

**SUMMARY PLAN DESCRIPTION**

**FOR THE**

**AMERICAN AIRLINES, INC.**

**VOLUNTARY EARLY OUT PROGRAM**

**AND**

**RETIREMENT HEALTH REIMBURSEMENT**

**ARRANGEMENT**

**EFFECTIVE SEPTEMBER 1, 2020**

**TABLE OF CONTENTS**

**ARTICLE I INTRODUCTION ..... 1**

**ARTICLE II ADMINISTRATIVE INFORMATION..... 2**

**ARTICLE III DEFINITIONS..... 4**

    3.1   **Cardholder Agreement** ..... 4

    3.2   **Claims Administrator** ..... 4

    3.3   **COBRA** ..... 4

    3.4   **Code** ..... 4

    3.5   **Company** ..... 4

    3.6   **Dependent Child** ..... 4

    3.7   **Disabled Dependent Child** ..... 5

    3.8   **Effective Date** ..... 6

    3.9   **Eligible Dependent** ..... 6

    3.10   **Eligible Retiree** ..... 6

    3.11   **Employee** ..... 6

    3.12   **Employer** ..... 7

    3.13   **ERISA**..... 7

    3.14   **Fiduciary** ..... 7

    3.15   **HIPAA** ..... 7

    3.16   **Incurred**..... 7

    3.17   **Maximum Contribution Amount**..... 7

    3.18   **Medical Expense** ..... 7

    3.19   **Named Fiduciary** ..... 7

    3.20   **Participant**..... 7

    3.21   **RHRA Plan** ..... 7

    3.22   **RHRA Account**..... 7

    3.23   **Spouse**..... 8

    3.24   **VEOP** ..... 8

    3.25   **VEOP Plan** ..... 8

**ARTICLE IV ELIGIBILITY AND COVERAGE ..... 9**

    4.1   Eligible Retiree..... 9

    4.2   Coverage..... 9

    4.3   Eligible Dependents ..... 9

    4.4   Qualified Medical Child Support Order ..... 9

**ARTICLE V BENEFITS ..... 10**

    5.1   Credits to the RHRA Account ..... 10

    5.2   Reimbursements Under the Plan. .... 10

    5.3   Coordination of Benefits Under the RHRA Plan ..... 12

    5.4   Repayment of Excess Reimbursements. .... 13

    5.5   Death of Retiree and Eligible Dependents of Deceased Retirees ..... 13

    5.6   Advance Premium Tax Credit Implications..... 14

<b>ARTICLE VI CLAIMS PROCEDURES.....</b>	<b>15</b>
6.1 Submission of Claims.....	15
6.2 Substantiation of Expenses.....	16
6.3 Initial Claims Decision.....	16
6.4 Appealing a Denied Claim .....	17
<b>ARTICLE VII PLAN ADMINISTRATION .....</b>	<b>21</b>
7.1 Amendment or Termination .....	21
7.2 Plan Expenses.....	21
7.3 Named Fiduciaries.....	21
7.4 Fiduciary Duties .....	21
7.5 Fiduciary Liability.....	21
7.6 Indemnity for Liability .....	22
7.7 Indemnification of Company.....	22
7.8 Code and ERISA Compliance.....	22
7.9 Applicable Laws .....	23
7.10 Effect of Mistake .....	23
7.11 Headings .....	23
<b>ARTICLE VIII STATEMENT OF ERISA RIGHTS.....</b>	<b>24</b>
<b>ARTICLE IX HIPAA PRIVACY AND SECURITY.....</b>	<b>26</b>
9.1 Permitted Uses and Disclosures of PHI by the Employer.....	26
9.2 Definitions .....	26
9.3 Certification.....	26
9.4 HIPAA Security Standards.....	28
<b>ARTICLE X COBRA .....</b>	<b>29</b>
10.1 COBRA Generally .....	29
10.2 Continuation of Coverage .....	29
10.3 Paying for COBRA .....	30
10.4 Electing COBRA.....	30
10.5 When COBRA Ends.....	30
10.6 Conversion Rights.....	31

**ARTICLE I**  
**INTRODUCTION**

This document is a Summary Plan Description (“SPD”) describing the American Airlines, Inc. Voluntary Early Out Program and Retirement Health Reimbursement Arrangement (“VEOP Plan”) provided by American Airlines, Inc. (the “Company”). The VEOP Plan is a component of the American Airlines, Inc. Retiree Health Reimbursement Arrangement Plan (the “RHRA Plan”), which is intended to qualify as a health reimbursement arrangement (“HRA”) within the meaning of Notice 2002-45 and an accident and health plan under Internal Revenue Code sections 105 and 106.

The information in this SPD is only a summary, and it does not contain all of the details included in the written RHRA Plan document. If there is a conflict between a specific provision in the RHRA Plan document and this SPD, then the RHRA Plan document controls. This SPD is intended to comply with the Summary Plan Description requirements under the Employee Retirement Income Security Act (“ERISA”) section 102, and implementing regulations under 29 C.F.R. section 2520.102-3. This SPD does not create a contractual right to employment or continued employment by American Airlines, Inc. or create other legal or equitable rights not specifically set out in this SPD.

American Airlines, Inc. expects to continue the VEOP Plan but, subject to the terms of any applicable collectively bargained agreement, reserves the right to amend or terminate it at any time and for any reason without the consent of and without prior notice to any Participant or Eligible Dependent.

**ARTICLE II**  
**ADMINISTRATIVE INFORMATION**

**Plan Name** American Airlines, Inc. Voluntary Early Out Program and Retirement Health Reimbursement Arrangement (“VEOP Plan”), which is a component of the American Airlines, Inc. Retiree Health Reimbursement Arrangement Plan (the “RHRA Plan”)

**Type of Plan** The VEOP Plan is a Welfare Benefit Plan (Group Health Plan) as defined by ERISA. This VEOP Plan is intended to qualify as an employer-provided medical reimbursement plan under Code Sections 105 and 106 and the regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45.

**The Plan Sponsor** American Airlines, Inc., or its authorized delegate

Mailing address:  
Mail Drop 8A203  
P.O. Box 619616  
DFW Airport, TX 75261-9616  
General Phone: 1-800-354-3412

Street address (do not mail to this address):  
1 Skyview Drive  
Fort Worth, Texas 76155

**Employer ID (EIN)** 13-1502798

**Plan Administrator** American Airlines, Inc.

**The Agent for Service of Legal Process** Managing Director of Retirement and Benefits  
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, TX 76155

<b>Plan Number</b>	525
<b>Plan Year</b>	Each Plan Year lasts for 12 months from January 1 to December 31.
<b>Type of Funding</b>	Benefits under the VEOP Plan are funded exclusively by Company contributions and paid from the Company's general assets. Nothing herein will be construed to require the Company to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Company from which any payment under this VEOP Plan may be made. There is no trust or other fund from which Benefits are paid.
<b>Type of Administration</b>	American Airlines, Inc. has delegated certain administrative functions to Fidelity Investments ("Claims Administrator"), including answering questions about eligibility on behalf of American Airlines, Inc. They can be reached at: 1-800-354-3412.

### ARTICLE III DEFINITIONS

In this document, there are some words and phrases that have specific meanings within the context of the VEOP Plan. To help the reader understand these words, they are defined here and capitalized in this document.

3.1 **Cardholder Agreement** means the agreement that governs the use of an electronic payment card.

3.2 **Claims Administrator** means Fidelity Investments.

3.3 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

3.4 **Code** means the Internal Revenue Code of 1986, as amended.

3.5 **Company** means American Airlines, Inc.

3.6 **Dependent Child** when child or dependent child is used throughout this document, it includes all of the following:

- Natural child;
- Legally adopted child;
- Natural or legally adopted child of a covered Spouse;
- Stepchild;
- Special Dependent, if all of the following requirements are met:
  - You or your Spouse must have legal custody or legal guardianship of the child. (It is not necessary for your Spouse to be covered under the Plan in order for a child for whom your Spouse has legal custody or legal guardianship to be eligible).
  - The child must maintain legal residence with you and be wholly dependent on you for maintenance and support.
  - You must submit a Statement of Dependent Eligibility for Special Dependent Form to American Airlines Benefits Service Center and American Airlines Benefits Service Center must approve the form. (Complete and return the form to American Airlines Benefits Service Center, along with copies of the official court documents awarding you custodianship or guardianship of the child.) You must receive confirmation from American Airlines Benefits Service Center notifying you of its determination.

- American Airlines Benefits Service Center will send you a letter notifying you of its findings. If your request is approved, the notification letter will include an approval date. If you submit your request within 60 days of the date that legal guardianship or legal custodianship is awarded by the court, coverage for the child is effective as of that date, pending approval by American Airlines Benefits Service Center. If you submit the request after the 60-day time frame, the child will not be added to your coverage.
- QMCSO Dependent: A child for whom you are required to provide coverage under a Qualified Medical Child Support Order (“QMCSO”) that is issued by the court or a state agency.

The term Child does not include any person who:

- Is in the military of any country or subdivision of any country; or
- Is covered under an employer group plan as an employee.

3.7 **Disabled Dependent Child** means a child age 26 or older who meets all of the following criteria:

- The Child is mentally or physically incapable of self-support and was deemed mentally or physically incapable of self-support prior to turning age 26.
- You complete and return the Statement of Dependent Eligibility Beyond Limiting Age Due to Mental or Physical Disability to the American Airlines Benefits Service Center prior to the date coverage would otherwise end, or if the child is not in coverage within 31 days of your qualifying Life Event (such as marriage or loss of coverage).
- The American Airlines Benefits Service Center will review your request for administrative eligibility, then forward your request to your Claims Administrator for medical review of the application for approval.
- The Child continues to meet the criteria for dependent coverage under this Plan, other than being 26.
- You provide additional medical proof of disability as may be required from time- to-time when requested. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if your Claims Administrator determines the Child is no longer disabled. If you elect to drop coverage for your Child, you may later reinstate it if requested within 60 days of your qualifying life event (such as loss of coverage).

- Either the Child maintains legal residence with you and is wholly dependent on you for maintenance and support, or you are required to provide coverage under a Qualified Medical Child Support Order (“QMCSO”) that is issued by the court or a state agency.
- You, while an employee or as the retiree, are required to take to these steps to request disability status for your dependent Child.

3.8 **Effective Date** means September 1, 2020.

3.9 **Eligible Dependent** means any individual who is related to you (the retiree) in one of the following ways:

- Spouse as defined in Section 3.23;
- Dependent Child as defined in Section 3.6 until the end of the month in which they turn 26; or
- Disabled Dependent Child age 26 or over, as defined in Section 3.7.

3.10 **Eligible Retiree** means an individual described in Section 4.1.

3.11 **Employee** means any person treated by the Employer as providing services to such Employer as a domestically based common law employee, whether the Employee is full-time, part-time, or on a Leave of Absence. “Employee” does not include:

- (1) any individual who performs services for the Employer pursuant to a leasing agreement between the Employer and a third-party, as defined in section 414(n) of the Internal Revenue Code, regardless of whether such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of the Employer;
- (2) any individual who is a temporary Employee, a provisional Employee, or an associate Employee, regardless of whether such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of the Employer; and
- (3) any individual who performs services for the Employer and is working in a classification described as independent contractor, is paid directly or indirectly through the Employer's accounts payable systems, or performs such services pursuant to a contract or agreement which provides that the individual is an independent contractor or consultant,

regardless of whether any such individual is later determined by a court or any governmental or administrative agency to be, or to have been, a common law employee of the Employer.

- 3.12 **Employer** means American Airlines, Inc. and any or any successor entity by merger, consolidation, purchase or otherwise.
- 3.13 **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.
- 3.14 **Fiduciary** means a person who has discretionary authority over the administration of the Plan within the meaning of ERISA section 3(21).
- 3.15 **HIPAA** means Health Insurance Portability and Accountability Act of 1996, as amended.
- 3.16 **Incurred** means the date the service, care or product giving rise to an expense has been furnished without regard to the date when you are formally billed for, are charged with, or pay for the service, care or product.
- 3.17 **Maximum Contribution Amount** means an amount the Company credits to the RHRA Account on your behalf under this Plan.
- 3.18 **Medical Expense** means medical care expenses as defined under Code section 213(d) that are Incurred by you or your Eligible Dependents as described under 5.2(c).
- 3.19 **Named Fiduciary** means a named fiduciary within the meaning of ERISA section 402(a)(2) and listed in Section 7.3.
- 3.20 **Participant** means an Eligible Retiree or Eligible Dependent who is participating in this Plan.
- 3.21 **RHRA Plan** means the American Airlines, Inc. Retiree Health Reimbursement Arrangement Plan of which this Plan is a component.
- 3.22 **RHRA Account** means a bookkeeping account established by the Company on your behalf to which the Company credits the Maximum Contribution

Amount, which is available to you for reimbursement for Medical Expenses Incurred by you and your Eligible Dependents.

3.23 **Spouse** means either a Spouse or Common Law Spouse, as defined below:

**Spouse:** Your Spouse means an individual who is lawfully married to the employee and not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.

**Common Law Spouse:** Common Law Spouses are eligible for enrollment in Plan benefits only if the common law marriage is recognized and deemed (certified) legal by the individual state where the employee resides, and only if the employee and spouse have fulfilled the state's requirements for common law marriage. To enroll your Common Law Spouse for benefits, you must complete and return a Common Law Marriage Recognition Request and provide proof of common law marriage, as specified on the form.

3.24 **VEOP** means the 2020 American Airlines, Inc. Voluntary Early Out Program.

3.25 **VEOP Plan** means the American Airlines, Inc. Voluntary Early Out Program and Retirement Health Reimbursement Arrangement as described herein and as amended from time to time.

**ARTICLE IV**  
**ELIGIBILITY AND COVERAGE**

- 4.1 Eligible Retiree You are an Eligible Retiree if, on the date you terminate employment with the Company, you satisfy all of the following:
- (a) You are an Employee in a workgroup for which the Company granted VEOP eligibility;
  - (b) You satisfy the following guidelines of the 65-point plan:
    - (i) You have at least ten years of company service, and
    - (ii) Your age combined with years of company service equal at least 65; and
  - (c) You elected to retire under the VEOP granted by the Company.
- 4.2 Coverage Coverage under this VEOP Plan shall begin on the effective date of your 65-point retirement.
- 4.3 Eligible Dependents Any individual who satisfies the definition of an “Eligible Dependent” in section 3.8 of the VEOP Plan is an Eligible Dependent. The term includes your Dependent Child and your Spouse. You are responsible for timely informing the Plan Administrator of any newly Eligible Dependents.
- If you marry after retirement, you may cover a new Spouse. If your Spouse remarries after you die, any subsequent Spouse of your Surviving Spouse cannot be a dependent.
- The Company reserves the right to request documented proof of dependent eligibility for benefits at any time.
- 4.4 Qualified Medical Child Support Order A Qualified Medical Child Support Order (“QMCSO”) is a type of order that is issued: (i) by a court of competent jurisdiction, or (ii) through an administrative process established under state law and which has the force and effect of law under applicable state law. The order is usually issued as part of a settlement agreement or divorce decree that provides for child support or health care coverage for

your child. The Plan Administrator will establish requirements for honoring a QMCSO.

**ARTICLE V**  
**BENEFITS**

5.1 Credits to the RHRA Account. The Employer shall allocate a notional credit to your RHRA Account if you elect to participate in the VEOP Plan. The notional credit is a one-time credit to your RHRA with the Maximum Contribution Amount. The Maximum Contribution Amount is based upon the number of years until you are eligible for Medicare, measured from the date participation in the VEOP Plan begins (as described in Section 4.2), as follows:

Number of years until you are Medicare-eligible (measured from date participation in Plan begins)	Maximum Contribution Amount
More than 4 years	\$150,000
More than 3 years but less than or equal to 4 years	\$140,000
More than 2 years but less than or equal to 3 years	\$130,000
More than 1 year but less than or equal to 2 years	\$120,000
Less than or equal to 1 year	\$110,000
Eligible for Medicare	\$100,000

5.2 Reimbursements Under the Plan.

- (a) All reimbursements for Incurred Medical Expenses under the VEOP Plan shall be made solely with Employer contributions and not provided pursuant to a salary reduction election or otherwise under a Code section 125 plan.
- (b) Reimbursements shall only be made for Medical Expenses Incurred by you or your Eligible Dependent. Each Medical Expense must be substantiated by you or your Eligible Dependent in accordance with Section 6.2.
- (c) Medical Expenses that may be reimbursed under this VEOP Plan include expenses Incurred for the diagnosis, cure, mitigation, treatment, or prevention of any disease, or for the purpose of affecting any structure or function of the body that are not reimbursed through any other plan or source including, but not limited to, the following:
  - (1) Out-of-pocket expenses such as deductibles, co-insurance, or co-pays under another medical, dental or vision plan;

- (2) Prescription drugs;
- (3) Over-the-Counter medicine/drugs used to alleviate or treat personal injuries or sickness of you and/or your Eligible Dependents. For instance, pain reliever, antacid, allergy medicine, cold medicine or insulin;
- (4) Hearing and vision expenses;
- (5) Dental expenses;
- (6) COBRA coverage or premiums for medical care insurance purchased on the healthcare exchange or the individual market;
- (7) If you are enrolled in Medicare, Medicare Part A expenses and premiums for Medicare Part B, Medicare Part D and supplemental plans as well as out-of-pocket medical expenses not covered by Medicare;
- (8) Medical devices or items you may purchase, such as, bandages, crutches and contact lens solution, and the like;
- (9) Menstrual Care Products, as defined in Code section 223(d)(2)(D); and
- (10) Premiums for qualified long-term care insurance under Code section 7702B up to the applicable limitations, which are indexed for inflation by the IRS each year.

Refer to the list of eligible items by visiting the [Fidelity NetBenefits](#) website.

- (d) Some expenses may not be reimbursed through your RHRA Account, including, but not limited to the following:
  - (1) Long-term care facility fees;
  - (2) Non-health insurance premiums (e.g., life insurance, auto insurance, short- or long-term disability coverage);
  - (3) Health club, exercise classes, and social activity fees and memberships (except in rare cases for treatment of medically diagnosed obesity where weight loss is part of the program);
  - (4) Vacation or travel for health reasons;

- (5) Certain other health care items and services such as,
  - (A) Cosmetic medical treatment, surgery, and prescriptions and cosmetic dental procedures, such as cosmetic tooth bonding or whitening;
  - (B) Electrolysis;
  - (C) Massage Therapy;
  - (D) Personal care items including cosmetics and toiletries;
  - (E) Vitamins and nutritional supplements, unless prescribed by a doctor;
  - (F) Weight loss programs (unless for treatment of medically diagnosed obesity);
  - (G) Wheelchair ramps; and
  - (H) Whirlpools.
- (6) A Medical Expense that is:
  - (A) Attributable to a deduction allowed under Code section 213 for any prior taxable year;
  - (B) Incurred before the effective date of this VEOP Plan;
  - (C) Incurred before you are a Participant in this VEOP Plan; or
  - (D) Reimbursed by another health plan.

For a full list of excluded expenses, refer to IRS [Publication 502](#).

- (e) Funds credited to your RHRA Account may continue to be used to reimburse you or your Eligible Dependents for Medical Expenses Incurred until no funds remain credited to your RHRA Account.
- (f) The maximum amount of reimbursement under this VEOP Plan for a Plan Year shall not exceed the amount credited to your RHRA Account.

5.3 Coordination of Benefits Under the RHRA Plan . In the event you are covered under this Plan and a Company-sponsored health flexible spending arrangement (“FSA”) under which you made salary reduction contributions

to the FSA during a Plan Year, in no case may you be reimbursed for the same Medical Expense by both this VEOP Plan and the FSA during such Plan Year. Reimbursements shall first be made from the FSA, and only when the FSA is exhausted shall reimbursements be made under this VEOP Plan.

- 5.4 Repayment of Excess Reimbursements. If it is determined that you have received payments under this VEOP Plan that exceed the amount of Medical Expenses that have been substantiated by you during the Plan Year, the Plan Administrator shall give you prompt written notice of any such excess amount, and you shall repay the amount of such excess to the Company in accordance with procedures established by the Plan Administrator. The Plan Administrator may offset future benefits by an amount equal to the excess reimbursement. If all attempts to recover the excess reimbursement are unsuccessful, the Plan Administrator may direct the Company to include such amounts in your gross income.
- 5.5 Death of Retiree and Eligible Dependents of Deceased Retirees Your RHRA provides survivor benefits that depend on who is covered under the VEOP Plan at the time of your death, as follows:

Coverage for You and . . .	When you die	When Spouse Dies
<i>Your Spouse</i>	<ul style="list-style-type: none"> <li>Your Spouse assumes your RHRA Account and can use it to reimburse expenses for him/herself until it is exhausted.</li> </ul>	When Your Spouse dies, any remaining balance is forfeited.
<i>Your Spouse and Your Dependent Child(ren)</i>	<ul style="list-style-type: none"> <li>Your Spouse assumes your RHRA Account and can use it to reimburse expenses for him/herself and your Dependent Child(ren) until it is exhausted.</li> <li>Your Spouse may not add new dependents.</li> </ul>	Any remaining balance is forfeited (regardless of whether or not any dependent children continue to be eligible).
<i>Your Dependent Child(ren)</i>	<ul style="list-style-type: none"> <li>Any remaining balance is forfeited (regardless of whether or not the dependent continues to be eligible).</li> </ul>	N/A

Any balance remaining in your RHRA Account is forfeited as of the date that no individual (e.g., a surviving Spouse or Dependent Child(ren) provided there is a surviving Spouse) is eligible for reimbursement of Medical Expenses from

your RHRA Account. Forfeitures are treated by the Company in a manner that complies with applicable provisions of ERISA and the Code.

- 5.6 Advance Premium Tax Credit Implications. Because the RHRA is an employer-provided group health plan, you may not be eligible for federal subsidies for coverage in the health insurance marketplace (*i.e.*, the exchange) as long as you have a positive balance in your RHRA Account. You should contact your personal financial or tax advisor if you have questions regarding your qualification for health insurance marketplace coverage and any potential subsidies for such coverage.

**ARTICLE VI**  
**CLAIMS PROCEDURES**

As a Participant in the VEOP Plan, you will automatically be provided with a debit card, which is linked to your RHRA Account. If you already have a Fidelity debit card, your RHRA Account will be linked to that pre-existing card.

Rather than paying a provider upfront and waiting to be reimbursed, you or your Spouse can use the payment card to electronically access funds to pay providers as you would with any other debit card. You should treat it like cash and secure it carefully. The Cardholder Agreement contains terms between you and the card issuer.

In addition, as with other health spending accounts that you may have through the Company, you or your Spouse can access your RHRA Account through [Fidelity NetBenefits](#) via [my.aa.com](#) or the [Retiree Jetnet Site](#). You may also access account information through the Fidelity NetBenefits mobile app.

6.1 Submission of Claims

- (a) You should use the payment card to pay any Medical Expense at any qualified provider as you would with any other debit card. Each time the card is used, funds are automatically deducted from your RHRA Account. If it cannot be clearly determined that the funds were used for Medical Expenses, you will be notified to submit any applicable receipts. It is important that you retain receipts for all payment card purposes. ***Note, you cannot use your Fidelity debit card to pay for medical premiums that you paid for on a pre-tax basis. Please submit a claim for reimbursement for these expenses as described below.***
- (b) If you cannot or choose not to use the payment card for a Medical Expense, you can submit a claim to request reimbursement. You will enter claim information online through [Fidelity NetBenefits](#). Alternatively, you can enter claim information through the Fidelity NetBenefits mobile app.
- (c) Claims Submission Deadline
  - (1) General Rule. You may submit claims for Medical Expenses Incurred up to 365 days after the date of the service. Requests for reimbursement received after that time will not be honored, except as set forth in (2), below.
  - (2) 45-Day Window Period. The Company will waive the General Rule described in (1), above, during a 45-day window period that the Company will establish and announce. During this 45-day window period, you may submit claims for Medical Expenses Incurred at any

time, provided such Medical Expenses were Incurred on or after the Effective Date of the VEOP Plan.

## 6.2 Substantiation of Expenses

- (a) When submitting a claim, you must attach a copy of the original itemized bill or receipt for the Medical Expense. The bill, receipt or other statement from an independent third party should clearly show the person Incurring the Medical Expenses, the nature of the Medical Expenses, the date the Medical Expense was Incurred, the amount of the requested reimbursement and other details that may be requested by the Plan Administrator.
- (b) If you paid for the expense with your Fidelity debit card, you will be required to comply with the same level of substantiation. In the event that additional documentation is needed, a notification and request will be sent to you. You will have 90 days to submit the required documentation. If the additional documentation is not received in the time frame specified or if it is received but it is determined by the Plan Administrator that the charge was not for a Medical Expense, then you will be required to refund the reimbursed amount to the Account. Tax consequences may apply and the Fidelity debit card usage will be suspended. If your card is suspended, you will need to submit paper claims for future requests for reimbursement, and the paper claim requests may be applied to the outstanding payment card transaction.

## 6.3 Initial Claims Decision

- (a) While many claims will be processed sooner than 30 days, the law provides that a 30-day period to process a claim is reasonable. The law also provides that if there are special circumstances, the 30-day period can be extended to 45 days. If an extension of time from 30 days is needed for processing, written notice of the extension will be furnished before the end of the initial 30-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a decision on the claim is expected to be given. If the extension is necessary to request additional information, the extension notice will describe the required information, and you 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. All actions of the Claims Administrator are on behalf of the Employer.
- (b) If a claim is denied in whole or in part, the Claims Administrator will notify you of the decision by written notice, in a manner calculated to be understood by the claimant. The notice will set forth:

- (1) The specific reasons for the denial of the claim;
- (2) A reference to specific provisions of the Plan on which the denial is based;
- (3) A description of any additional material or information to perfect the claim and an explanation of why such material or information is necessary;
- (4) An explanation of the procedure for review of the denied or partially denied claim, including your right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review;
- (5) 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);
- (6) 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); and
- (7) Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits.

The Claims Administrator is also required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale.

#### 6.4 Appealing a Denied Claim

- (a) As a Participant in the VEOP Plan, you have the right to appeal adverse benefit determinations. Adverse benefit determinations are determinations that result in a include denial, withholding and reduction of benefits described in the VEOP Plan, and also include rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).  
The VEOP Plan has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First and Second Level Appeals

involving adverse benefit determinations are conducted by the Claims Administrator.

(b) First Level Appeals to the Claims Administrator.

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the Claims Administrator as described in the following procedures:

- (1) Within 180 days of receipt of a notice of denial on the claim, you or your authorized representative must send a written request for a review of the claim. The request should be sent to the Claims Administrator. You must submit issues and comments in writing. These actions must be taken at your own expense. If you fail to file a request for review within 180 days of the denial notification, the claim is deemed abandoned and you are precluded from reasserting it or filing a Second Level Appeal.
- (2) Within 60 days after the request for review is received, the Claims Administrator will make a decision. The decision on review will be in writing and will include:
  - (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 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 for benefits;
  - (D) 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 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);
- (G) Any conflict of interest, such that decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, shall not be based upon the likelihood that the individual will support the denial of benefits; and
- (H) The Claims Administrator is required to provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with the claim, as well as any new or additional rationale for a denial and a reasonable opportunity for you to respond to such new evidence or rationale.

(b) Second Level Appeals to the Claims Administrator.

Upon the Claims Administrator upholding a denial of a claim in whole or in part, you (or your authorized representative) have the right to submit a Second Level Appeal to the Claims Administrator. You may also upon request, and receive free of charge, reasonable access and copies of all documents, records, and other information relevant to your claim for benefits. You may submit issues and comments in writing.

- (1) The appeal will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- (2) You or your authorized representative has 180 days following the receipt of a notification of an adverse benefit determination on the First Level Appeal within which to file a Second Level Appeal. If you do not file your Second Level Appeal within this time frame, you waive your right to file the Second Level Appeal of the determination.
- (3) A Second Level Appeal must include a description of the issues and relevant evidence. 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.

- (4) The Claims Administrator must render a decision on the Second Level Appeal no more than 60 days after its receipt of the Second Level Appeal.
- (5) If the Claims Administrator denies the Second Level Appeal, 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 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 for benefits;
  - (D) 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 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).

You must use and exhaust VEOP Plans' administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the VEOP Plans' prescribed procedures in a timely manner will also cause you to lose your right to sue under ERISA 502(a) regarding an adverse benefit determination. If you have exhausted your administrative claim and appeal procedures, you may only bring suit in a federal district court if you file your action or suit within two years of the date after the adverse benefit determination is made on final appeal.

The Plan Administrator has the final discretionary authority to make benefit decisions, and its decision will be final and binding.

**ARTICLE VII**  
**PLAN ADMINISTRATION**

- 7.1 Amendment or Termination Although the Company intends to continue this VEOP Plan indefinitely, subject to the terms of any applicable collectively bargained agreement, the Company expressly and specifically reserves the sole and exclusive right to amend or terminate the VEOP Plan. Any amendment or termination will be evidenced by a written instrument duly executed by an officer of the Company.
- 7.2 Plan Expenses.
- (a) All reasonable expenses incurred in administering the VEOP Plan will be paid by the Company. If any expenses are charged to you (for example, the charge associated with requesting a replacement or second electronic payment card), notification will be provided.
  - (b) All forfeitures will be used by the Company to offset any losses it has incurred for benefit payments under the VEOP Plan and/or to reduce costs of administering the VEOP Plan. After this, forfeitures may be used in any manner authorized by relevant law.
- 7.3 Named Fiduciaries The Named Fiduciary of this VEOP Plan is the Company, which may designate other Named Fiduciaries of the VEOP Plan.
- 7.4 Fiduciary Duties Each Fiduciary must discharge its duties with respect to the VEOP Plan:
- (a) Solely in the interest of Participants and for the exclusive purpose of providing benefits to them and defraying reasonable expenses of administering the VEOP Plan;
  - (b) With the care, skill, prudence, and diligence under the circumstances that a prudent person acting in a like capacity and familiar with like matters would use in the conduct of an enterprise of like character and with like aims; and
  - (c) In accordance with the documents and instruments governing the VEOP Plan insofar as the documents and instruments are consistent with the provisions of ERISA.
- 7.5 Fiduciary Liability.
- (a) For Fiduciary's Own Actions. No Fiduciary is liable for its own act, or failure to act, unless the Fiduciary causes actual loss to the VEOP Plan

or to a Participant by failing to properly discharge a fiduciary duty or responsibility expressly imposed upon the Fiduciary by the VEOP Plan or by law.

- (b) For Actions of Other Fiduciaries. No Fiduciary is liable for the act, or failure to act, of another Fiduciary unless the first Fiduciary commits one or more of the following breaches of his/her fiduciary responsibilities:
- (1) If he/she participates knowingly in, or knowingly undertakes to conceal, an act or omission of another Fiduciary, knowing the act or omission is a breach;
  - (2) If, by his/her failure to observe applicable standards in the administration of his/her specific responsibilities which give rise to his/her status as a Fiduciary, he/she enables the other Fiduciary to commit a breach; or
  - (3) If he/she has actual knowledge of a breach by the other Fiduciary, unless he/she makes reasonable efforts under the circumstances to remedy the breach.

#### 7.6 Indemnity for Liability

The Company indemnifies each Employee, officer, and director of the Company, and all persons formerly serving in this capacity, acting on behalf of the VEOP Plan, against any and all liabilities or expenses, including all legal fees relating thereto, arising in connection with the exercise of their duties and responsibilities to the VEOP Plan, provided however that the Company does not indemnify any person for liabilities or expenses covered by insurance nor due to that person's own gross negligence or willful misconduct.

- 7.7 Indemnification of Company If you receive one or more payments or reimbursements under this VEOP Plan on a tax-free basis that do not qualify for tax-free treatment under the Code, then you will indemnify and reimburse the Company for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from the payments or reimbursements.

- 7.8 Code and ERISA Compliance It is intended that this VEOP Plan meet all applicable requirements of the Code and all regulations issued thereunder. In the event of any conflict between any provisions of the Code and/or ERISA, the provisions of the Code and ERISA will control, and any conflicting provision of this Plan will be superseded to the extent of the conflict.

- 7.9 Applicable Laws The provisions of the VEOP Plan will be construed and enforced according to the laws of the State of Texas other than its laws respecting choice of law, to the extent not preempted.
- 7.10 Effect of Mistake Clerical errors or omissions in information provided to you does not deprive you of your right to receive a benefit, and does not affect the amount of your benefit. Conversely, clerical errors or omissions do not cause you to have the right to receive a benefit to which you are not entitled and if you receive an overpayment by mistake, you must repay the overpayment, if requested to do so. The Company, through the Claims Administrator, 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 VEOP Plan any overpayment, or making catch-up payments to you for an underpayment. The failure to enforce any provision of the VEOP Plan does not affect the VEOP Plan's right thereafter to enforce such provision, nor does such failure affect its right to enforce any other VEOP Plan provision.
- 7.11 Headings The headings of the various sections are inserted for the convenience of reference and are not to be regarded as part of this VEOP Plan or as indicating or controlling the meaning of any provision.

**ARTICLE VIII**  
**STATEMENT OF ERISA RIGHTS**

As a Participant in this VEOP Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

- Examine, without charge, at the Plan Administrator's office or at the Human Resource office, all Plan documents governing the Plan and a copy of the latest annual report (5500 series) filed by the Plan with the U.S. Department of Labor (if any). You may also request and examine the Plan's qualified medical child support order ("QMCSO") procedures at no charge.
- Obtain, upon written request to the Plan Administrator, copies of all Plan documents governing the Plan and a copy of the latest annual report (5500 series) filed by the Plan with the U.S. Department of Labor (if any). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report.
- Continue healthcare coverage for you or your Eligible Dependents if there is a loss of coverage under the Plan as the result of a Qualifying Event. You, Your Spouse or Dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

In addition to creating rights for you, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Plan Participants and beneficiaries. No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way which would prevent you from obtaining Plan benefits or exercising your rights under ERISA.

If the claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision

or lack thereof concerning the qualified status of a domestic relation order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in federal court. The court will decide who should pay court cost and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, it could do so if it finds your claim to be frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**ARTICLE IX**  
**HIPAA PRIVACY AND SECURITY**

- 9.1 Permitted Uses and Disclosures of PHI by the Employer The VEOP Plan 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 Article. If the persons to whom information is disclosed violate this section, or applicable law, the Plan shall cease disclosing such information.
- 9.2 Definitions Unless otherwise indicated, any definitions under this Article shall have the meaning given them under the HIPAA Privacy Rule.
- 9.3 Certification The VEOP Plan only will disclose information to the Employer under this Article upon a certification by the Employer of the following:
- (a) Further Disclosure. The Employer agrees not to use or further disclose the information obtained under this Article other than as permitted or required by the SPD or Plan document, or as required by law.
  - (b) Agents. The Employer will require that any agents, including any subcontractors, to whom it provides protected health information received under this Article agree to the same restrictions and conditions that apply to the Employer with respect to such information.
  - (c) Employment Actions. The Employer agrees not to use or disclose any information received under this Article for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Employer.
  - (d) Duty to Report. The Employer will report to the Plan any use or disclosure of information that is inconsistent with the uses or disclosures provided for under this Article of which it becomes aware.

- (e) Access. The Employer will make available any information it holds under this Article in order for the Plan to comply with the access requirements under the HIPAA Privacy Rule.
- (f) Amendment. The Employer will make available any information it holds under this Article in order for the Plan 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.
- (g) 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 Plan to respond to a request by an individual for an accounting of disclosures of protected health information in accordance with the HIPAA Privacy Rule.
- (h) 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 VEOP Plan available to the Secretary of Health and Human Services, for purposes of the Secretary determining the Plan's compliance with the HIPAA Privacy Rule.
- (i) Return of Information. The Employer will, if feasible, return or destroy all protected health information received from the VEOP Plan 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. If such return or destruction is not feasible, the Employer will limit further uses or disclosures of the information to those purpose that make the return or destruction of the information infeasible.
- (j) Adequate Separation. The Employer will establish adequate separation between the Employer and the VEOP Plan, 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 the VEOP Plan administration functions.

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

#### 9.4 HIPAA Security Standards

- (a) **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 Plan, as required in the HIPAA Security Standards.
- (b) **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.
- (c) **Security Incidents.** The Employer will report to the VEOP Plan any security incident under the HIPAA Security Standards of which it becomes aware.
- (d) **Adequate Separation.** The Employer will establish reasonable and appropriate security measures to ensure adequate separation between the VEOP Plan and the Employer, in support of the requirements described in this Article.

**ARTICLE X**  
**COBRA**

10.1 COBRA Generally

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”), allows you and your Eligible Dependents to temporarily continue coverage under the RHRA if coverage would end under certain circumstances, which are known as Qualifying Events (described below). Continuation coverage must be elected in accordance with Plan rules and is subject to federal law, regulations, and interpretations.

Eligibility for continuation of coverage depends on the circumstances that result in the loss of existing coverage for you and your Eligible Dependents. The sections below explain who is eligible to elect continuation of coverage and the circumstances that result in eligibility for this coverage continuation.

10.2 Continuation of Coverage

Once you have met age and service requirements and you retire, COBRA coverage is available to your Spouse or dependent child(ren) if they are Eligible Dependents and their coverage would otherwise end because of one of the following Qualifying Events:

- Your death (see the Death section);
- Your divorce or legal separation (you must send Benefits Service Center a copy of your divorce decree or other form of documentation proving you are divorced within 60 days of the date of your divorce);  
or
- Your Eligible Dependent who is a child becoming ineligible for coverage (you must notify Benefits Service Center within 60 days of the date your child becomes ineligible).

COBRA coverage for your Eligible Dependent continues for up to 36 months if coverage ends due to one of the above events.

In addition to the above, if you lose your RHRA account coverage within one year before or after the company declares Chapter 11 bankruptcy and the Company continues to offer any other health care benefits, this is a Qualifying Event entitling you and any of your Eligible Dependents covered under the Plan the day before the event to elect COBRA continuation coverage. In this situation, your coverage may continue until your death. Coverage for your Eligible Dependents may continue until the earlier of:

- The exhaustion of the RHRA Account balance;
- Their death; or
- 36 months after the date of your death.

### 10.3 Paying for COBRA

To maintain COBRA continuation of coverage, you must pay the full cost of continuation of coverage on time (i.e., a premium related to expected use of benefits based on actuarial principles), including any additional expenses permitted by law. Your first payment is due within 45 days after you elect continuation of coverage. Premiums for subsequent months of coverage are due on the first day of each month for that month's coverage. If you elect continuation of coverage, you will receive payment coupons or invoices from Alight Solutions indicating when each payment is due. Contributions are due even if you have not received your payment coupons. Failure to pay the required contribution on or before the due date, or by the end of the grace period, will result in termination of COBRA coverage, without the possibility of reinstatement.

### 10.4 Electing COBRA

If your coverage under the VEOP Plan would otherwise end because of one of the Qualifying Events described in Section 10.2, you may elect to continue your coverage under the RHRA Account as part of your continuation of coverage options available through Alight Solutions, the COBRA administrator. Alight Solutions will mail a COBRA package to your home address (or to the address you provide) after you or your Eligible Dependents experience a Qualifying Event.

You (or your dependents) must provide written notification of your desire to elect to purchase continuation of coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage, or else you lose your right to elect to continue coverage.

You and your dependents may each independently elect continuation of coverage. Once you elect continuation of coverage, the first premium for the period beginning on the date you lost coverage through your election is due 45 days after you make your election. If you waive continuation of coverage and then decide that you want to elect to continue coverage within your 60-day election period, you may only obtain coverage effective after you notify the Plan Administrator. If you want to revoke your prior waiver, you must notify the American Airlines Benefits Service Center before your 60-day election period expires.

### 10.5 When COBRA Ends

COBRA coverage ends when one of the following events occurs:

- The COBRA period ends;
- Payment for coverage is not paid on a timely basis;
- American Airlines stops offering the RHRA Plan (other than due to Chapter 11 bankruptcy of the Company);
- The RHRA account balance is exhausted;
- The person who elected COBRA becomes covered under another group medical plan and meets any pre-existing condition prohibitions or limitations; or
- The person who elected COBRA becomes entitled to Medicare after COBRA coverage has started (Dependents may be eligible for continued COBRA coverage).

#### 10.6 Conversion Rights

If Your Spouse or Eligible Dependents do not elect COBRA, eligibility for the RHRA Plan will end.