Expenses through pre-tax salary reduction.

4.02 Benefits. The Plan permits Eligible Employees to pay for the cost of the following benefits on a pre-tax salary reduction basis:

(a) the Medical Benefit;

(b) the Dental Benefit;

(c) the Vision Benefit; and

(d) the Accidental Death and Dismemberment Benefit.

The type and amount of benefits offered under the types of coverage listed above are subject to and governed by the terms and conditions of such coverage. This Plan shall not apply to personal accident or business travel premiums paid by the Employer or to any premiums paid by the Eligible Employee on an after-tax basis.

4.03 Qualifying Expenses. Qualifying Expenses are all or a portion of the costs for the benefits made available to an eligible employee under Section 4.02. The Employer shall notify the Participant prior to the beginning of the Plan Year what portion of the cost of these Benefits are the sole financial responsibility of the Participant. Qualifying Expenses include all or a portion of the costs for insurance premiums required to be paid by an eligible employee, or the contributions for self-funded coverage required to be paid by an eligible employee.

## ARTICLE V
## HEALTH CARE FLEXIBLE SPENDING ACCOUNT & LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

5.01 Generally. Eligible Employees may choose to reduce their compensation on a pre-tax basis under the Health Care Flexible Spending Account Benefit Option or the Limited Purpose Flexible Spending Account Benefit Option. However, for each Plan Year that a Participant elects the High Deductible Health Plan, he shall only be permitted to participate in a Limited Purpose FSA. The purpose of the Health Care FSA and Limited Purpose FSA is to allow Eligible Employees to receive reimbursement for Qualifying Medical Expenses that are not reimbursed by any other plan or claimed as an income tax deduction. It is intended that the Health Care FSA and Limited Purpose FSA operate in accordance with the rules under Code section 125 and qualify as an "accident and health plan" within the meaning of Code section 105(e) such that reimbursements will be eligible for exclusion from Participants' taxable income under Code section 105(b).

5.02 Establishment of Account. An Employer establishes and maintains on its books a Health Care FSA and Limited Purpose FSA for each Participant who elects to participate in the Health Care FSA or Limited Purpose FSA. Each Plan Year is accounted for separately.

5.03 Crediting of Account. A Participant's Health Care FSA or Limited Purpose FSA is credited, as of each date compensation is paid to the Participant (including the final date on which compensation is paid to a Participant terminating from employment), with an amount equal to the reduction made in such compensation in accordance with the Participant's Election and Pay Reduction Arrangement. Notwithstanding this, as described in Section 11.01(c)(1), the total amount elected by the Participant for the Plan Year is, at all times, available for reimbursement without regard to whether the claims exceed the balance of the Participant's

Health Care FSA for the Plan Year at the time of the reimbursement. All amounts credited to the Health Care FSA or Limited Purpose FSA are the property of the Employer until paid out pursuant to Article XI.

5.04 Debiting of Account. A Participant's Health Care FSA or Limited Purpose FSA for each Plan Year is debited from time to time in the amount of any payment to or for the benefit of the Participant for Qualifying Medical Expenses, as provided in Section 5.06, only if the Participant applies for reimbursement on or before March 31st of the year following the Plan Year in which the Qualifying Medical Expenses were incurred.

5.05 Forfeiture of Account. If any balance remains credited to the Participant's Health Care FSA or Limited Purpose FSA after all reimbursements are made for that Plan Year, such balance in excess of an amount equal to 20 percent of the maximum salary reduction contribution under Code section 125(i) for that Plan Year is not carried over to reimburse the Participant for Qualifying Medical Expenses incurred during a subsequent Plan Year, and is not available to the Participant in any other form or manner. Instead, such balance remains the property of the Employer, and the Participant forfeits all rights with respect to such balance. Remaining balances of up to an amount equal to 20 percent of the maximum salary reduction contribution under Code section 125(i) for that Plan Year shall be added to the Participant's Health Care FSA or Limited Purpose FSA balance in the subsequent Plan Year. For Participants who do not elect the High Deductible Health Plan for a Plan Year Hand have remaining balances from the previous Plan Year in the Participant's Limited Purpose FSA, the Participant shall be deemed to have made an election for and will be automatically enrolled in a Health Care FSA with an account balance equal to the remaining balance from the Previous Plan Year of up to an amount equal to 20 percent of the maximum salary reduction contribution under Code section

125(i) for that Plan Year. For Participants who elect the High Deductible Health Plan for a Plan Year and have remaining balances from the previous Plan Year from the Participant's Health Care FSA, the Participant shall be deemed to have made an election for and will be automatically enrolled in a Limited Purpose FSA with an account balance equal to the remaining balance from the previous Plan Year of up to an amount equal to 20 percent of the maximum salary reduction contribution under Code section 125(i) for that Plan Year.

5.06 Reimbursement of Qualifying Medical Expenses. Each Participant is entitled to receive, for each Plan Year, reimbursement of Qualifying Medical Expenses up to the amount elected by the Participant (not to exceed $3,300, or such higher amount as indexed and allowed by law), provided:

(a) such expenses are incurred during the Plan Year (expenses are treated as incurred when the health care services are provided and not when the Participant is billed, charged for, or pays for the services);

(b) such expenses are not reimbursable by the Medical Benefit, Dental Benefit or Vision Benefit or any other medical benefit plan or coverage; and

(c) such expenses are submitted on or before March 31st of the year following the Plan Year in which the expenses are incurred.

5.07 Qualifying Medical Expenses.

(a) Health Care FSA. Qualifying Medical Expenses for purposes of the Health Care FSA are expenses incurred by a Participant, Spouse, or Dependent:

(1) For "medical care," within the meaning of Code section 213(d). Examples of Qualifying Medical Expenses are:

(i) deductibles and co-payments under any Medical Benefit, Vision Benefit or Dental Benefit sponsored by the Employer or under other accident and health insurance of the Participant, Spouse, or Dependents;

(ii) dental care, including routine dental checkups, orthodontic work, and dentures;

(iii) medicines or other drugs, including over-the-counter medicines and drugs, if such drugs are purchased to remedy current medical conditions for the Participant, Spouse, or Dependents;

(iv) eye care, including vision checkups, eyeglasses, and contact lenses;

(v) hearing care, including hearing examinations and hearing aids; and

(vi) routine physical examinations; or

(2) For menstrual care products as defined in Code section 223(d)(2)(D).

Notwithstanding the foregoing, Qualifying Medical Expenses do not include premium payments for other medical plan coverage, including premiums paid for medical coverage under a plan maintained by the employer of a Spouse or Dependent.

(b) Limited Purpose FSA. Qualifying Medical Expenses for purposes of the Limited Purpose FSA are expenses incurred by a Participant, Spouse, or Dependent for:

(1) dental care, including routine dental checkups, orthodontic work, and dentures; and

(2) eye care, including vision checkups, eyeglasses, and contact lenses.

Notwithstanding the foregoing, Qualifying Medical Expenses do not include premium payments for other dental or vision plan coverage, including premiums paid for dental or vision coverage under a plan maintained by the employer of a Spouse or Dependent.

5.08 Refund of Duplicate Reimbursement. If a Participant receives reimbursement under the Health Care FSA or Limited Purpose FSA, and reimbursement for the same expense is made under another plan, he or she is required to refund the reimbursement under the Health Care FSA or Limited Purpose FSA to his or her Employer. The amount of the Participant's elected coverage under the Plan, to the extent of any such refund, is reinstated for the Plan Year in which the reimbursement was originally made.

## ARTICLE VI
## DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

6.01 Generally. Eligible Employees may choose to salary reduce their compensation on a pre-tax basis under the Dependent Care FSA. The purpose of the Dependent Care FSA is to allow Eligible Employees to receive reimbursement for Qualifying Dependent Care Expenses not reimbursed by any other plan or claimed as an income tax credit. It is intended that the Dependent Care FSA qualify as a dependent care assistance program within the meaning of Code section 129.

6.02 Establishment of Account. An Employer establishes and maintains on its books a Dependent Care FSA for each Participant who has elected to participate in the Dependent Care FSA Benefit Option. Each Plan Year is accounted for separately.

6.03 Crediting of Account. A Participant's Dependent Care FSA for each Plan Year is credited, as of each date compensation is paid to the Participant in such Plan Year (including the final date on which compensation is paid to a Participant terminating from employment), an amount equal to the reduction made in such compensation in accordance with the Participant's Election and Pay Reduction Arrangement. All amounts credited to a Dependent Care FSA are the property of the Employer until paid out.

6.04 Debiting of Account. A Participant's Dependent Care FSA for each Plan Year is debited from time to time in the amount of any payment to or for the benefit of the Participant for Qualifying Dependent Care Expenses, as provided in Section 6.06, only if the Participant applies for reimbursement on or before March 31st of the year following the Plan Year in which the Qualifying Dependent Care Expenses are incurred. As described in Section 11.01(c)(2), with respect to the Dependent Care FSA, no reimbursement or payment may at any time exceed the

balance of the Participant's Dependent Care FSA for the Plan Year at the time of the reimbursement or payment.

6.05 Forfeiture of Accounts. If any balance remains credited to the Participant's Dependent Care FSA after all reimbursements are made for that Plan Year and subsequent Grace Period, such balance is not carried over to reimburse the Participant for Qualifying Dependent Care Expenses during a subsequent Plan Year, and is not available to the Participant in any other form or manner. Instead, such balance remains the property of his or her Employer, and the Participant forfeits all rights with respect to such balance.

6.06 Reimbursement of Qualifying Dependent Care Expenses. Each Participant is entitled to receive, for each Plan Year and subsequent Grace Period, reimbursement of Qualifying Dependent Care Expenses up to the amount elected by the Participant (not to exceed $5,000). Subject to the last sentence of this Section 6.06, Qualifying Dependent Care Expenses are expenses incurred by a Participant which satisfy the following conditions:

(a) are incurred for the care of a Dependent of the Participant or for related household services; expenses are treated as incurred when the services are provided and not when the Participant is billed, charged for, or pays for the services;

(b) are paid or payable to a dependent care service provider;

(c) are incurred during the Plan Year or subsequent Grace Period (expenses are treated as incurred when the dependent care services are provided and not when the Participant is billed, charged for, or pays for the services); and

(d) are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant.

Qualifying Dependent Care Expenses do not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is: (1) a Dependent of the Participant who is under the age of 13 and who lives with the taxpayer for over half the calendar year, (2) a Dependent of the Participant who is mentally or physically unable to care for himself, lives with the taxpayer for over half the calendar year, and regularly spends at least eight hours each day in the Participant's household, or (3) a Spouse of the Participant who is mentally or physically unable to care for himself, lives with the taxpayer for over half the calendar year, and regularly spends at least eight hours each day in the Participant's household.

6.07 Report to Participants on or Before January 31. On or before each January 31, the Employer will furnish to each Participant who participated in the Dependent Care FSA Benefit Option during the prior calendar year a Form W-2 showing the amount of salary reduction contributions made by that Participant during such year with respect to the Dependent Care FSA.

## ARTICLE VII
ELECTION AND PAY REDUCTION ARRANGEMENT

7.01 Period of Coverage; Agreement Generally Irrevocable. Subject to Article III, an Election and Pay Reduction Arrangement is effective for the entire Plan Year beginning after the date of the Agreement, or, in the case of an individual who becomes an Eligible Employee on or after the first day of the Plan Year, the remainder of the Plan Year in which the Agreement is entered. An Election and Pay Reduction Arrangement is irrevocable during the Plan Year, except as provided in Sections 7.03 through 7.08.

7.02 Limits on Salary Reduction Amounts Elected. A Participant must elect a minimum of $120 in an Election and Pay Reduction Arrangement in order to participate in the Health Care FSA, Limited Purpose FSA or the Dependent Care FSA. The maximum limits on salary reduction amounts that a Participant may elect in an Election and Pay Reduction Arrangement shall be determined by the Employer and are set forth in Sections 4.03, 5.06 and 6.06.

7.03 Change in Election Due to Change in Status. A change in Election during the Plan Year is allowed if the following three conditions are satisfied:

(a) One or more of the following "change in status" events occur:

(1) marriage,

(2) divorce,

(3) legal separation,

(4) annulment,

(5) death of Spouse or Dependent,

(6) birth, adoption of child, or placement for adoption of child,

(7) change in the employment status of the Employee, Spouse or Dependent,

(8) a Dependent satisfying or ceasing to satisfy eligibility requirements, or

(9) change in the place of residence of the Employee, Spouse or Dependent.

(b) The proposed change in Election is on account of and corresponds with that change in status (*i.e.*, the proposed change bears a logical relationship to the event that has occurred); and

(c) The change in status affects eligibility under the Plan (*i.e.*, an Employee, Spouse or Dependent either gains or loses coverage in response to an event).

7.04 Change in Election Due to Certain Other Events. A Participant may change his or her Election during the Plan Year with respect to the Medical Benefit, Vision Benefit, Dental Benefit, or Health Care FSA if any of the following events occur:

(a) A special enrollment right under HIPAA (only for plans that are not exempt from HIPAA special enrollment rules);

(b) A judgment, decree or order requiring that an Employee's child receive accident or medical coverage under a plan (including a Qualified Medical Child Support Order);

(c) A Participant's eligibility for Medicare or Medicaid; or

(d) If the Employee, his Spouse or Dependent experiences a COBRA qualifying event and elects to continue coverage under the Plan, the Employee may increase his or her election for the remainder of the Plan Year to pay for such COBRA coverage.

7.05 Change in Cost or Coverage of a Benefit Option. Generally, a Participant may not

change his or her Election in response to a change in cost or coverage of a Benefit Option. However, the Plan Administrator, in its sole discretion, shall have the ability to allow Participants to make mid-year changes in election with respect to the Benefit Options, as described in this Section.

(a) Automatic cost changes: If the cost of a Benefit Option increases (or decreases) during a period of coverage, the Plan Administrator may, on a reasonable and consistent basis, automatically make a prospective increase (or decrease) in the Participant's pre-tax contributions.

(b) Significant cost changes: If the cost charged to Employees for a Benefit Option significantly changes, the Plan Administrator may, on a reasonable and consistent basis, allow Participants to make a corresponding change in pre-tax contributions.

(c) Significant curtailment: If Employees have a significant curtailment of coverage under a Benefit Option (for example, there is a significant increase in the deductible, the copay, or the out-of-pocket cost sharing limit under the Medical Benefits), the Plan Administrator may, on a reasonable and consistent basis, allow Participants to revoke their elections and receive any similar coverage available under the Plan.

(d) Significant curtailment that is a loss of coverage: If coverage is curtailed so significantly that it amounts to a loss of coverage, the Plan Administrator may, on a reasonable and consistent basis, allow Participants to revoke their elections and, in lieu thereof, elect either to receive on a prospective basis similar coverage available under the Plan or drop coverage if no similar coverage is available.

(e) A loss of coverage for purposes of subparagraph (d) means a complete loss of coverage under the option. This includes the elimination of an option, an HMO ceasing

to be available, or a substantial decrease in the medical care providers available under the option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the physicians participating in a preferred provider network or an HMO).

(f) Addition or improvement of an option. If a Benefit Option adds an option or if coverage under an existing Benefit Option is significantly improved during a period of coverage, the Plan Administrator may, on a reasonable and consistent basis, allow Employees (whether or not they have previously made an election) to revoke their election and, in lieu thereof, make an election on a prospective basis for the improved option.

(g) Change in coverage under another employer plan. An Employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or of another employer) if: (i) the other cafeteria plan is administered in a manner that is consistent with the cafeteria plan regulations setting forth permitted election changes, or (ii) the other cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the Cafeteria Plan.

(h) With respect to the Dependent Care FSA only, an Employee may change his or her Election if there occurs any event that causes a dependent to no longer meet the definition of Dependent or the Employee provides documentation that demonstrates that he or she has experienced an increase or decrease in dependent care provider fees (except for increases by a provider who is related to the Employee), he or she chooses a different dependent care provider who charges a different amount, or he or she makes a change to his or her or his or her Spouse's regular work schedule that increases or decreases his or her need for dependent care.

7.06 Health Savings Account. With respect solely to the HSA, a Participant who makes an election to contribute an amount on a pre-tax salary reduction basis to his or her HSA may change such election on a prospective basis at any time during the Plan Year, subject to any restrictions adopted by the Employer as permitted by law. Such restrictions, if any, will apply to all Participants.

7.07 Required Change in Election. A Participant's election will be changed as necessary pursuant to Section 10.05 to comply with the applicable nondiscrimination rules.

7.08 Change in Election Due to FMLA Leave or State Paid Family Leave ("PFL"). Notwithstanding Section 3.04, a Participant on FMLA Leave or, where required, State PFL, may change or revoke his or her Election under the Premium Payment Arrangement with respect to the Medical Benefit, Health Care FSA or Limited Purpose FSA, subject to the following limitations:

(a) Revoking Coverage. A Participant absent on FMLA Leave or State PFL may elect to cease participation in the Premium Payment Arrangement, the Health Care FSA or the Limited Purpose FSA at the time the leave begins.

(b) Resuming Coverage. Upon return to employment as an Eligible Employee from FMLA Leave or State PFL, a Participant who has revoked coverage under the Premium Payment Arrangement may elect to reinstate his or her coverage on a prospective basis but only at the level of coverage in effect under the Premium Payment Arrangement before his FMLA Leave began (adjusted to conform to any amendments to the Plan or a Benefit Option made during the period of FMLA Leave). With respect to the Health Care FSA or Limited Purpose FSA, the preceding sentence applies, except that a Participant may either (1) make up the contributions that were due during the period of FMLA Leave or State PFL, in which case

the Participant will resume coverage at the same annual amount elected before FMLA Leave began, or (2) not make up such contributions, with the annual amount of coverage reduced accordingly. In either event, upon return from leave, the Eligible Employee must resume contributions to pay for the applicable level of coverage, without regard to the balance in his/her account.

(c) Continuing Coverage. A Participant on FMLA Leave or State PFL who wishes to continue participation in the Plan during FMLA Leave or State PFL may pay the premiums on an after-tax basis during the leave (*i.e.,* pay as you go). Failure to pay such premiums will result in the discontinuance of coverage under the Plan during the Leave period. With respect to the Health Care FSA and the Limited Purpose FSA, the previous sentence will not apply to any amounts carried over from the prior Plan Year under Section 5.05 that have not yet been used in the current Plan Year. Such carry over amounts are available during the Leave period regardless of whether the Participant elects to continue participation in the Health Care FSA Benefit Option or Limited Purpose FSA Benefit Option during the Leave period.

(d) FMLA Generally. It is the responsibility of the Employer to determine if it is bound by FMLA and, if so, to ensure the requirements are met in accordance with the rights and provisions described by law.

7.09 Change in Election During Last Two Month of Plan Year. Notwithstanding anything to the contrary in this Article VII, during the last two months of a Plan Year, a Participant may not change his or her election with respect to the Health Care FSA, Limited Purpose FSA or Dependent Care FSA for the remainder of the Plan Year.

## ARTICLE VIII
HEALTH SAVINGS ACCOUNT

8.01 HSA Benefits. An HSA-Eligible Individual can elect to participate in the HSA by electing to salary reduce on a pre-tax basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian with which the Employer has entered into an agreement to forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Plan). As described in Article VII, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

8.02 Contributions for Cost of Coverage for HSA; Maximum Limits. The annual Contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant, but in no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High-Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the Contribution is made ($4,300 for single and $8,550 for family are the statutory maximum amounts for 2025). An additional catch-up Contribution of $1,000 may be made for Participants who are age 55 or older. In addition, the maximum annual Contribution shall be:

(a) reduced by any matching (or other) Employer Contribution made on the Participant's behalf (there are currently no such Employer Contributions other than pre-tax salary reductions made under the Plan), or such amount that the employer contributes pursuant to a company-sponsored wellness program;

(b) prorated for the number of months in which the Participant is an HSA-Eligible Individual; and

(c) divided equally among the pay periods in the year, without exception.

8.03 Recording Contributions for HSA. As described in Section 8.05, the HSA is not an employer-sponsored employee benefit plan—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Participant, not by the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Participant makes via Election and Pay Reduction Arrangement —such a list is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to track HSA Contributions a Participant makes pursuant to the Election and Pay Reduction Arrangement, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

8.04 Tax Treatment of HSA Contributions and Distributions. The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code section 223.

8.05 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan. HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA pursuant to the Election and Pay Reduction Arrangement. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan. The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement

of "qualified eligible medical expenses" as set forth in Code section 223(d)(2). The Employer has no authority or control over the funds deposited in an HSA. Even though this Plan may allow contributions to an HSA through salary reductions, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

## ARTICLE IX
## CONTRIBUTIONS

9.01 Funding Arrangement. The Employer may, in its discretion, credit an amount under the Plan each Plan Year to be allocated toward the cost of a Participant's elected benefits under his Election and Pay Reduction Arrangement. This credited amount, referred to in the Plan for ease of expression as an "employer contribution," will be paid from the Employer's general assets. Before the beginning of each Plan Year, the Employer will determine the annual employer contribution, if any, and the costs for benefit coverage under the Benefit Options and communicate this information to Eligible Employees.

9.02 Participant Contribution. If, after allocation of any employer contribution for the Plan Year, a Participant's elected benefits under his Election and Pay Reduction Arrangement would not fully be paid, the Participant's pay shall be reduced for each applicable payroll period on a pre-tax basis in accordance with his Election and Pay Reduction Arrangement by the amount of the applicable Participant cost.

## ARTICLE X
## NONDISCRIMINATION

10.01 Highly Compensated Individuals. This Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate, or as to contributions and benefits, in compliance with the requirements of Code section 125(b)(1).

10.02 Key Employees. Payments made under the Plan for or on behalf of Key Employees of the Employer shall not exceed 25-percent of the aggregate of the payments made for or on behalf of all Employees under the Plan, in compliance with the requirements of Code section 125(b)(2).

10.03 Dependent Care FSA Benefit Option. With respect to the Dependent Care FSA Benefit Option, the average benefits provided to employees who are not Highly Compensated Employees shall be at least 55-percent of the average benefits provided to Highly Compensated Employees in compliance with the requirements of Code section 129(d)(8), and the Dependent Care FSA Benefit Option shall not discriminate in favor of Highly Compensated Employees as to eligibility in compliance with Code section 129(d)(3) or as to contributions or benefits in compliance with Code section 129(d)(2).

10.04 Health Care FSA. With respect to the Health Care FSA, the Plan shall not discriminate in favor of Highly Compensated Individuals as to eligibility to participate, or as to contributions and benefits, in compliance with the requirements of Code section 105(h).

10.05 Modification of Election. The Employer shall send a notice to any Participants whose benefits under the Plan would cause the Plan to violate the requirements of this Article X and indicate the salary reduction amount that, if elected by the Participant, would allow the Plan to qualify under the Code by the end of the Plan Year. The Participant so notified under this Article X will then have 30 days to enter into a modified Election and Pay Reduction

Arrangement, valid for the remainder of the Plan Year, electing no more than that salary reduction amount. In the absence of a modification, the Participant's participation in the Plan for the Plan Year will be entirely terminated.

## ARTICLE XI
BENEFIT CLAIMS AND OTHER PAYMENT PROVISIONS

11.01 Claims Procedures

(a) Generally. A Participant who has entered into an Election and Pay Reduction Arrangement for a Plan Year may pay for Qualifying Dependent Care Expenses or Qualifying Medical Expenses with his or her own funds and request reimbursement from the Plan in accordance with the procedures described in Section 11.01(b).

(b) Filing a Claim for Reimbursement. A Participant (or an authorized representative) who has entered into an Election and Pay Reduction Arrangement for a Plan Year may request reimbursement of Qualifying Medical Expenses and/or Qualifying Dependent Care Expenses that are reimbursable under Article V and/or VI, respectively, by submitting the request in writing, to the Employer's designated claims administrator ("Claims Administrator") in such form as the Claims Administrator may prescribe, setting forth:

(1) the amount, date, and nature of the expense with respect to which a benefit is requested;

(2) the name of the person to which the expense was/is to be paid; and

(3) such other information the Claims Administrator may require.

Such request for Qualifying Medical Expenses, or Qualifying Dependent Care Expenses, must be submitted no later than March 31st of the year following the Plan Year in which the expenses are incurred and must be accompanied by bills, invoices, receipts, or other statements showing the amounts of such expenses from the provider, together with any additional documentation that the Claims Administrator may request.

(c) Reimbursement or Payment of Claims. The Claims Administrator will cause the Participant to be reimbursed for Qualifying Medical Expenses and/or Qualifying

Dependent Care Expenses for which the Participant submits documentation in accordance with Section 11.01(b) and that are reimbursable under Articles V or VI, respectively.

(1) Health Care FSA. With respect to the Health Care FSA, the total amount elected by the Participant for the Plan Year is, at all times, available for reimbursement without regard to whether the claims exceed the balance of the Participant's Health Care FSA for the Plan Year at the time of the reimbursement.

(2) Dependent Care FSA. With respect to the Dependent Care FSA, no reimbursement or payment under this Section 11.01(c) may at any time exceed the balance of the Participant's Dependent Care FSA for the Plan Year at the time of the reimbursement or payment. Any Qualifying Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence will be reimbursed or paid if and when the balance in such Dependent Care FSA for the Plan Year equals the amount of such expenses.

(d) Denial of Health Care FSA or Dependent Care FSA Claims. If a claim under the Health Care FSA and/or Dependent Care FSA is denied in whole or in part, the Claims Administrator will notify the claimant of the decision by written notice, in a manner calculated to be understood by the claimant.

(1) Timing of Notice. When a Participant's claim for reimbursement of Qualified Medical Expenses and/or Qualified Dependent Care Expenses is denied, a notice will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days, and a notice will be sent indicating the circumstances requiring

the extension and the date by which the Plan expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and the Participant will be given at least 45 days to submit the information. The Claims Administrator then will make its determination within 15 days from the date the Plan receives the additional information, or, if earlier, the deadline to submit the additional information.

(2) Content of Notice. The notice will set forth:

(A) the specific reasons for the denial of the claim;

(B) a reference to specific provisions of the Plan on which the denial is based;

(C) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

(D) an explanation of the procedure for review of the denied or partially denied claim, including the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;

(E) a disclosure of any internal rule, guideline, or protocol relied on in making the adverse determination (or statement that such information is available free of charge upon request); and

(F) if the denial is based on a medical necessity or experimental treatment or similar limit, an explanation of

the scientific or clinical judgment for the determination (or statement that such information will be provided free of charge upon request).

(e) Request for Appeal of Denial of Health Care FSA and/or Dependent Care FSA Claim. Upon denial of a claim in whole or in part, a claimant (or his authorized representative) has the right to submit a written request to the Claims Administrator, and upon request and free of charge, the right to reasonable access and copies of all documents, records, and other information relevant to the claimant's claim for benefits and may submit issues and comments in writing.

(1) Scope of Appeal. The appeal takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(2) Timing of Request for Appeal. A request for appeal must be submitted within 180 days of receipt by the claimant of written notice of the denial of the claim. If the claimant fails to file a request for appeal within 180 days of the denial notification, the claim is deemed abandoned and the claimant precluded from reasserting it.

(3) Contents of Request for Appeal. A request must include a description of the issues and evidence the claimant deems relevant. Failure to raise issues or present evidence on review will preclude those issues or evidence from being presented in any subsequent proceeding or judicial review of the claim.

(f) Request for Second Appeal of Denial of Health Care FSA and/or Dependent Care FSA Claim. Upon the Claims Administrator upholding a denial of a claim in whole or in part, a claimant (or his authorized representative) has the right to submit a written request to the Claims Administrator for a second-level appeal of the denied claim, and upon request and free of charge, the right to reasonable access and copies of all documents, records, and other information relevant to the claimant's claim for benefits and may submit issues and comments in writing.

(1) Scope of Appeal. The appeal will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(2) Timing of Request for Appeal. A request for appeal must be submitted within 180 days of receipt by the claimant of written notice of the denial of the claim. If the claimant fails to file a request for appeal within 180 days of the denial notification, the claim is deemed abandoned and the claimant precluded from reasserting it.

(3) Contents of Request for Appeal. A request must include a description of the issues and evidence the claimant deems relevant. Failure to raise issues or present evidence on review will preclude those issues or evidence from being presented in any subsequent proceeding or judicial review of the claim.

(g) Denial Upon First or Second Appeal of Health Care FSA or Dependent Care FSA Claim.

(1) Timing of Denial Notice. The Claims Administrator must render a decision on the appeal of the claim no more than 60 days after the Claims Administrator's receipt of the request for appeal.

(2) Contents of Denial. If the Claims Administrator issues an adverse determination, it will provide a written decision setting forth:

(A) the specific reason or reasons for the denial of the claim;

(B) a reference to specific Plan provisions on which the adverse determination was made;

(C) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(D) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring an action under ERISA section 502(a);

(E) a disclosure of any internal rule, guideline, or protocol relied on in making the adverse determination (or statement that such information is available free of charge upon request); and

(F) if the denial is based on a medical necessity or experimental treatment or similar limit, an explanation of

the scientific or clinical judgment for the determination (or statement that such information will be provided free of charge upon request).

(3) Authority of the Claims Administrator. To the extent of its responsibility to review the denial of benefit claims, the Claims Administrator has full authority to interpret and apply in its discretion the provisions of the Plan. The decision of the Claims Administrator is final and binding upon any and all claimants and any person making a claim through or under them. Benefits will be paid only if the Claims Administrator decides in its discretion that the claimant is entitled to them.

(h) Limits on Right to Judicial Review. A claimant must follow the claims procedures described by this Section 11.01 before taking action in any other forum regarding a claim for benefits under the Plan. Any suit or legal action initiated by a claimant under the Plan must be brought by the claimant no later than two years following a final decision on the claim for benefits under these claims procedures. The two year statute of limitations on suits for benefits applies in any forum where a claimant initiates such suit or legal action. If a civil action is not filed within this period, the claimant's benefit claim is deemed permanently waived and abandoned.

11.02 Payments to Minors and Incompetents.

(a) Minors. If proof of legal guardianship satisfactory to the Plan Administrator is provided, payments owing to a minor may be made to the minor's legal guardian.

(b) Incompetents. If the Employer is served with an order of a court of competent jurisdiction that declares that a person entitled to benefits under the terms of the Plan

is unable for any reason (including, but not limited to, illness, infirmity, or mental incapacity) to attend to her affairs, the Employer shall comply with such order. The Plan Administrator shall have no duty to investigate whether or not an individual is competent.

11.03 Discharge of Obligation; Receipt and Release. All payments from the Plan constitute a complete discharge of all obligations of the Plan and the Employer to the extent of the portion of the Account paid. The Employer may require the payee, as a condition precedent to any payment, to execute a receipt and release.

11.04 Nonalienation. No benefit payable under the Plan may be subject in any manner to anticipation, sale, transfer, assignment, pledge, encumbrance, security interest or charge, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or grant a security interest in the same is void and of no effect; nor may any such benefit be in any manner considered liable for or subject to the debts, contracts, liabilities, engagements or torts of the person entitled to such benefit.

11.05 Withholding Taxes. The Employer may make any appropriate arrangements to deduct from all amounts paid under the Plan any taxes required to be withheld by any government or government agency. The Participant bears responsibility for all taxes on amounts paid under the Plan to the extent that no taxes are withheld, irrespective of whether withholding is required.

11.06 Missing Persons. If the Employer cannot locate a Participant, after making a reasonably diligent effort, including by giving written notice addressed to the Participant's last known address as shown by the records of the Employer, the amount payable to the Participant is forfeited. If the Participant subsequently applies for benefits, the amount so forfeited will be paid to the Participant.

11.07 Clerical Errors or Omissions. Clerical errors or omissions in information provided to a Participant do not deprive a Participant of his right to receive a benefit, and do not affect the amount of his benefit. Conversely, clerical errors or omissions do not cause a Participant to have the right to receive a benefit to which he is not entitled and a Participant receiving an overpayment by mistake must repay the overpayment, if requested to do so. The Employer reserves the right to correct any mistake in any reasonable manner, including but not limited to, adjusting the amount of future benefit payments, repaying to the Plan any overpayment, or making catch-up payments to a Participant for an underpayment. The failure to enforce any provision of the Plan does not affect the Plan's right thereafter to enforce such provision, nor does such failure affect its right to enforce any other Plan provision.

## ARTICLE XII
PLAN ADMINISTRATION

12.01 Plan Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

(b) To interpret the Plan, its interpretation thereof in good faith to be final and conclusive on all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan, or to change elections under the Plan;

(d) To appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan. Any such allocation, delegation, or designation shall be in writing.

12.02 Reliance on Tables and other Materials. In administering the Plan, the Plan Administrator will be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the

instructions of, the administrators of the policy or plan options under the Plan, or by accountants, counsel, or other experts employed or engaged by the Plan Administrator.

12.03 Plan Interpretation.

(a) Applicable Law. The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA and the Code to the extent applicable, and to the extent not preempted by ERISA, according to applicable state law. The Plan may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

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

(c) Gender and Number. In order to shorten and to improve the readability of the Plan document, phrases such as "his or her," "he or she," and "Employee or Employees," are used sparingly. Except where otherwise indicated by the context, any gender may be construed to include all genders and the singular or plural may be construed to include the plural or singular, respectively.

(d) Other Interpretive Principles. When a reference is made in the Plan to Articles, Sections, or Appendices, such reference is to an Article or Section of or Appendix to this Plan unless otherwise indicated. The table of contents and headings contained in the Plan are for reference purposes only and shall not affect the meaning or interpretation of the Plan.

12.04 Required Information.

(a) A Participant must furnish the Plan Administrator with such information or proof as requested.

(b) The Plan Administrator may rely on any information furnished by a Participant.

(c) If a person claiming benefits under the Plan makes a false statement that is material to the person's claim for benefits, the Plan Administrator may adjust the benefits payable to the person or require that the payments be returned to the Plan, or take any other reasonable action.

(d) Failure on the part of a Participant to comply with a request by the Plan Administrator for information or proof within a reasonable period of time is sufficient grounds for delay in the payment of any benefits that may be due under the Plan until information or proof is received.

12.05 HIPAA Compliance. The Health Care FSA is subject to the HIPAA Compliance provisions set forth in this Section 12.05.

(a) Permitted Uses and Disclosures of Protected Health Information by the Employer. The Health Care FSA only may disclose protected health information to the Employer, to enable the Employer to carry out plan administration functions or as otherwise permitted by the Standards for Privacy of Individually Identifiable Health Information ("HIPAA Privacy Rule"). Only persons involved with plan administration functions may have access to any information disclosed under this Section 12.05. If the persons to whom information is disclosed violate this Section 12.05, or applicable law, the Health Care FSA shall cease disclosing such information.

(b) Definitions. Unless otherwise indicated, any definitions under this Article shall have the meaning given them under the HIPAA Privacy Rule.

(c) Certification. The Health Care FSA only will disclose information to the Employer under this Section 12.05 upon a certification by the Employer of the following:

(1) Further Disclosure. The Employer agrees not to use or further disclose the information obtained under this Section 12.05 other than as permitted or required by this document, or as required by law.

(2) Agents. The Employer will require that any agents, including any subcontractors, to whom it provides protected health information received under this Section 12.05 agree to the same restrictions and conditions that apply to the Employer with respect to such information.

(3) Employment Actions. The Employer agrees not to use or disclose any information received under this Section 12.05 for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Employer.

(4) Duty to Report. The Employer will report any use or disclosure of information that is inconsistent with the uses or disclosures provided for under this Section 12.05 of which it becomes aware.

(5) Access. The Employer will make available any information it holds under this Section 12.05 in order for the Health Care FSA to comply with the access requirements under the HIPAA Privacy Rule.

(6) Amendment. The Employer will make available any information it holds under this Section 12.05 in order for the Health Care FSA to comply with the amendment requirements under the HIPAA Privacy Rule, and

will incorporate any amendments to Protected Health Information it holds, as required under the HIPAA Privacy Rule.

(7) Accounting. The Employer agrees to document and provide a description of any disclosures of protected health information, and information related to such disclosures, as would be required for the Health Care FSA to respond to a request by an individual for an accounting of disclosures of protected health information in accordance with the HIPAA Privacy Rule.

(8) Internal Books. The Employer agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Health Care FSA available to the Secretary of Health and Human Services, for purposes of the Secretary determining the Health Care FSA's compliance with the HIPAA Privacy Rule.

(9) Return of Information. The Employer will, if feasible, return or destroy all protected health information received from the Health Care FSA that the Employer maintains in any form, and retain no copies of such information, when it is no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further uses or disclosures of the information to those purposes that make the return or destruction of the information infeasible.

(10) Adequate Separation. The Employer will establish adequate separation between the Employer and the Health Care FSA, as required under the HIPAA Privacy Rule. The Employer will limit access to protected health information to those employees or classes of employees entitled to use or

disclose such information and will require that these employees only may use or disclose such information for plan administration functions.

(11) Noncompliance. The Employer will resolve issues of noncompliance with the terms of this Section 12.05 by persons entitled to use or disclose protected health information in a timely manner.

(d) HIPAA Security Standards.

(1) Safeguards. The Employer will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, as defined in the HIPAA Security Standards, 45 CFR Parts 160, 162 and 164, that it creates, receives, maintains, or transmits on behalf of the Health Care FSA, as required in the HIPAA Security Standards.

(2) Agents. The Employer will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

(3) Security Incidents. The Employer will report to the Health Care FSA any security incident under the HIPAA Security Standards of which it becomes aware.

(4) Adequate Separation. The Employer will establish reasonable and appropriate security measures to ensure adequate separation between the Health Care FSA and the Employer, in support of the requirements described in this Article.

12.06 Agent for Service of Legal Process. The name and address of the person designated as agent for the service of legal process with respect to this Plan shall be:

Executive Vice President, Chief People Officer
American Airlines, Inc.

Mailing address:
Mail Drop 8A204
P.O. Box 619616
DFW Airport, TX 75261-9616

Express Delivery address:
1 Skyview Drive
Mail Drop 8A204
Fort Worth, Texas 76155

Service of process may also be made upon the Plan Administrator.

## ARTICLE XIII
PLAN AMENDMENT OR TERMINATION

13.01 Amendment.

(a) Amendment by the Company. Subject to Section 13.01(b), the Company has the right to amend or modify the Plan in whole or in part, prospectively or retroactively, at any time and for any reason by adopting a written amendment.

(b) Limits on Right to Amend. A purported amendment to the Plan is not effective to the extent it deprives a Participant of a right to receive benefits to which he has already become entitled, except as permitted by applicable law.

13.02 Termination of Plan. The Company reserves the sole and exclusive right at any time to terminate the Plan by written action.

*  *  *  *  *

Executed this 23rd day of _____December, 2024.

**AMERICAN AIRLINES, INC.**

By: _____

L. Mecole Brown
Executive Vice President, Chief People Officer