YOUR EMPLOYEE BENEFIT PLAN

AMERICAN AIRLINES, INC. AND OTHER PARTICIPATING SUBSIDIARIES OF AMR CORPORATION

Optional Short Term Disbility Benefits
January 1, 2006

INTRODUCTION

We are pleased to present you with a Certificate of Insurance for group disability insurance. This Certificate states your benefits and summarizes some special services available to you at no additional cost. All of us appreciate the financial protection that group benefit plans provide in the event of illness or injury. Group disability insurance is an especially important benefit since it replaces a reasonable portion of your income lost due to a disability.

Your Employer recognizes the value of your services and the impact your absence can have on the organization. Therefore your benefit plan has been designed with a goal of rehabilitation and return to work in mind. The plan offers financial incentives for returning to work, while still receiving a benefit.

The benefits outlined in this Certificate are the foundation for comprehensive managed disability services. These special services focus on your *abilities*, versus a disability, and are available to you at no additional cost. They are tailored to meet your individual needs and are designed to help you to return to work as soon as possible. Managed disability services may also coordinate with other benefit programs in which you participate.

Your comprehensive disability program includes:

Financial Incentives for returning to work.

Return to Work Program that focuses on vocational rehabilitation, which means identifying the necessary training, therapy, job modifications and accommodations that can help you return to work.

Easy Claim Application Process that may be started simply by calling an "800" claims hotline or sending us a claim form. Initial submission of the claim should be made no later than 5 days following your original date of disability or as soon as reasonably possible thereafter.

This Certificate is in an easy-to-read format and we urge you to read it carefully. We also recommend you keep it with your other important records for future reference. If you have any questions about the Certificate or the benefits it provides, please contact your Employer.

MetLife

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE
For the Employees of

American Airlines, Inc.
(called the Employer)

This is your Certificate of Insurance for Short Term Disability Insurance as long as you are insured under This Plan. The Group Policy and this Certificate may be changed or canceled according to the terms, conditions and provisions of the Group Policy. This Certificate describes the benefits under the Plan in effect as of January 1, 2006. Any prior Certificate relating to the coverage set forth herein is void.

MetLife in its discretion has authority to interpret the terms, conditions, and provisions of the entire contract. This includes the Group Policy, Certificate and any Amendments.

The Group Policy is delivered in and administered according to the laws of the governing jurisdiction.

Whenever a reference to "you" or "your" is made in this Certificate of Insurance, it means the covered Employee. Reference to "we", "us" or "our" means MetLife. Reference to "This Plan" means that part of the Employer's plan of employee benefits that is insured by MetLife.

C. Robert Henrikson
President and Chief Operating Officer

Group Policy No.: 29920-G

Florida Residents: The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

For Maryland residents: The group insurance policy providing coverage under this certificate was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

Form G.24303-Cert.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll-free telephone number for information or to make a complaint at

1-800-638-5433

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact MetLife first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-5433

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
Fax # 512 - 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

Arkansas residents please be advised of the following:

IMPORTANT NOTICE

IF YOU HAVE A QUESTION CONCERNING YOUR COVERAGE OR A CLAIM, FIRST CONTACT YOUR GROUP EMPLOYER OR GROUP ACCOUNT ADMINISTRATOR. IF, AFTER DOING SO, YOU STILL HAVE A CONCERN, YOU MAY CALL METLIFE'S TOLL-FREE TELEPHONE NUMBER:

1-800-638-5433

IF YOU ARE STILL CONCERNED AFTER CONTACTING BOTH YOUR GROUP EMPLOYER AND METLIFE, YOU SHOULD FEEL FREE TO CONTACT:

ARKANSAS INSURANCE DEPARTMENT
CONSUMER SERVICES DIVISION
1200 WEST THIRD
LITTLE ROCK, ARKANSAS 72201-1904

California residents please be advised of the following:

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT METLIFE AT:

METROPOLITAN LIFE INSURANCE COMPANY
200 PARK AVENUE
NEW YORK, NY 10166
ATTN: CORPORATE CONSUMER RELATIONS DEPARTMENT
1-800-638-5433

IF, AFTER CONTACTING METLIFE REGARDING A COMPLAINT, YOU FEEL THAT A SATISFACTORY RESOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

CALIFORNIA DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1-800-927-4357 (within California)
1-213-897-8921 (outside California)

Georgia residents please be advised of the following:

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

Utah residents please be advised of the following:

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.

- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 — whichever is lower. Other caps also apply:

- $100,000 in net cash surrender values.
- $500,000 in life insurance death benefits (including cash surrender values).
- $500,000 in health insurance benefits.
- $200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

· **COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.**

· **COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.**

· **THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.**

· **INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULHIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.**

· **THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.**

Utah Life and Health Insurance
Guaranty Association
955 E. Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Virginia residents please be advised of the following:

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166
Attn: Corporate Customer Relations Department

To phone in a claim related question, you may call Claims Customer Service at:

1-800-638-5433

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

1-800-552-7945 - In-state toll-free
1-804-371-9691 - Out-of-state

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Wisconsin residents please be advised of the following:

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

Metropolitan Life Insurance Company
Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison.

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PLAN HIGHLIGHTS

This Plan Highlights section is a summary of your Short Term Disability Benefits and provisions. See the rest of your Certificate for more information.

It is important to read the rest of your Certificate. It describes your benefits as well as any exclusions and limitations that apply to these benefits. Please read it carefully. You should talk with your Employer if you have any questions.

You will notice that some of the terms used in your Certificate begin with capital letters. These terms have special meanings. They are explained in this Certificate.

EMPLOYEE ELIGIBILITY

Eligible Employee: All Management /Specialist Employees, Agents, Support Staff, Skycaps, or Employees represented by the Transport Workers Union (TWU) Employees who are employed and paid for services by the Employer.

Optional Short Term Disability Eligibility Waiting Period:

Active Management /Specialist Employees: None

Active Agents, Support Staff, Skycaps, or Employees represented by the Transport Workers Union (TWU): 6 months of continuous employment with the Employer

Eligibility Date: January 1, 2006 or the date you complete the Eligibility Waiting Period, whichever is later.

SHORT TERM DISABILITY BENEFITS

Optional Short Term Disability Benefits	**Amount Of Benefits**
Weekly Benefit.....	50% of your Predisability Earnings, derived from Adjusted Monthly Salary, less any benefits from all other sources.
Maximum Benefit Duration:	
TWU Employees.....	26 weeks
All Other Employees.....	26 weeks or until Long Term Disability benefits begin, whichever is earlier
Waiting Period	8 days or the exhaustion of company sponsored accrued sick pay, whichever is later.
Maximum Covered Salary	$200,000 annually

Work Incentive:

Work while Disabled: No offset for employment earnings unless the total income you are receiving (including Rehabilitation Incentive and Family Care Expenses) exceeds 100% of your Predisability Earnings.

Rehabilitation Incentive: While participating in an approved Rehabilitation Program your Weekly Benefit before reduction for Other Income Benefits is increased by 10%.

Family Care Expenses: While participating in an approved Rehabilitation Program, after the 4th week of Disability, up to $100 per week incurred for Eligible Family Care Expenses for each Eligible Family Member.

LIMITATIONS

Limitation for Occupational Disabilities: Benefits are not payable for any Disability: (i) which happens in the course of any work performed by you for wage or profit; or (ii) for which you are eligible to receive benefits under any Workers' Compensation or any similar law.

Limitation for Pre-existing Conditions: Coverage for Pre-existing Conditions begins 12 months after your Effective Date of coverage.

CONTRIBUTIONS

Your Short Term Disability Benefits are paid for by you.

BENEFITS CHECKLIST

In order to receive benefits under This Plan, you must provide to us at your expense, and subject to our satisfaction, all of the following documents. These are explained in this Certificate. Initial submission of these documents should be made no later than the 12th week following your original date of disability.

- ✓ Proof of Disability.
- ✓ Evidence of continuing Disability.
- ✓ Proof that you are under the Appropriate Care and Treatment of a Doctor throughout your Disability.
- ✓ Information about Other Income Benefits.
- ✓ Any other material information related to your Disability which may be requested by us.

EMPLOYEE ELIGIBILITY

Active Employee

You are an Active Employee if you:

1. are an Eligible Employee working for the Employer doing all the material duties of your occupation at (i) your usual place of business; or (ii) some other location that your Employer's business requires you to be;

2. are a citizen or legal resident of the United States or Canada; and

3. are not a temporary or seasonal employee.

You will be deemed an Active Employee if:

1. you meet the above conditions; and

2. you are absent from work solely due to vacation days, holidays, scheduled days off, or approved leaves of absence not due to Disability.

Effective Date of Coverage

If you make written application for coverage no later than 3 months after your Eligibility Date and agree to have the required contributions deducted from your pay, you will be covered on the later of:

1. your Eligibility Date;

2. the date you meet the Active Employee requirements; or

3. the date of your written application.

If you enroll in this plan, your participation is required for two calendar years. If you fail to enroll for coverage at the initial offering, you will be required to wait until the next annual enrollment period and your enrollment will be treated as a Waiver of Coverage.

Waiver of Coverage

If you were eligible for coverage under the prior plan but did not elect to be covered under the prior plan, you will be required to provide Evidence of Good Health satisfactory to us. Your coverage will become effective when we approve your Evidence of Good Health.

"Evidence of Good Health" is a statement providing your medical history. We will use this statement to determine your insurability under This Plan. This statement must be provided to us at your expense.

Changes in Amount of Weekly Benefit

The amount of your Weekly Benefit may change as a result of a change in your earnings or class. The new Weekly Benefit amount:

1. will take effect on the date of the change; and

2. will apply only to Disabilities commencing thereafter.

However, if you are not an Active Employee on the above date, the new Weekly Benefit amount will take effect on the date you are again an Active Employee.

Form G.24303-B

SHORT TERM DISABILITY BENEFITS

A. Weekly Benefit

You will be paid a Weekly Benefit, in accord with Plan Highlights, if we determine that:

1. you are Disabled; and

2. you became Disabled while covered under This Plan.

Benefits will begin to accrue on the date following the day you complete your Waiting Period. Payment of the Weekly Benefit will start on the date one week after completion of the Waiting Period. Subsequent payments will be made each week thereafter. Payment is based on the number of days you are Disabled during each one week period.

Contributions are required for the time that Weekly Benefits are payable.

After we determine that you are Disabled, your Weekly Benefits will not be affected by:

1. termination of This Plan;

2. termination of your coverage; or

3. any plan change that is effective after the date you became Disabled.

When Benefits End

Weekly Benefits will end on the earliest of the following dates:

1. the end of the Maximum Benefit Duration;

2. the date you are no longer Disabled;

3. the date you fail to provide us with any of the information listed in Plan Highlights under Benefits Checklist;

4. the day you die;

5. the date you fail to attend a medical examination requested by us as described in Medical Examination.

Waiting Period

Your Waiting Period begins on the day you become Disabled. It is a period of time during which no benefits are payable. Your Waiting Period is shown in Plan Highlights. You must be under the continuous care of a Doctor during your Waiting Period.

Definition of Disability

"Disabled" or "Disability" means that, due to sickness, pregnancy or accidental injury, you:

1. are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and

2. are unable to earn more than 80% of your Predisability Earnings at your Own Occupation for any employer in your Local Economy.

Your loss of earnings must be a direct result of your sickness, pregnancy or accidental injury. Economic factors such as, but not limited to, recession, job obsolescence, paycuts and job-sharing will not be considered in determining whether you meet the loss of earnings test.

For an Employee whose occupation requires a license, "loss of license" for any reason does not, in itself, constitute Disability.

"Appropriate Care and Treatment" means medical care and treatment that meet all of the following:

1. it is received from a Doctor whose medical training and clinical experience are suitable for treating your Disability;

2. it is necessary to meet your basic health needs and is of demonstrable medical value;

3. it is consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;

4. it is consistent with the diagnosis of your condition; and

5. its purpose is maximizing your medical improvement.

"Doctor" means a person who: (i) is legally licensed to practice medicine; and (ii) is not related to you. A licensed medical practitioner will be considered a Doctor:

1. if applicable state law requires that such practitioners be recognized for the purposes of certification of disability; and

2. the care and treatment provided by the practitioner is within the scope of his or her license.

"Own Occupation" means the activity that you regularly perform and that serves as your source of income. It is not limited to the specific position you held with your Employer. It may be a similar activity that could be performed with your Employer or any other employer.

"Local Economy" means the geographic area surrounding your place of residence which offers reasonable employment opportunities. It is an area within which it would not be unreasonable for you to travel to secure employment. If you move from the place you resided on the date you became Disabled, we may look at both that former place of residence and your current place of residence to determine local economy.

Work Incentive

While you are Disabled, you are encouraged to work or participate in a Rehabilitation Program during your Waiting Period or while Weekly Benefits are being paid to you. Reimbursement for Eligible Family Care Expenses may also be available when you work or participate in an approved Rehabilitation Program while Disabled.

When you work while Disabled, you will receive the sum of the following amounts:

1. your Weekly Benefit (including your Rehabilitation Incentive when applicable);

2. the amount of your earnings for working while Disabled; and

3. the amount of Family Care Expenses for which you are eligible.

Your Weekly Benefit will be reduced if the total amount you receive from the above sources and Other Income Benefits exceeds 100% of your Predisability Earnings. Your Weekly Benefit will be reduced by that portion of the total you receive which exceeds 100% of your Predisability Earnings.

If your Weekly Benefit is reduced as a result of your receiving earnings from any work or service while Disabled, the Minimum Weekly Benefit will not apply.

"Rehabilitation Program" means:

1. a return to active employment by you on either a part-time or full-time basis in an attempt to enable you to resume gainful employment or service in an occupation for which you are reasonably qualified taking into account your training, education, experience and past earnings; or

2. participating in vocational training or physical therapy. This must be deemed by one of our rehabilitation coordinators to be appropriate.

Rehabilitation Incentive

While Disabled, your Weekly Benefit, before reduction for Other Income Benefits, is increased by 10% when you participate in a Rehabilitation Program approved by us.

Family Care Expenses

After the 4th week of Disability, when you work or participate in a Rehabilitation Program approved by us, you will be reimbursed for

Eligible Family Care Expenses incurred with respect to each Eligible Family Member.

"Eligible Family Member" means a person who is:

1. living with you as part of your household; and

2. chiefly dependent on you for support.

"Eligible Family Care Expenses" mean the weekly expenses incurred by you in order for you to participate in a Rehabilitation Program, up to $60 for each Eligible Family Member. These are expenses incurred:

1. to provide child care with respect to an Eligible Family Member under age 13. Child care must be provided by a licensed child care facility or other qualified child care provider. The child care provider may not be a member of your immediate family or living in your residence.

2. to provide care to an Eligible Family Member who as a result of mental or physical impairment, is incapable of caring for himself or herself. Family Care Expenses for services provided by a member of your immediate family or any one living in your residence will not be reimbursed.

Eligible Family Care Expenses do not include expenses for which you are eligible for reimbursement under any other group plan or from any other source.

You must provide satisfactory proof to us that you incurred such charges. You must give us proof that the Eligible Family Member is incapable of caring for himself or herself and is chiefly dependent on you for support. The proof must be satisfactory to us.

Predisability Earnings

"Predisability Earnings" means your Adjusted Monthly Salary divided by 4,333.

"Adjusted Monthly Salary" means your monthly salary based on your annual base salary or annualized hourly pay, plus any skill or license premiums and market rate differentials, as determined by the Employer's established personnel practices.

B. Reduction of Benefits - Other Income Benefits

Your Weekly Benefit is reduced by Other Income Benefits shown below. The Weekly Benefit payable to you:

1. will not be less than the amount shown in Plan Highlights under Minimum Weekly Benefit (except in the case of an Overpayment or while receiving work earnings);

2. will not be further reduced due to cost-of-living increases payable under Other Income Benefits after the correct reductions has been determined;

3. will not be reduced by any reasonable attorney fees included in any award or settlement; and

4. will not be reduced by any sources other than those shown below.

If you receive Other Income Benefits in a lump sum instead of in weekly payments, you must provide to us satisfactory proof of the breakdown of: (i) the amount attributable to lost income; and (ii) the time period for which the lump sum is applicable. If you do not provide this information to us, we may reduce your Weekly Benefit by an amount equal to the Weekly Benefit otherwise payable. We will reduce the Weekly Benefit each month until the lump sum has been exhausted. However, if we are given proof of the time period and amount attributable to lost income, we will make a retroactive adjustment.

List of Sources of Other Income Benefits

1. **Work Earnings, Rehabilitation Incentive, and Family Care Expenses** will not be used to reduce your Weekly Benefit except as described in Work Incentive.

2. No-fault Auto Laws

Only the basic reparations portion for loss of income of a law providing for payments without determining fault in connection with automobile accidents will be counted. Supplemental disability benefits you buy under a no-fault auto law will not be counted.

3. Third Party Recovery

The amount of recovery you receive for loss of income as a result of claims against a third party by judgment, settlement or otherwise.

4. Other Programs or Plans including:

a. a compulsory benefit program of any government which provides payment for loss of time from your job because of your disability will be counted;

b. any other group disability income plan, fund, or other arrangement, no matter what called, if the Employer contributes toward it or makes payroll deductions for it, will be counted; and

c. any sick pay or other salary continuation, other than vacation pay, paid to you by the Employer will be counted.

Exceptions to Other Income Benefits

Other Income Benefits will not include:

1. group credit or mortgage disability insurance benefits; or

2. early retirement benefits not taken into constructive receipt; or

3. individual Insurance policies.

C. Temporary Recovery

Once benefits become payable under This Plan, you may Temporarily Recover from your Disability. If you become Disabled again due to the

same or related condition, you may not have to begin a new Waiting Period.

Once you have satisfied your Waiting Period, a period of Temporary Recovery is your return to work for less than 3 months for each period of Temporary Recovery.

During the Temporary Recovery you will not qualify for any change in coverage caused by a change in any of the following:

1. the rate of earnings used to determine your Predisability Earnings; or

2. the terms, provisions, or conditions shown in your Certificate of Insurance.

If your recovery lasts longer than the Temporary Recovery period allowed, when you become Disabled again you will have to begin a new Waiting Period.

D. Concurrent Disability

If a new Disability occurs while Weekly Benefits are payable, it will be treated as part of the same period of Disability. Weekly Benefits will continue while you remain Disabled. They will be subject to both of the following:

1. the Maximum Benefit Duration; and

2. Limitations and Exclusions that apply to the new cause of Disability.

E. Limitations

Limitation for Occupational Benefits

No benefits are payable for any Disability: (i) which happens in the course of any work performed by you for wage or profit; or (ii) for which you are eligible to receive benefits under any Workers' Compensation or any similar law.

Limitation for Pre-existing Conditions

You may be Disabled due to a Pre-existing Condition. No benefits are payable under This Plan in connection with that Disability unless your Waiting Period starts after you have been an Active Employee under This Plan for 12 consecutive months.

A Pre-existing Condition is an injury, sickness, or pregnancy for which you in the 3 months before your Effective Date:

1. received medical treatment, consultation, care, or services;

2. took prescription medications or had medications prescribed; or

3. had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care, or treatment.

F. Exclusions

This Plan does not cover any Disability which results from or is caused or contributed to by:

1. war, insurrection, or rebellion;

2. active participation in a riot;

3. intentionally self-inflicted injuries or attempted suicide;

4. committing a felony.

5. elective treatment or procedures such as, but not limited to:

- **a.** cosmetic surgery or treatment primarily to change appearance
- **b.** in vitro fertilization
- **c.** embryo transfer procedure
- **d.** artificial insemination
- **e.** sex-change surgery
- **f.** reversal of sterilization
- **g.** liposuction
- **h.** radial keratotomy

TERMINATION OF COVERAGE

This provision applies to you if you are not Disabled.

You will cease to be covered on the earliest of the following dates:

1. the date This Plan terminates;

2. the date you cease to be an Eligible Employee;

3. the date you stop making any required contributions;

4. the date you go on strike or are locked out; or

5. the date you are laid-off.

Approved Leave of Absence

Your Employer may continue your coverage for an approved leave of absence by paying the required premium payments. Coverage may continue until the earliest of:

1. the date the Employer stops paying the required premium;

2. the date the leave ends;
or

3. the last day of the month in which your leave of absence begins.

In the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA}, the period may be extended for a period agreed to by you and your Employer. It may not exceed 12 weeks following the date the leave begins. Your Employer must continue to pay the required premium.

Reinstatement of Coverage

If your coverage ends, you may become covered again as an Eligible Employee. Coverage is subject to the following:

1. If your coverage ends because you cease to be an Eligible Employee, and if you become an Eligible Employee again within 3 months, the Eligibility Waiting Period will be waived. You will not have to provide Evidence of Good Health.

2. If your coverage ends because you cease making the required contribution while on an approved Family Medical Leave Act (FMLA) leave of absence, and you become an Eligible Employee again within 31 days of the earlier of:

   a. the end of the period of leave you and your Employer agreed upon; or

   b. the end of the 12 week period following the date your leave began;

   the Eligibility Waiting Period will be waived and you will not have to provide Evidence of Good Health.

3. In all other cases, if your coverage ends because you fail to make the required contribution, you must provide Evidence of Good Health to become covered again.

4. If you become covered again as described in 1. and 2. above, the Pre-existing Condition Limitation will be applied as if there had been no gap in coverage.

Form G.24303-D

EXTENSION OF BENEFITS

This provision applies if your coverage ceases while you are Disabled.

During your Waiting Period your coverage will continue while you are continuously Disabled until the end of your Waiting Period. Benefits will begin after the end of your Waiting Period. Your coverage will continue in either of the following situations:

1. This Plan terminates; or

2. you cease to be an Eligible Employee but required payments are made to us.

Benefits are payable if your Disability began while coverage was in force and continues without interruption after termination.

Extension of benefits beyond the period coverage was in force is limited to the Maximum Benefit Duration. Extension of benefits is subject to all of the following:

1. your Waiting Period; and

2. payment of any required contributions; and

3. all other applicable provisions of This Plan.

Form G.24303-C

CLAIMS

Notice of Disability

Notify us of your Disability as soon as you are able.

To notify us you may call us directly. You may obtain this phone number from your Employer. You will be instructed on how to give proof of Disability. You will be required to answer all questions concerning your Disability.

If you do not receive statements or instructions within 15 days after you have notified us, you may submit your statement in a letter.

Proof of Disability

Provide proof of Disability within 45 days after the end of your Waiting Period.

No benefits are payable for claims submitted more than 6 months after the date of Disability. However, you can request that benefits be paid for late claims if you can show that:

1. it was not reasonably possible to give written proof of Disability during the 6 month period; and

2. proof of Disability satisfactory to us was given to us as soon as was reasonably possible.

Documentation

At your expense, you must provide documented proof of your Disability. Proof includes, but is not limited to:

1. the date your Disability started;

2. the cause of your Disability; and

3. the prognosis of your Disability.

You will be required to provide signed authorization for us to obtain and release medical and financial information, and any other items we may reasonably require in support of your Disability.

These will include but are not limited to:

1. proof of continuing Disability;

2. proof you have applied, or are not eligible, for Other Income Benefits. If you do not provide proof you have applied for Other Income Benefits, we may reduce your Weekly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit;

3. proof that you applied for Social Security disability benefits until denied at the Administrative Law Judge level; and

4. proof you have applied for Workers' Compensation benefits or benefits under a similar law. If you do not provide proof that you have applied for these benefits, we may reduce your Weekly Benefit. The reduction will be based on our estimate of what you would be eligible to receive through proper and timely pursuit.

If you do not provide satisfactory documentation within 60 days after the date we ask for it, your claim may be denied.

Method of Payment

When we determine you are Disabled:

1. Weekly Benefits are paid one week after you qualify for them and on a weekly basis thereafter.

2. Benefits will be paid to you. However, benefits unpaid at your death will be paid to:

    a. your spouse, if living; otherwise

    b. your children, if living, divided equally;

    c. your estate. If benefits are payable to your estate, we may pay up to $1,500 to someone related to you by

blood or by marriage whom we deem entitled to this amount. We will be discharged to the extent of any payment made in good faith.

3. Weekly Benefits due for a period of less than a week will be paid at a daily rate of 1/7th of the Weekly Benefit payable.

Right To Recover Overpayments

We have the right to recover from you any amount that we determine to be an Overpayment. You have the obligation to refund to us any such amount. Our rights and your obligations in this regard are also set forth in the reimbursement agreement you are required to sign when you become eligible for benefits under This Plan. This agreement: (i) confirms that you will repay all Overpayments; and (ii) authorizes us to obtain any information relating to Other Income Benefits.

An Overpayment occurs when we determine that the total amount paid by us on your claim is more than the total of the benefits due under This Plan. This includes any Overpayments resulting from:

1. retroactive awards received from sources shown in the List of Other Income Benefits;

2. fraud; or

3. any error we make in processing your claim.

The Overpayment equals the amount we paid in excess of the amount we should have paid under This Plan. In the case of a recovery from a source other than This Plan, our Overpayment recovery will not be more than the amount of the recovery.

You have the right to appeal any Overpayment recovery.

An Overpayment also occurs when payment is made by us that should have been made under another group plan. In that case, we may recover the payment from one or more of the following:

1. any other insurance company;

2. any other organization; or

3. any person to or for whom payment was made.

We may, at our option, recover the Overpayment by:

1. reducing or offsetting against any future benefits payable to you or your survivors;

2. stopping future benefit payments (including Minimum Benefits) which would otherwise be due under This Plan. Payments may continue when the Overpayment has been recovered; or

3. demanding an immediate refund of the Overpayment from you.

Legal Actions

No legal action of any kind may be filed against us:

1. within the 60 days after proof of Disability has been given; or

2. more than three years after proof of Disability must be filed. This will not apply if the law in the area where you live allows a longer period of time to file proof of Disability.

Medical Examinations

We will have the right to have you examined at reasonable intervals by medical specialists of our choice. The examination will be at our expense. Failure to attend a medical examination or cooperate with the medical examiner may be cause for denial or suspension of your benefits.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for 2 years. It can be declared invalid due to non-payment of premium.

No statement of health used by any person to get coverage can be used to declare coverage invalid if the person has been covered under This Plan for 2 years. In order to use a statement of health to deny

coverage before the end of 2 years, it must have been signed by the person. A copy of the signed statement must be given to the person or the person's beneficiary.

Assignment

You may not assign your benefits. This means that you may not give or transfer your benefits to anyone else.

Workers' Compensation

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance or any government mandated temporary disability income benefits law.

Form G.24303-E

THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION.

SPECIAL SERVICES

RETURN TO WORK PROGRAM

Goal of Rehabilitation

The goal of MetLife is to focus on Employees' **abilities,** instead of disabilities. This "abilities" philosophy is the foundation of our Return to Work Program. By focusing on what Employees **can do** versus what they can't, we can assist you in returning to work sooner than expected.

Incentives For Returning To Work

Your disability plan is designed to provide clear advantages and financial incentives for returning to work either full-time or part-time, while still receiving a Disability benefit. In addition to financial incentives, there may be personal benefits resulting from returning to work. Many Employees experience higher self-esteem and the personal satisfaction of being self-sufficient and productive once again. If it is determined that you are capable but you do not participate in the Return to Work Program, your Disability benefits may cease.

Vocational Rehabilitation Services

As a covered Employee you are automatically eligible to participate in our Return to Work Program. The Program focus is vocational rehabilitation, which means identifying the necessary training and therapy that can help you return to work. In many cases, this means helping you return to your former occupation, although rehabilitation can also lead to a new occupation which is better suited to your condition and makes the most of your abilities.

There is no additional cost to you for the services we provide, and they are tailored to meet your individual needs. These services include, but are not limited to, the following:

1. **Vocational Analyses**

   Assessment and counseling to help determine how your skills and abilities can be applied to a new or a modified job with your Employer.

2. **Labor Market Surveys**

   Studies to find jobs available in your locale that would utilize your abilities and skills.

3. **Retraining Programs**

   Programs to facilitate return to your previous job, or to train you for a new job.

4. **On-Site Job Analyses**

   Analyses to determine what modifications may be made to maximize your employment opportunities.

5. **Job Modifications/Accommodations**

   Changes in your job or accommodations to help you perform the previous job or a similar vocation, as required of your Employer under the Americans With Disabilities Act (ADA).

6. **Training in Job Seeking Skills**

   Special training to identify abilities, set goals, develop resumes, polish interviewing techniques, and provide other career search assistance.

Rehabilitation Staff

The Case Management Specialist handling your claim will begin the rehabilitation process. You may be referred to our professional Rehabilitation staff that includes Registered Nurses and vocational rehabilitation coordinators. Registered Nurses might address how

your medical condition impacts your ability to return to work. Vocational rehabilitation coordinators will focus on identifying how your abilities can be best applied to either your previous job or a new job.

These rehabilitation specialists will contact you personally. They will coordinate their activities with your medical carrier and/or attending physician for a broad understanding of your diagnosis, prognosis, and expected return to work date.

Rehabilitation Vendor Specialists

In many situations, the services of independent vocational rehabilitation specialists may be utilized. Services are obtained at no additional cost to you; MetLife pays for all vendor services. Selecting a rehabilitation vendor is based on:

1. Attending physician's evaluation and recommendations;

2. Your individual vocational needs; and

3. Vendor's credentials, specialty, reputation, and experience.

When working with vendors, you and your Doctor still maintain control and direction of the case.

THE FOLLOWING IS ADDITIONAL INFORMATION.

ERISA INFORMATION

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE AMERICAN AIRLINES, INC. DISABILITY INSURANCE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

NAME AND ADDRESS OF EMPLOYER

American Airlines, Inc.
5255 Amon Carter Blvd MD 4412
Ft. Worth, TX 76155

PLAN ADMINISTRATOR NAME, BUSINESS ADDRESS AND PHONE NUMBER

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

EMPLOYER IDENTIFICATION NUMBER: 13-1502798

PLAN NUMBER	COVERAGE	PLAN NAME
516	Short Term Disability Benefits	American Airlines, Inc. Employee Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

MetLife is liable for any benefits under the Plan. The group policy specifies the time when and the circumstances under which MetLife is liable for Short Term Disability Benefits.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes seeking payment of benefits, service of legal process may be made upon MetLife by serving MetLife's designated agent to accept service of process.

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan. In the event Your insurance ends in accordance with the DATE YOUR INSURANCE ENDS subsection of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st.

QUALIFIED DOMESTIC RELATIONS ORDERS/QUALIFIED MEDICAL CHILD SUPPORT ORDERS

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified

Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO).

CLAIMS INFORMATION

Disability Benefits Claims

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Claim Submission

For claims for disability benefits, the claimant must report the claim to MetLife and, if requested, complete the appropriate claim form. The claimant must also submit the required proof as described in the "Filing A Claim" section of the certificate.

Claim forms requested by MetLife must be submitted in accordance with the instructions on the claim form.

Initial Determination

After you submit a claim for disability benefits to MetLife, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date you submitted your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information

from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. Further, if an internal rule, protocol, guideline or other criteria was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who

made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45 day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that you may request a copy free of charge. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan administrator's office and at other specified locations, all Plan documents, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 the above rights. For instance, if you request a copy of Plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a Federal court. In such a 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 administrator. If you have a claim for benefits which 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 relations order or a medical child support order, you may file suit in a 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 you may file suit in a Federal court.

The court will decide who should pay court costs 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, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your 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 your 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.

FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but American Airlines, Inc. reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of American Airlines, Inc. shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.