| E400F   | <b>~</b>          | Employ                    | ver-Provi  | ded F             | lealth Insu                                    | ran             | ce (  | Offer and                                | d Cover | age   | VOID      |     | OMB N  | lo. 1545-2251 | PUUTSU      |  |
|---|-------------------|---------------------------|--|-------------------|--|-----------------|---|--|---------|---|-----------|-----|--|---------------|-------------|--|
| E 1095-C Department of the Trea   | isury             | p                         | /er-Provided Health Insurance Offer and Coverage  ► Do not attach to your tax return. Keep for your records.  ► Go to www.irs.gov/Form1095C for instructions and the latest information. |                   |  |                 |   |  |         |   | CORRECTED |     |  | 202           | l l         |  |
| Part   Employee   2 Social security number (SSN)                                      |                   |                           |  |                   |  |                 | Applicable Large Employer Member (Employer)                             |  |         |   |           |     | 8 Employer identification number (EIN)<br>13-1502798 |               |             |  |
| Name of employee (first name, middle initial, last name)     NAGARJUN R MARAM VENKATA |                   |                           |  |                   |  |                 |   | 7 Name of employer AMERICAN AIRLINES INC |         |   |           |     |  |               |             |  |
| 3 Street address (including apartment no.) 215 N MOORE RD APT 6008                    |                   |                           |  |                   |  |                 | 9 Street address (including room or suite no.) 1 SKYVIEW DRIVE MD 8A203 |  |         |   |           |     | 10 Contact telephone number<br>888-860-6178          |               |             |  |
| 4 City or town COPPELL  |                   | 5 State or province<br>TX | ce   | 6 Country<br>7501 | 6 Country and ZIP or foreign postal code 75019 |                 |   | or town<br>WORTH                         |         | 12 State or province                        |           |     | 13 Country and ZIP or foreign postal code 7 6155     |               |             |  |
| Part II Employee Offer of Coverage Employee's Age                                     |                   |                           |  |                   |  | ge on January 1 |   |  |         | Plan Start Month (enter 2-digit number): 01 |           |     |  |               |             |  |
|   | All 12 Months     | Jan                       | Feb  | Mar Apr M         |  | М               | lay   | June                                     | July    | Aug   | Sept      | Oct |  | Nov           | Dec         |  |
| 14 Offer of Coverage<br>(enter required code)   |                   | 1н                        | 1н   | 1н                | 1н   | 11              | Н   | 1н                                       | 1н      | 1н  | 1н 1н     |     |  | 1н            | 1A          |  |
| 15 Employee Required Contribution (see instructions)                                  | \$                | s                         | \$ \$  |                   | \$ \$  | ;               |   | s  | s       | s   | s         | s   |  | \$            | \$          |  |
| 16 Section 4980H<br>Safe Harbor and Other<br>Relief (enter code,<br>f applicable)     |                   | 2A                        | 2A   | 2A                | 2A   | 21              | A   | 2A                                       | 2A      | 2A  | 2A        | 2A  |  | 2D            | 2C          |  |
|   |                   |                           |  |                   |  |                 |   |  |         |   |           |     |  |               |             |  |
| 17 ZIP Code   |                   |                           |  |                   |  |                 |   |  |         |   |           |     |  |               |             |  |
| For Privacy Act and Pa  | perwork Reduction | on Act Notice, se         | e separate instruction   | ons.              |  | (               | Cat. No. 6  | 60705M                                   | •       |   |           |     |  | Form 10       | 95-C (2021) |  |

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× Part III Covered Individuals – If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other TIN is not available) (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec First name, middle initial, last name x x 18 NAGARJUN R MARAM VENKATA \*\*\*-\*\*-0006 ×× \*\*\*-\*\*-8845 RIYANSHIKA R MARAM XX \*\*\*-\*\*-1510 20 SOWMYA S PANTA 21 29

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