American Eagle Airlines

Employee Benefits Guide

IMPORTANT BENEFITS NOTICE FOR EMPLOYEES OF AMERICAN EAGLE AIRLINES, INC. AND ITS AFFILIATES

December 15, 2008

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of the new health and welfare plan benefits plan. This new benefit plan becomes effective on January 1, 2009, and this new plan is the Group Health and Welfare Benefits Plan for Employees of American Eagle Airlines, Inc. and Its Affiliates (Plan 501, EIN# 38-2036404, referenced here as the "Eagle Plan"). The information in this notice applies only to the new Eagle Plan (effective January 1, 2009), and not to your existing coverage for 2008.

You will be receiving a Summary Plan Description for the new Eagle Plan in February, 2009. In the meantime, use this document to obtain information about the new Eagle Plan, along with your existing Eagle Summary Plan Description, as many of the provisions will be the same as in the new Eagle Plan.

Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in the Employee Benefit Guide ("EBG")). When you receive your new Eagle Plan Summary Plan Description is February, 2009, it will contain the information in this document, as well as all provisions, limitations, and exclusions of the new Eagle Plan.

Beginning January 1, 2009, the Eagle Plan's self-funded medical option – the PPO Copay Option, PPO Deductible Option, Minimum Coverage Option, and Out-of-Area Option – are administered by two network and/or claims administrators: Aetna and Blue Cross and Blue Shield of Texas, replacing UnitedHealthcare. Except where otherwise noted in this document, all references to UnitedHealthcare are replaced by "your network and/or claims administrator."

In "Contact Information" on page 1, the following text replaces the following sections:

For Information About:	Contact:	At:
Medical Coverage		
Out-of-Area Coverage , PPO-Deductible, PPO-Copay and Minimum Coverage Options	**Aetna** P.O. Box 981106 El Paso, TX 79998-1106	**(800) 572-2908** For other information, visit: **Web site:** www.aetnanavigator.com **Provider directory:** www.aetna.com/docfind/custom/americaneagle
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	**(877) 235-9258** For other information, visit: **Web site:** www.bcbstx.com **Provider directory:** www.bcbstx.com/americaneagle
Coverage for Incapacitated Child and Special Dependents (PPO-Deductible and PPO-Copay Options)	**Aetna** P.O. Box 981106 El Paso, TX 79998-1106	**(800) 572-2908** For other information, visit: **Web site:** www.aetnanavigator.com **Provider directory:** www.aetna.com/docfind/custom/ameri

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	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	**(877) 235-9258** For other information, visit: **Web site:** www.bcbstx.com **Provider directory:** www.bcbstx.com/americaneagle
CheckFirst (Predetermination of Benefits) (Except HMOs)		
Out-of-Area Coverage , PPO-Deductible, PPO-Copay and Minimum Coverage Options	**Aetna** P.O. Box 981106 El Paso, TX 79998-1106	**(800) 572-2908** For other information, visit: **Web site:** www.aetnanavigator.com **Provider directory:** www.aetna.com/docfind/custom/americaneagle
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	**(877) 235-9258** For other information, visit: **Web site:** www.bcbstx.com **Provider directory:** www.bcbstx.com/americaneagle
QuickReview (Pre-authorization for hospitalization)		
Out-of-Area Coverage , PPO-Deductible, PPO-Copay and Minimum Coverage Options	**Aetna** P.O. Box 981106 El Paso, TX 79998-1106	**(800) 572-2908** For other information, visit: **Web site:** www.aetnanavigator.com **Provider directory:** www.aetna.com/docfind/custom/americaneagle
	Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	**(877) 235-9258** For other information, visit: **Web site:** www.bcbstx.com **Provider directory:** www.bcbstx.com/americaneagle
Vision Insurance		
Vision Insurance Benefit	**OptumHealth Vision** (formerly Spectera, Inc.) 2811 Lord Baltimore Drive Baltimore, MD 21244	**(800) 638-3120** **Web site:** www.optumhealthvision.com

In "Contact Information" on page 1, remove the section "Supplemental Medical Plan" and remove all references to the Supplemental Medical Plan.

In "Benefits at a Glance" on page 5, the following text is inserted as the first paragraph in the section:

Effective December 31, 2008 (at 11:59:59 p.m.), Eagle's health and welfare benefits were separated from all American Airlines, Inc.-sponsored benefit plans, and Eagle became the sponsor of its own health and welfare benefits. This new plan, effective January 1, 2009, is the Group Health and Welfare Benefit Plan for Employees of American Eagle Airlines, Inc. and Its Affiliates ("Eagle Plan"). This new Eagle Plan will include the following benefits, most of which are patterned after the Eagle benefits in the

prior (American Airlines, Inc.-sponsored) health and welfare benefit plans:

Type of Benefit	Self-Funded or Insured	Administrator or Insurer	Funding Mechanism
Medical Benefit			
PPO Copay	Self-funded	Aetna or BCBS	Company and Employee Contributions, and General Assets of the Company
PPO Deductible	Self-funded	Aetna or BCBS	
Out-of-Area	Self-funded	Aetna or BCBS	
Minimum Coverage	Self-funded	Aetna or BCBS	Company and Employee Premiums
HMOs (PR, USVI)	Insured	Humana or Triple S	Company and Employee Premiums
TRICARE Supplement	Insured	ASI Insurance Co	Employee Premiums
Dental Benefit	Self-funded	MetLife	Company and Employee Contributions
Vision Benefit			
OptumHealth Vision	Insured	OptumHealth	Employee Contributions
EyeMed	Discount Program	EyeMed	Employee Contributions
Life Insurance			
Employee Basic	Insured	MetLife	Company Premiums
Employee Optional Life	Insured	MetLife	Employee Premiums
Spouse Life	Insured	MetLife	Employee Premiums
Child Life	Insured	MetLife	Employee Premiums
AD&D Insurance			
Basic AD&D	Insured	LINA (Cigna)	Company Premiums
VPAI	Insured	LINA (Cigna)	Employee Premiums
MPAI	Insured	LINA (Cigna)	Company Premiums
Special Purpose	Insured	LINA (Cigna)	Company Premiums
Special Risk	Insured	LINA (Cigna)	Company Premiums
Terrorism and Hostile Act Accident Insurance	Insured	LINA (Cigna)	Company Premiums
Optional Short Term Disability	Insured	MetLife	Employee Premiums
Long Term Disability	Insured	MetLife	Employee Premiums
Flexible Spending Accounts (FSAs)			
Health Care FSA	Self-funded	PayFlex	Employee Contributions
Dependent Day Care FSA	Self-funded	PayFlex	Employee Contributions
Long Term Care Insurance	Insured	MetLife	Employee Premiums

In "Benefits at a Glance," "Medical Benefit Options" on page 5, the following text is inserted before the subheading "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options":

Beginning January 1, 2009, the Eagle Plan's self-funded medical option – the PPO Copay Option, PPO Deductible Option, Minimum Coverage Option and Out-of-Area Option – are administered by two network and/or claims administrators:

- *Aetna*
- *Blue Cross and Blue Shield of Texas*

Each state will have one preferred network and/or claims administrator. Your preferred network and/or claims administrator is determined by the ZIP code of your Jetnet alternate address on record. Jetnet allows you to list two addresses — a permanent address (for tax purposes or for your permanent residence) and an alternate address (for a P.O. Box or street address other than your permanent residence). Since many employees maintain more than one residence, you may list both addresses in Jetnet; however, your alternate address determines your network and/or claims administrator. If you do not have an alternate address listed in Jetnet, your network and/or claims administrator is based on your permanent address.

A network and/or claims administrator is the health plan administrator that processes health care claims and manages a network of care providers and health care facilities. The list of the network and/or claims administrators by state resides on Jetnet.

In "Benefits at a Glance" on page 6, delete the section "Supplemental Medical Plan" in its entirety.

In "Enrollment," "Benefit ID Cards" on page 26, the first paragraph is replaced as follows:

If you elected to participate in Flexible Spending Account(s), PayFlex will mail your an FSA card (your "FSA card") to you. For information on how the card works, see the Flexible Spending Accounts sections beginning on page 147.

In "Medical Benefits," "Medical Benefit Options," "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Option" on page 48, the following text is inserted after the second paragraph on the page:

In a few rare cases, a U.S. employee may live outside all of the network areas and not have ready access to any of the provider networks. Effective January 1, 2009, if you reside in a ZIP code which is outside of the preferred network providers' service areas, you will have at least one Out-of-Area Option available. You will not incur any penalty or reduction in benefits if you use a provider outside the preferred administrator's network, as long as your ZIP code is considered "out-of-area."

In "Medical Benefits," "Medical Benefit Options," "PPO-Copay Option" on page 50, the following text is inserted after the second paragraph on the page:

Under the Eagle Plan effective January 1, 2009, if a covered employee or dependent makes a visit to a network obstetrician-gynecologist (OB-GYN) for preventive care or for treatment other than preventive care, the PPO-Copay Option's copayment rate is $20.

In "Medical Benefits," "Medical Benefit Options," "Health Maintenance Organizations (HMOs)" on page 55, the following text replaces the eighth paragraph on the page:

Under the Eagle Plan effective January 1, 2009, Domestic Partners of Eagle Plan HMO participants will be eligible to be covered under the Humana Puerto Rico and Triple S HMOs.

In "Medical Benefit Options," "Medical Benefit Options Comparison," "Mental Health and Chemical Dependency Benefits" on page 65, the following text is added as the first paragraph in the section:

Effective January 1, 2009, use of the network and/or claims administrators applies to network, claim, and overall care management (including mental health care). Aetna and Blue Cross and Blue Shield of Texas' internal medical case management administrators replace UnitedHealthcare's care management for the Eagle Plan.

The Aetna and Blue Cross and Blue Shield's care management programs are:

- *Aetna's Healthy Living (care management); Beginning Right (prenatal); Health Connections (case management)*
- *Blue Cross and Blue Shield's Get Fit, Eat Right and Live Well (care management); Special Beginnings (prenatal); Blue Care Connections (case management)*

These programs include services for health risk identification and assessment, lifestyle management and wellness programs, prenatal care management, chronic and catastrophic care management, confidential health care decision counseling (24-hour nurselines), and mental health care management. These are voluntary and confidential programs to help Eagle employees better manage their health needs, get healthier, and stay healthier.

Programs are offered to employees, but are external to the Eagle Plan.

The section "Supplemental Medical Plan" on pages 88 – 107, is stricken in its entirety. Effective December 31, 2008, Eagle has terminated its participation in the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries. The Eagle Plan does not offer any supplemental medical plan coverage for 2009.

In "Life and Accident Insurance Benefits," "Employee Term Life Insurance," "Contributory Term Life Insurance Benefits" on page 117, the following paragraph is added after the first paragraph in the section:

During 2009 annual enrollment, Eagle employees who are currently enrolled in the employee optional life insurance may increase their life insurance by one level for the 2009 plan year, without proof of good health.

Eagle employees who are not currently enrolled in optional life insurance may enroll in optional life insurance without providing proof of good health, equal to one times the employee's annual salary. This option for increasing coverage without proof of insurability is for the 2009 annual enrollment only (occurring during October, 2008).

In "Accident Insurance Benefit," "AD&D and VPAI Benefits" on page 125, directly before the section titled "Travel Accident Services":

Terrorism and Hostile Act AD&D Insurance for Eagle Pilots and Eagle Flight Attendants

Effective January 1, 2009, the Eagle Plan has increased the Terrorism and Hostile Act AD&D Insurance coverage. The insurance covers both Eagle pilots and Eagle flight attendants while on duty, and covers accidental death, dismemberment, and permanent total disability resulting from terrorism, sabotage, or other hostile actions anywhere in the world.

Effective January 1, 2009, the maximum benefit of this insurance is $200,000 per covered individual, and loss must occur within 365 days after the date of the covered accident.

If Injury Results in:	*T&HAAI Benefit Is:*
Loss of Life	*Full benefit amount*
Loss of Two or More Hands and/or Feet	*Full benefit amount*
Loss of Sight of Both Eyes	*Full benefit amount*
Loss of Sight of One Eye	*Full benefit amount*
Loss of One Hand or Foot	*1/2 benefit amount*
Loss of Speech	*1/2 benefit amount*
Loss of Hearing in Both Ears	*1/2 benefit amount*

The aggregate maximum of all benefits paid under this insurance, per accident, is $10,000,000.

In addition, this insurance provides a permanent and total disability (PTD) benefit of $200,000 per covered individual efective January 1, 2009,. If the covered individual becomes permanently and totally disabled from a covered accident; remains permanently and totally disabled for the duration of the waiting period (12 months after the date of the covered accident); and at the end of the waiting period, is certified by a physician to be disabled for the remainder of his/her life; the insurance will pay a lump sum benefit of $200,000, less any other AD&D benefit paid under the Eagle Plan for the covered loss causing the disability.

The section "Long Term Disability Insurance" on pages 139 – 144, is stricken in its entirety. With the separation of Eagle benefits effective January 1, 2009, Eagle will no longer participate in the American Airlines, Inc. Long Term Disability Insurance, but will offer employees participation in fully insured long term disability insurance, underwritten and insured by MetLife. Eagle employees who are currently in claim (either receiving long term disability benefits or are in their elimination period) under the American Airlines, Inc. Long Term Disability Plan shall remain as claimants in the plan until their benefits end (in accordance with the provisions described in the American Eagle Benefits Guide). The new fully insured long term disability insurance (from MetLife) in the new Eagle Health and Welfare Plan (effective January 1, 2009) will cover Eagle participants for disabilities beginning on or after January 1, 2009.

The section "Long Term Disability Insurance" on pages 139 – 144, is replaced with the following text:

LONG TERM DISABILITY INSURANCE

ELIGIBILITY

All regular employees on U.S. payroll of American Eagles, Inc. and Its Affiliates, which includes Flight Attendants, Non-Management Non-Union, Management and Pilots, are eligible for the Long Term Disability Insurance.

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for your eligible class as shown in the SCHEDULE OF BENEFITS.

You will be eligible for insurance the later of:

1. *January 1, 2009; and*

2. *The day after the date you complete the waiting period. The waiting period is one (1) month and begins on the date you become an eligible employee.*

ENROLLMENT PROCESS

If you are eligible for the Long Term Disability Insurance, you may enroll by completing the required form. You will receive this form when you enroll for your benefits. If you enroll for Long Term Disability Insurance, you must give permission for your premiums to be deducted from your paychecks.

DATE YOUR INSURANCE TAKES EFFECT

Enrollment When First Eligible

You must complete the enrollment process within 60 days of first becoming eligible. Your insurance will take effect on the date you become eligible, if you are an active employee on that date.

If you do not complete the enrollment process within 60 days of first becoming eligible, you will not be able to enroll until the next annual enrollment period

If you are not an active employee on the date your insurance would take effect, your insurance will take effect on the date you begin active employment.

Annual Enrollment
During annual enrollment, you may enroll in the Long Term Disability Insurance and will be required to give evidence of your insurability. You may also make changes to your Long Term Disability Insurance coverage. Your Long Term Disability Insurance coverage will take effect on the later of:

- *The January 1, following annual enrollment; or*
- *If you are not actively employed on the date your coverage would otherwise take effect, your coverage will take effect on the day you resume active employment.*

Changes in your disability Income Insurance will only apply to disabilities commencing on or after the date of the change.

Enrollment Due to a Qualifying Life Event
Under the rules of the Eagle Plan, you may enroll for Long Term Disability insurance outside of the annual enrollment period, only if you experience a qualifying life event.

If you are not actively employed on the date your coverage would otherwise take effect, coverage will take effect on the day you resume active employment.

Qualifying life events include:

- *marriage;*
- *the birth, adoption or placement for adoption of a dependent child;*
- *divorce, legal separation or annulment;*
- *the death of a dependent;*
- *a change in your or your dependent's employment status, such as beginning or ending employment, strike, lockout, taking or ending a leave of absence, changes in worksite or work schedule, if it causes you or your dependent to gain or lose eligibility for coverage.*

If you experience a qualifying life event, you will have 60 days from the date of that change to make a request. If you are approved, the changes will take effect on the first day of the month following the date of your request, if you are an active employee on that date.

If you are not an active employee on the date the change would take effect, the change will take effect on the day you resume active employment.

DATE YOUR LONG TERM DISABILITY INSURANCE ENDS

Your insurance will end on the earliest of:

1. *The date the Group Policy ends; or*
2. *The date insurance ends for your class; or*
3. *The end of the period for which your last premium is paid; or*

4. *The date you cease to be an active employee, if you are not disabled on that date; or*
5. *The date you retire; or*
6. *The date your employment ends.*

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

Reinstatement of Long Term Disability Insurance
If your insurance ends, you may become insured again as follows:

1. *If your insurance ends because:*

    - *You cease to be in an eligible class; or*
    - *Your employment ends; and*
    - *You become a member of an eligible class again within 3 months of the date your insurance ended, you will not have to complete a new waiting period or provide evidence of your insurability.*

2. *If your insurance ends because the required premium for your insurance has not been paid because you are on an approved Family Medical Leave Act (FMLA) leave of absence, and you become a member of an eligible class within 31 days of the earlier of:*

    - *The end of the period of leave you and the Company agreed upon; or*
    - *The end of the 12-week period following the date your leave began,*

    You will not have to complete a new waiting period or provide evidence of your insurability.

3. *In all other cases where your insurance ends because the required premium for your insurance has not been paid, you will be required to provide evidence of your insurability.*

If you become insured again as described in either 1 or 2 above, the pre-existing condition limitation for will be applied as if your insurance remained in effect with no interruption.

MAXIMUM BENEFIT PERIOD

The maximum benefit period is the later of your Normal Retirement Age or the period shown below:

Your Age on the Date of Your Disability	*Benefit Period*
Less than 60	*To age 65*
60	*60 months*
61	*48 months*
62	*42 months*
63	*36 months*
64	*30 months*
65	*24 months*
66	*21 months*
67	*18 months*
68	*15 months*
69 and over	*12 months*

**The Maximum Benefit Period is subject to the LIMITED DISABILITY BENEFITS and DATE BENEFIT PAYMENTS END sections.*

***Note:** If you cease or refuse to participate in a Rehabilitation Program that is required by MetLife, your monthly benefit payment will end.*

EVIDENCE OF INSURABILITY

MetLife may require you to provide evidence of insurability. Your evidence of insurability may be deemed unsatisfactory by MetLife if:

- *You make a late request. A late request is one made more than 60 days after you become eligible. However, if such request was made due to a qualifying life event, it will not be considered to be a late request.*

- *You do not give MetLife evidence of insurability or the evidence of insurability is not accepted by MetLife as satisfactory, you will not be covered.*

You must provide evidence of insurability at your expense, including the expenses for making any necessary copies and paying for postage fees.

If you become disabled while insured, Proof of Disability must be sent to MetLife. When MetLife receives your Proof of Disability, MetLife will review the claim. If MetLife approves the claim, MetLife will pay the monthly benefit, up to the maximum benefit period, as shown in the SCHEDULE OF BENEFITS, subject to THE DATE BENEFIT PAYMENTS END section.

DISABILITY INCOME INSURANCE

To verify that you continue to be disabled without interruption after MetLife's initial approval, MetLife may periodically request that you send MetLife proof of your disability. Proof may include physical exams, exams by independent medical examiners, in-home interviews or functional capacity exams, as needed.

While you are disabled, your monthly benefit will not be affected if:

- *Your insurance ends; or*

- *The Group Policy is amended to change the plan of benefits for your class.*

BENEFIT PAYMENT

If MetLife approves your claim, benefits will begin to accrue on the day after the day you complete your elimination period. MetLife will pay the first monthly benefit one month after the date your benefits begin to accrue. MetLife will make subsequent payments monthly thereafter so long as you remain disabled. Payments will be based on the number of days you are disabled during each month and will be pro-rated for any partial month of disability.

If you die, MetLife will pay the amount of any due and unpaid benefits as described in the GENERAL PROVISIONS subsection entitled Disability Income Benefit Payments: Who MetLife Will Pay.

While you are receiving monthly benefits, you will not be required to pay premiums for the cost any disability income insurance defined as Contributory Insurance.

RECOVERY FROM A DISABILITY

If you return to active employment, MetLife will consider you to have recovered from your disability.

The provisions of this section will not apply if your insurance has ended and you are eligible for insurance under another group long term disability plan.

If You Return to Active Employment before Completing Your Elimination Period
If you return to active employment before completing your elimination period for a period of 60 days or less, and then become disabled again due to the same or related illness or accidental injury, MetLife will not require you to complete a new elimination period. MetLife will not count those days towards the completion of your elimination period.

If you return to active employment for a period of more than 60 days, and then become disabled again, you will have to complete a new elimination period.

The term "active employment" only includes those days you actually work.

If You Return to Active Employment after Completing Your Elimination Period
If you return to active employment after completing your elimination period for a period of 3 months or less, and then become disabled again due to the same or related illness or accidental injury, MetLife will not require you to complete a new elimination period. For the purpose of determining your benefits, MetLife will consider your disability to be a part of the original disability and will apply the same terms, provisions and conditions that were used for your original disability.

If you return to active employment for a period of more than 3 months and then become disabled again, you will have to complete a new elimination period.

For purposes of this provision, the term active employment includes all of the continuous days which follow your return to work for which you are not disabled.

REHABILITATION INCENTIVES

Rehabilitation Program Incentive
If you participate in a Rehabilitation Program, MetLife will increase your monthly benefit by an amount equal to 10% of the monthly benefit. MetLife will do so before MetLife reduces your monthly benefit by any other income.

Work Incentive
While you are disabled, MetLife encourage you to work. If you work while you are disabled and are receiving monthly benefits, your monthly benefit will be adjusted as follows:

- *Your monthly benefit will be increased by your Rehabilitation Program Incentive, if any; and*
- *Reduced by other income as defined in the DISABILITY INCOME INSURANCE: INCOME WHICH WILL REDUCE YOUR DISABILITY BENEFIT section.*

Your adjusted monthly benefit will not be reduced by the amount you earn from working, unless your adjusted monthly benefit plus the amount you earn from working and the income you receive from other income exceeds 100% of your predisability earnings, as calculated in the definition of disability.

In addition, the minimum monthly benefit will not apply.

Limit on Work Incentive
After the first 24 months following your elimination period MetLife will reduce your monthly benefit by 50% of the amount you earn from working while disabled.

MetLife will reduce your disability benefit by the amount of all other income. Other income includes the following:

1. *Any disability or retirement benefits which you, your Spouse or child(ren) receive or are eligible to receive because of your disability or retirement under:*
    - *Federal Social Security Act;*
    - *Railroad Retirement Act;*
    - *Any state or public employee retirement or disability insurance.*
2. *Any income received for disability or retirement under the Eagle Retirement Plan, to the extent that it can be attributed to Eagle's contributions.*
3. *Any income received for disability under:*
    - *A group insurance policy to which the you have made a contribution, such as:*
        - *benefits for loss of time from work due to disability;*
        - *installment payments for permanent total disability;*
        - *a no-fault auto law for loss of income, excluding supplemental disability benefits;*
        - *a government compulsory benefit plan or program which provides payment for loss of time from your job due to your disability, whether such payment is made directly by the plan or program, or through a third party;*
        - *a self-funded plan, or other arrangement if Eagle contributes toward it or makes payroll deductions for it;*

- *any sick pay, vacation pay or other salary continuation that Eagle pays to you; or*
- *workers compensation or a similar law which provides periodic benefit;*

4. *Any income that you receive for working while disabled including but not limited to salary, commissions, overtime pay, bonus pay or other extra pay arrangements from any source.*

REDUCING YOUR DISABILITY BENEFIT BY THE ESTIMATED AMOUNT OF YOUR SOCIAL SECURITY BENEFITS

If there is a reasonable basis for you to apply for benefits under the Federal Social Security Act, MetLife assumes that you have applied for your Social Security benefits. To apply for Social Security benefits means to pursue these benefits until you receive approval from the Social Security Administration, or a notice of denial of benefits from an administrative law judge.

MetLife will reduce the amount of your disability benefit by the amount of Social Security benefits MetLife estimates that you, your Spouse or child(ren) are eligible to receive because of your disability or retirement. MetLife will begin to do this after you have received 24 months of disability benefit payments, unless MetLife has received:

- *Approval of your claim for Social Security benefits; or*
- *A notice of denial of such benefits indicating that all levels of appeal have been exhausted.*

However, within 6 months following the date you became disabled, you must:

- *Send MetLife proof that you have applied for Social Security benefits;*
- *Sign a reimbursement agreement in which you agree to repay MetLife for any overpayments MetLife may make to you under this insurance; and*
- *Sign a release that authorizes the Social Security Administration to provide information directly to MetLife concerning your Social Security benefits eligibility.*

If you do not satisfy the above requirements, MetLife will reduce your disability benefits by the estimated Social Security benefits starting with the first disability benefit payment that coincides with the date you were eligible to receive Social Security benefits.

In either case, when you receive approval or final denial of your claim for Social Security benefits as described above, you must notify MetLife immediately. MetLife will adjust the amount of your disability benefit. You must promptly repay MetLife for any overpayment.

SINGLE SUM PAYMENT

If you receive other income in the form of a single sum payment, you must, within 10 days after receipt of such payment, give written proof satisfactory to MetLife of:

- *The amount of the single sum payment;*
- *The amount to be attributed to income replacement; and*

- *The time period for which the payment applies.*

When MetLife receives this proof, MetLife will adjust the amount of your disability benefit.

If MetLife does not receive written proof as described above, and MetLife knows the amount of the single sum payment, MetLife may reduce your disability benefit by an amount equal to such benefit until the single sum has been exhausted.

If MetLife adjusts the amount of your disability benefit due to a single sum payment, the amount of the adjustment will not result in a benefit amount less than the minimum amount, except in the case of an overpayment.

If you receive other income in the form of a single sum payment and MetLife does not receive the written proof described above within 10 days after you receive the single sum payment, MetLife will adjust the amount of your disability benefit by the amount of such payment.

MetLife will not reduce your disability benefit to less than the minimum benefit shown in the SCHEDULE OF BENEFITS, or by:

- *Cost of living adjustments that are paid under any of the above sources of other income;*
- *Reasonable attorney fees included in any award or settlement. If the attorney fees are incurred because of your successful pursuit of Social Security disability benefits, such fees are limited to those approved by the Social Security Administration*
- *Group credit insurance;*
- *Mortgage disability insurance benefits;*
- *Early retirement benefits that have not been voluntarily taken by you;*
- *Veteran's benefits;*
- *Individual disability income insurance policies;*
- *Benefits received from an accelerated death benefit payment; or*
- *Amounts rolled over to a tax qualified plan unless subsequently received by you while you are receiving benefit payments.*

Your disability benefit payments will end on the earliest of:

- *The end of the Maximum Benefit Period;*
- *The date benefits end as specified in the section entitled LIMITED DISABILITY BENEFITS;*
- *The date you are no longer disabled;*
- *The date you die;*
- *The date you cease or refuse to participate in a Rehabilitation Program that MetLife requires;*
- *The date you fail to have a medical exam requested by MetLife as described in the Physical Exams subsection of the GENERAL PROVISIONS section; or*

- *The date you fail to provide required proof of continuing disability.*

While you are disabled, the benefits described in this certificate will not be affected if:

- *Your insurance ends; or*
- *The Group Policy is amended to change the plan of benefits for your class.*

Pre-existing Condition means an illness or accidental injury for which you:

- *Received medical treatment, consultation, care, or services; or*
- *Took prescription medication or had medications prescribed in the 3 months before your insurance under this certificate takes effect.*

MetLife will not pay benefits for a disability that results from a pre-existing condition, if you have been actively employed for less than 12 consecutive months after the date your disability insurance takes effect.

For Disabilities Due to Alcohol, Drug or Substance Abuse or Addiction, and Mental or Nervous Disorders or Diseases
If you are disabled due to:

- *Alcohol;*
- *Drug or substance addiction; or*
- *Mental or nervous disorders or diseases*

MetLife will limit your disability benefits to a lifetime maximum equal to the lesser of:

- *24 months; or*
- *The maximum benefit period.*

If your disability is due to alcohol, drug or substance addiction, MetLife requires you to participate in an alcohol, drug or substance addiction recovery program recommended by a physician. MetLife will end disability benefit payments at the earliest of the period described above or the date you cease, refuse to participate, or complete a recovery program.

If you are confined in a hospital or mental health facility at the end of the 24 month period for which benefits are to be paid, MetLife will continue your monthly benefits during your confinement. If you continue to be disabled when you are discharged, MetLife will continue your monthly benefits for up to a 90 day recovery period following the end of your hospital or mental health facility confinement. If you become reconfined at any time during this 90 day recovery period and remain confined for at least 14 consecutive days, MetLife will continue your monthly benefits during that confinement period and for one additional recovery period for up to 90 days.

MetLife will determine if a disability is the result of a mental or nervous disorder or disease.

This limitation will not apply to a disability resulting from:

- *Schizophrenia;*

- *Dementia; or*
- *Organic brain disease.*

A mental health facility is a facility licensed in the jurisdiction in which it is located to provide care and treatment for a mental or nervous disorder or disease. Such facility must provide care on a 24 hour a day basis under the supervision of a staff of physicians, and must provide a broad range of nursing care on a 24 hour a day basis by or under the direction of a registered professional nurse.

A mental or nervous disorder or disease means a medical condition which meets the diagnostic criteria set forth in the most recent edition of the Diagnostic And Statistical Manual Of Mental Disorders as of the date of your disability. A condition may be classified as a mental or nervous disorder or disease regardless of its cause.

For Disability Due to Neuromuscular, Musculoskeletal or Soft Tissue Disorder
Neuromuscular, musculoskeletal or soft tissue disorder including, but not limited to, any disease or disorder of the spine or extremities and their surrounding soft tissue; including sprains and strains of joints and adjacent muscles, unless the disability has objective evidence of:

- *Seropositive arthritis;*
- *Spinal tumors, malignancy, or vascular malformations;*
- *Radiculopathies;*
- *Myelopathies;*
- *Traumatic spinal cord necrosis; or*
- *Myopathies.*

MetLife will limit your disability benefits to a lifetime maximum equal to the lesser of:

- *24 months; or*
- *The maximum benefit period.*

Seropositive Arthritis means an inflammatory disease of the joints supported by clinical findings of arthritis plus positive serological tests for connective tissue disease.

Spinal means components of the bony spine or spinal cord.

Tumor(s) means abnormal growths which may be malignant or benign.

Vascular Malformations means abnormal development of blood vessels.

Radiculopathies means disease of the peripheral nerve roots supported by objective clinical findings of nerve pathology.

Myelopathies means disease of the spinal cord supported by objective clinical findings of spinal cord pathology.

Traumatic Spinal Cord Necrosis means injury or disease of the spinal cord resulting from traumatic injury with resultant paralysis.

Myopathies means disease of skeletal muscle supported by clinical, hystological, biochemical and/or electrodiagnostic findings.

MetLife will not pay for any disability caused or contributed to by:

1. *War, whether declared or undeclared, or act of war, insurrection, rebellion or terrorist act;*
2. *Your active participation in a riot;*
3. *Intentionally self-inflicted injury;*
4. *Attempted suicide; or*
5. *Commission of or attempt to commit a felony, assault or other serious crime, or engaged in an illegal occupation.*

FILING A CLAIM

You can obtain a claim form from MetLife. Return the completed claim form, with the required proof of disability, to MetLife, who will certify your insurance under the Group Policy. Send the certified claim form and proof of disability to MetLife, to the address listed on the claim form.

When MetLife receives the claim form and proof of disability, MetLife will review the claim and, if MetLife approves it, MetLife will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR INSURANCE BENEFITS

When you file an initial claim for benefits, the notice of claim and the required proof of disability should be sent to MetLife within 90 days of the date of a loss, following the steps below:

Step 1
You may give MetLife notice by calling MetLife at the toll free number shown on the Certificate Face Page within 20 days of the date of a loss.

Step 2
MetLife will send you a claim form, with instructions on how to complete it. You should receive the claim form within 15 days.

Step 3
When you receive the claim form, fill it out as instructed and return it with the required proof of disability as described in the claim form.

If you do not receive a claim form within 15 days after giving MetLife notice of claim, proof of disability may be sent using any form sufficient to provide MetLife with the required proof of disability.

Step 4
You must give MetLife proof of disability not later than 90 days after the date of loss.

If notice of claim or proof of disability is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and proof of disability are given as soon as is reasonably possible.

Items to be Submitted for a Disability Income Insurance Claim
When submitting proof of disability on an initial or continuing claim for Disability Income insurance, the following items are required:

- *Documentation which must include, but is not limited to, the following information:*
  - *the date your disability started;*
  - *the cause of your disability;*
  - *the prognosis of your disability;*
  - *the continuity of your disability; and*
  - *your application for:*
  - *other income;*
  - *Social Security disability benefits; and*
  - *Workers compensation benefits or benefits under a similar law.*
- *Written authorization for MetLife to obtain and release medical, employment and financial information and any other items MetLife may reasonably require to document your disability or to determine your receipt of or eligibility for other income; and*
- *Any and all medical information, including but not limited to:*
  - *X-ray films; and*
  - *photocopies of medical records, including:*
    - *histories,*
    - *physical, mental or diagnostic examinations; and*
    - *treatment notes; and*
    - *the names and addresses of all:*
      - *physicians and medical practitioners who have provided you with diagnosis, treatment or consultation;*
      - *hospitals or other medical facilities which have provided you with diagnosis, treatment or consultation; and*
      - *pharmacies which have filled your prescriptions within the past three years.*

Time Limit on Legal Actions.
A legal action on a claim may only be brought against MetLife during a certain period. This period begins 60 days after the date proof of disability is filed and ends 3 years after the date such proof of disability is required.

SPECIAL SERVICES

Social Security Assistance Program
If your claim for disability benefits under this plan is approved, MetLife provides you with assistance in applying for Social Security disability benefits. Before outlining the details of this assistance, you should understand why applying for Social Security disability benefits is important.

Why You Should Apply For Social Security Disability Benefits
Both you and Eagle contribute payroll taxes to Social Security. A portion of those tax dollars are used to finance Social Security's program of disability protection. Your spouse and children may also be eligible to receive Social Security disability benefits due to your disability.

There are several reasons why it may be to your financial advantage to receive Social Security disability benefits. Some of them are:

1. ***Avoids Reduced Retirement Benefits***
   Should you become disabled and approved for Social Security disability benefits, Social Security will freeze your earnings record as of the date Social Security determines that your disability has begun. This means that the months/years that you are unable to work because of your disability will not be counted against you in figuring your average earnings for retirement and survivors benefit.

2. ***Medicare Protection***
   Once you have received 24 months of Social Security disability benefits, you will have Medicare protection for hospital expenses. You will also be eligible to apply for the medical insurance portion of Medicare.

3. ***Trial Work Period***
   Social Security provides a trial work period for the rehabilitation efforts of disabled workers who return to work while still disabled. Full benefit checks can continue for up to 9 months during the trial work period.

4. ***Cost-of-Living Increases Awarded by Social Security Will Not Reduce your Disability Benefits***
   MetLife will not decrease your disability benefit by the periodic cost-of-living increases awarded by Social Security. This is also true for any cost-of-living increases awarded by Social Security to your spouse and children.

   This is called a Social Security "freeze." It means that only the Social Security benefit awarded to you and your dependents will be used by MetLife to reduce your disability benefit; with the following exceptions:

   a) *An error by Social Security in computing the initial amount;*
   b) *A change in dependent status; or*
   c) *Eagle submitting updated earnings records to Social Security for earnings received prior to your disability.*

   Over a period of years, the net effect of these cost-of-living increases can be substantial.

How MetLife Assists You in the Social Security Approval Process
As soon as you apply for disability benefits, MetLife begins assisting you with the Social Security approval process.

1. ***Assistance Throughout the Application Process***
   MetLife has a dedicated team of Social Security Specialists. These Specialists, many of whom have worked for the Social Security Administration, work at MetLife. They provide

expert assistance up front, offer support while you are completing the Social Security forms, and help guide you through the application process.

2. ***Guidance Through Appeal Process by Social Security Specialists***
   Social Security disability benefits may be initially denied, but are often approved following an appeal. If your benefits are denied, our dedicated team of Social Security Specialists provides expert assistance on an appeal if your situation warrants continuing the appeal process. They guide you through each stage of the appeal process. These stages may include:
   a) *Reconsideration by the Social Security Administration*
   b) *Hearing before an Administrative Law Judge*
   c) *Review by an Appeals Council established within the Social Security Administration in Washington, D.C.*
   d) *A civil suit in Federal Court.*

3. ***Social Security Attorneys***
   Depending on your individual needs, MetLife may provide a referral to an attorney who specializes in Social Security law. The Social Security approved attorney's fee is credited to the Long Term Disability overpayment, which results upon your receipt of the retroactive Social Security benefits. The attorney's fee, which is capped by Social Security law, will be deducted from the lump sum Social Security Disability benefits award and will not be used to further reduce your Long Term Disability benefit.

Early Intervention Program
The MetLife Early Intervention Program is offered to all covered employees, and your participation is voluntary. The program helps identify early those employees who might benefit from vocational analyses and rehabilitation services before they are eligible for Long Term Disability benefits. Early rehabilitation efforts are more likely to reduce the length of your Long Term Disability and help you return to work sooner than expected.*

If you cannot work, or can only work part-time due to a disability, your employer will notify MetLife. MetLife's Clinical Specialists may be able to assist you by:

1. *Reviewing and evaluating your disabling condition, even before a claim for Long Term Disability benefits is submitted (with your consent);*
2. *Designing individualized return to work plans that focus on your abilities, with the goal of return to work;*
3. *Identifying local community resources;*
4. *Coordinating services with other benefit providers, including: medical carrier, short term disability carrier,* workers' compensation carrier, and state disability plans;*
5. *Monitoring return to work plans in progress and modifying them as recommended by the attending physician (with your consent).*

MetLife's assistance is offered at no cost to you.

** If you also have Optional MetLife Short Term Disability insurance, this service is provided automatically. Notification by your employer is not necessary.*

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, MetLife can assist you in returning to work sooner than expected.

Incentives For Returning To Work
Your disability insurance 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.

Return-to-Work Services
As a covered employee you are automatically eligible to participate in our Return-to-Work Program. The program aims to identify 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 MetLife provides, 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. Also identify one's earning potential for a specific occupation.

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

4. ***Job Modifications/Accommodations***

   Analyses of job demands and functions to determine what modifications may be made to maximize your employment opportunities.

   This also includes 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).

5. ***Job Seeking Skills and Job Placement Assistance***

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

Return-to-Work Program Staff
The Case Manager handling your claim will coordinate return-to-work services. You may be referred to a clinical specialist, such as a Nurse Consultant, Psychiatric Clinical Specialist, or Vocational Rehabilitation Consultant, who has advanced training and education to help people with disabilities return to work. One of our clinical specialists will work with you directly, as MetLife as with local support services and resources. They have returned hundreds of individuals to meaningful, gainful employment.

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, MetLife continues to collaborate with you and your doctor to develop an appropriate return-to-work plan.

DEFINITIONS

As used in this section, the terms listed below will have the definition described below.

Active employment or actively employed *means that you are performing all of the usual and customary duties of your job on a full-time basis. This must be done at:*

- *Your place of business;*
- *An alternate place approved by the Company; or*
- *A place to which the Company's business requires you to travel.*

You will be deemed to be actively employed during weekends or approved vacations, holidays or business closures if you were actively employed on the last scheduled work day preceding such time off.

Appropriate care and treatment *means medical care and treatment that is:*

- *Given by a physician whose medical training and clinical specialty are appropriate for treating your disability;*
- *Consistent in type, frequency and duration of treatment with relevant guidelines of national medical research, health care coverage organizations and governmental agencies;*
- *Consistent with a Physician's diagnosis of your disability; and*
- *Intended to maximize your medical and functional improvement.*

Beneficiary *means the person(s) to whom MetLife will pay insurance as determined in accordance with the GENERAL PROVISIONS section.*

Consumer Price Index *means the CPI-W, the Consumer Price Index for Urban Wage Earners and Clerical Workers published by the U.S. Department of Labor. If the CPI-W is discontinued or replaced, MetLife reserves the right to substitute any other comparable index.*

Contributory insurance *means insurance for which you are required to pay any part of the premium.*

Disabled *or* ***disability*** *means that, due to illness or as a direct result of accidental injury:*

- *You are receiving appropriate care and treatment and complying with the requirements of such treatment; and*
- *During the first 24 months of illness or accidental injury, you are unable to perform each of the material duties of your own occupation; and*
- *After such period, unable to perform the duties of any gainful occupation for which you are reasonably qualified taking into account your training, education and experience.*

For purposes of determining whether a disability is the direct result of an accidental injury, the disability must have occurred within 90 days of the accidental injury and resulted from such injury independent of other causes.

If you are disabled and have received a monthly benefit for 12 months, MetLife will adjust your predisability earnings only for the purposes of determining whether you continue to be disabled and for calculating the Return to Work Incentive, if any. MetLife will make the initial adjustment as follows:

MetLife will add to your Predisability Earnings an amount equal to the product of:

- *Your Predisability Earnings times the lesser of:*
- *Seven percent (7%); or*
- *The annual rate of increase in the Consumer Price Index for the prior calendar year.*

Annually thereafter, MetLife will add an amount to your adjusted Predisability Earnings calculated by the method set forth above but substituting your adjusted Predisability Earnings from the prior year for your Predisability Earnings. This adjustment is not a cost of living benefit.

If your occupation requires a license, the fact that you lose your license for any reason will not, in itself, constitute disability.

Elimination period *means the period of your disability during which MetLife does not pay benefits. The elimination period begins on the day you become disabled and continues for the period shown in the SCHEDULE OF BENEFITS.*

Full-time *means active employment on a regular work schedule for the eligible class of employees to which you belong. The work schedule must be at least 30 hours a week.*

Illness *means sickness, disease or pregnancy, including complications of pregnancy.*

Normal Retirement Age *means that as defined by the federal Social Security Administration on the date your disability starts.*

Own occupation *means the essential functions you regularly perform that provide your primary source of earned income.*

Physician *means:*

- *A person licensed to practice medicine in the jurisdiction where such services are performed; or*
- *Any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.*

The term does not include:

- *You;*
- *Your spouse; or*
- *Any member of your immediate family including your and/or your spouse's:*
  - *parents;*
  - *children (natural, step or adopted);*
  - *siblings;*
  - *grandparents; or*
  - *grandchildren.*

Predisability earnings *means annual base salary or annualized hourly pay, plus skill and license premiums and market differentials. MetLife calculates this amount on a monthly basis.*

The term includes:

- *Contributions you were making through a salary reduction agreement with the Company to any of the following:*
- *An Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;*
- *An executive non-qualified deferred compensation arrangement; and*
- *Your fringe benefits under an IRC Section 125 plan.*

The term does not include:

- *Commissions;*
- *Awards and bonuses;*
- *Overtime pay;*
- *The grant, award, sale, conversion and/or exercise of shares of stock or stock options;*

- *The Company's contributions on your behalf to any deferred compensation arrangement or pension plan; or*
- *Any other compensation from the Company.*

Proof of disability *means written evidence satisfactory to MetLife that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, proof of disability must establish:*

- *The nature and extent of the loss or condition;*
- *MetLife's obligation to pay the claim; and*
- *Your right to receive payment.*

Proof of disability must be provided at your expense.

Rehabilitation program *means a program that has been approved by us for the purpose of helping you return to work. It may include, but is not limited to, your participation in one or more of the following activities:*

- *Return to work on a modified basis with a goal of resuming employment for which you are reasonably qualified by training, education, experience and past earnings;*
- *On-site job analysis;*
- *Job modification/accommodation;*
- *Training to improve job-seeking skills;*
- *Vocational assessment;*
- *Short-term skills enhancement;*
- *Vocational training; or*
- *Restorative therapies to improve functional capacity to return to work.*

Retirement Plan *means a plan which**:***

- *Provides retirement benefits to employees; and*
- *Is funded in whole or in part by Eagle contributions.*

The term does not include:

- *Profit sharing plans;*
- *Thrift or savings plans;*
- *Non-qualified plans of deferred compensation;*
- *Plans under IRC Section 401(k) or 457;*
- *Individual retirement accounts (IRA);*
- *Tax sheltered annuities (TSA) under IRC Section 403(b);*
- *Stock ownership plans; or*
- *Keogh (HR-10) plans.*

Signed *means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to MetLife and consistent with applicable law.*

Spouse *means your lawful spouse.*

Written or writing *means a record which is on or transmitted by paper or electronic media which is acceptable to MetLife and consistent with applicable law.*

In "Flexible Spending Accounts," "Overview" on page 147, the following text replaces the fifth paragraph:

Effective January 1, 2009, employees who elect participation in an HCFSA and/or a DDFSA will use either an FSA card or automatic reimbursement, depending on the medical plan option elected during October benefits enrollment.

In "Flexible Spending Accounts," "Overview" on page 147, the following text replaces the sixth paragraph:

Effective January 1, 2009, the FSA administrator changed from UnitedHealthcare to PayFlex — for both HCFSAs and DDFSAs. PayFlex's Web site, www.mypayflex.com, allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access "Frequently Asked Questions (FAQs)," and manage direct deposit and automatic rollover features.

In "Flexible Spending Accounts," "Health Care FSA" on page 147, the following paragraph is inserted as the first paragraph in the section:

Prior to January 1, 2009, UnitedHealthcare administered the FSAs and processed your claims once you enrolled in an FSA. Effective January 1, 2009, the FSA administrator changed from UnitedHealthcare to PayFlex. Claims for eligible expenses incurred on or after January 1, 2009, should be submitted to PayFlex. Claims incurred in 2008 and though the grace period (March 15, 2009) should be submitted to PayFlex by June 15, 2009.

In "Flexible Spending Accounts" on page 148, the first two sentences of the first paragraph are replaced as follows:

Note: Effective January 1, 2009, the Flexible Spending Account administrator changed from UnitedHealthcare to PayFlex. Claims for eligible expenses incurred on or after January 1, 2009, should be submitted to PayFlex.

In "Flexible Spending Accounts," "Dependent Day Care Flexible Spending Account," "How the DDFSA Works" on page 154, the following text is added as the last sentence in the section "Conditions for Deposit and Maximum Allowable Deposit Amounts":

If you are a Highly Compensated Employee, as defined by the Internal Revenue Code, your allowable annual pre-tax contribution may be less than $5,000 per calendar year. For example, for 2009 a Highly Compensated Employee, as defined by the Internal Revenue Code is an individual who has an annual income of $105,000 or more. The DDFSA limit in 2009 for Highly Compensated Employees is $2,500. This amount may be subject to change, and you will be notified if your maximum contribution changes.

In "Flexible Spending Accounts," "Health Care FSA," "Receiving Reimbursement" and "Filing Claims" on pages 151 – 153 the text in these sections is replaced with the following text:

You may receive reimbursement from your HCFSA through two different methods. How you receive reimbursement depends on the medical option you elect during October benefits enrollment. See the chart below for more information.

Your medical option	Your reimbursement method is ...
PPO Copay Option	FSA card or automatic reimbursement
Minimum Coverage Option	Automatic reimbursement
PPO Deductible Option	Automatic reimbursement
Out-of-Area Coverage Option	Automatic reimbursement
HMO	FSA card

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link at www.mypayflex.com.

All participants have the option to file online or paper claims with PayFlex. See www.mypayflex.com for more information.

Beginning January 1, 2009, if you had an FSA for 2008 and did not elect an FSA for 2009, you will file any remaining 2008 FSA claims through PayFlex using online and/or paper claims. See www.mypayflex.com for more information.

You have until March 15 to use your prior year's balance and until June 15 to file claims.

In "Flexible Spending Accounts," "Dependent Day Care Flexible Spending Accounts," on page 153, the following text replaces the first paragraph:

Note: Prior to January 1, 2009, UnitedHealthcare administered the FSAs and processed your claims once you enrolled in an FSA. Effective January 1, 2009, the FSA administrator changed from UnitedHealthcare to PayFlex. Claims for eligible expenses incurred on or after January 1, 2009, should be submitted to PayFlex. Claims incurred in 2008 and though the grace period (March 15, 2009) should be submitted to PayFlex by June 15, 2009.

In "Flexible Spending Accounts," "Dependent Day Care Flexible Spending Account," "Receiving Reimbursement" and "Filing Claims" on pages 155 – 157, the following text replaces these sections:

All participants who have a DDFSA will automatically receive an FSA card. You can also submit a claim for reimbursement online at www.mypayflex.com or complete a paper claim and send it to PayFlex by fax or mail. The fax number and mailing address are available on www.mypayflex.com.

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link at www.mypayflex.com.

Beginning January 1, 2009, if you had a DDFSA for 2008 and did not elect a DDFSA for 2009, you will file any remaining 2008 FSA claims through PayFlex using online and/or paper claims. See www.mypayflex.com for more information.

You have until March 15 to use your prior year's balance and until June 15 to file claims.

In "Flexible Spending Accounts," on page 157, the following section is added as a new section:

If You Elect Both a Health Care and Dependent Day Care FSA

If you elect both types of FSAs it will affect how you are reimbursement for eligible expenses. All participants may submit claim for reimbursement online at www.mypayflex.com or complete a paper claim and send it to PayFlex by fax or mail. The fax number and mailing address are available on www.mypayflex.com.

Your Medical Option Election	***If you have …***	***Your reimbursement method is ...***
PPO Co-Pay Plan	*The Health Care FSA (HCFSA) and the Dependent Day Care FSA (DDFSA)*	*For the HCFSA, you will be required to make choice between an FSA card and auto rollover at time of enrollment on Benefits Workstation.* *If auto rollover is elected, you will have to file manual claims for the DDFSA.* *If an FSA card is elected, you will receive a single an FSA card that will work for both the HCFSA and the DDFSA.*
PPO Deductible/OOA Plan	*The Health Care FSA (HCFSA) and the Dependent Day Care FSA (DDFSA)*	*For the HCFSA, you will not be able to elect an FSA card; you will automatically default to auto rollover.* *For the DDFSA, you will be required to file manual claims.*

Your Medical Option Election	*If you have …*	*Your reimbursement method is ...*
Minimum Coverage Plan	*The Health Care FSA (HCFSA) and the Dependent Day Care FSA (DDFSA)*	*For the HCFSA, you will not be able to elect an FSA card; you will automatically default to auto rollover.* *For the DDFSA, you will be required to file manual claims.*
HMOs	*The Health Care FSA (HCFSA) and the Dependent Day Care FSA (DDFSA)*	*For the HCFSA, you will automatically receive an FSA card; auto rollover will not be an option for this group.* *For the DDFSA, you will be required to file manual claims.*

You may elect to have your reimbursements deposited directly into your checking or savings account, simply by providing your account information online via the Direct Deposit link at www.mypayflex.com.

If you had an FSA for 2008 and did not elect an FSA for 2009, you will file your remaining 2008 FSA claims using online and/or paper claims. See www.mypayflex.com for more information.

You have until March 15 to use your prior year's balance and until June 15 to file claims.

END OF SUMMARY OF MATERIAL MODIFICATIONS

CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE FOR AMERICAN EAGLE AIRLINES EMPLOYEES

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of clarifications to the summary plan description – the American Eagle Employee Benefits Guide ("EBG"). These clarifications, together with the EBG, make up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in your EBG).**

These clarifications apply to:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798; referred to herein as the "Plan")

In "Benefits at a Glance," "Vision Insurance Benefit" on page 7, the following clarifications apply:

> You have the opportunity to enroll in vision coverage, insured and administered by OptumHealth Vision (formerly known as Spectera, Inc.), a national vision care company. The Vision Benefit offers a network of providers, including retail chains such as Eyemasters, as well as independent providers. To locate participating providers, log on to www.myoptumhealthvision.com or contact OptumHealth Vision (formerly known as Spectera, Inc.) at 800-638-3120.

In "Eligibility," "Dependent Eligibility" on page 14, the following clarification applies after the first paragraph:

> When a dependent is covered, that dependent must be covered under the same medical, dental and vision benefits as the employee. A dependent cannot be covered under a different benefit than the employee. For example, if you elect to cover your dependents for medical and you select the PPO Copay for yourself, you cannot select PPO Deductible coverage for your dependents. They will receive PPO Copay coverage – the same as you. This applies to all dependents of an employee, including domestic partners.

In "Enrollment," Making Changes During the Year," "Life Events," "Benefit Coverages Affected by Life Events" on page 34, the following clarifications apply:

> **Vision Insurance Benefit:** You may add coverage for yourself and your eligible dependents if you experience a qualifying Life Event. The Vision Insurance Benefit is structured in a manner similar to the Medical Options the Company offers and is insured and administered by OptumHealth Vision (formerly known as Spectera, Inc.), a national vision care company. This coverage offers a network of providers and co-payments for certain vision services.

In Vision Insurance Benefit on page 114, the following text is inserted as the first paragraph in the section:

> Effective January 1, 2009, the administrator's name has changed from Spectera, Inc. to OptumHealth Vision.

In "Vision Benefits" on pages 114 – 116, in all instances Spectera are replaced with OptumHealth Vision (formerly known as Spectera, Inc.).

In "Vision Benefits" on pages 114 – 116, in all instances www.spectera.com is replaced with www.myoptumhealthvision.com.

In "Life and Accident Insurance Benefits," Accident Insurance Benefit," "Other Accident Insurance" on page 128, the following clarification applies:

> The Company provides other accident insurance for certain situations described in this section. Other accident insurance programs include Management Personnel Accident Insurance (MPAI), Special Risk Accident Insurance (SRAI) and Special Purpose Accident Insurance (SPAI). These insurance coverages all have the following features:

END OF CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the Group Health and Welfare Plan for American Eagle Airlines, Inc. and Its Affiliates.

These plans provide coverage for reconstructive surgery, as follows:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery or reconstruction of the other breast to produce a symmetrical appearance;
- Services in connection with other complications resulting from a mastectomy, such as treatment of lymphademas; and
- Prostheses.

This information is also available in your Employee Benefits Guide – in both the CD-ROM version (if applicable to your work group) sent to you in July – August, 2005, and via *Jetnet* in e-HR.

END OF ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

2009 American Eagle Medical Plan Comparison Chart

2009 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
DEDUCTIBLES / MAXIMUMS						
Individual Annual Deductible	$250	$250	None	$1,000	$500	$2,000
Family Annual Deductible	$750	$750	None	$2,000	Not Applicable	$4,000
Individual Annual Out-of-Pocket Maximum*	$2,000	$2,000	$2,000	$3,000	$4,000	$5,000
Individual Lifetime Medical Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
PREVENTIVE CARE						
Annual Routine Physical Exam	20% coinsurance without deductible waived	20% coinsurance without deductible waived	$20 copayment*	20% coinsurance without deductible waived	Not Covered	Not Covered
Pap Test	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
Screening Mammogram according to age guidelines, (Age 35 thru 39- one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond- once every year)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
PSA screening and colorectal screening (according to age guidelines - routine coverage begins at age 50)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
Well Child office visits and immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	$20 copayment*	20% coinsurance without deductible waived	Not Covered	Not Covered
MEDICAL SERVICES						
Primary Care Physician's Office Visit	20% coinsurance	20% coinsurance	$20 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	20% coinsurance	$35 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Gynecological Care Visit	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	$20 copayment* (for preventive and diagnostic visits)	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Diagnostic Mammogram according to age guidelines, (Age 35 thru 39- one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond- once every year)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)
Pregnancy - Physician Services	20% coinsurance	20% coinsurance	$20 copayment* per visit $350 max copayment per pregnancy (includes prenatal/postnatal/delivery)	20% coinsurance	40% coinsurance	40% coinsurance
PSA and colorectal diagnostic exam (according to age guidelines - routine coverage begins at age 50) Diagnostic	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)
Second Surgical Opinion	20% coinsurance	20% coinsurance	$20 copay PCP $35 copay Specialist	20% coinsurance	40% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	20% coinsurance	$25 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Chiropractic Care Visit	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	$35 copayment* (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	20% coinsurance	$35 copayment* per visit (max copayment of $350 per person per year)	20% coinsurance	40% coinsurance	40% coinsurance

2009 American Eagle Medical Plan Comparison Chart

2009 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
Allergy Care	20% coinsurance	20% coinsurance	$35 copayment* per visit (max copayment of $350 per person per year)	20% coinsurance	40% coinsurance	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office or a network laboratory/radiology center	20% coinsurance	40% coinsurance	40% coinsurance
OUTPATIENT SERVICES						
Outpatient Surgery in Physician's Office	20% coinsurance	20% coinsurance	$20 copay PCP $35 copay Specialist	20% coinsurance	40% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
HOSPITAL SERVICES						
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	20% coinsurance	$150 copayment* per year, plus 20% coinsurance for all other hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via Jetnet within 60 days or these charges will not be covered.)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance for all hospital based services (hospital admission copayment of $150 does not apply to baby)	20% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office	20% coinsurance	40% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance	No Cost	20% coinsurance	20% coinsurance	40% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% coinsurance	$75 copayment* (Waived if admitted to the hospital) plus 20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
OUT-OF-HOSPITAL CARE						
Convalescent and Skilled Nursing facility, following hospitalization	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance	20% coinsurance	$20 copayment/day	20% coinsurance	40% coinsurance	40% coinsurance
Hospice Care	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital; $20 copayment per day if home care	20% coinsurance	40% coinsurance	40% coinsurance
OTHER SERVICES						

2009 American Eagle Medical Plan Comparison Chart

2009 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance	20% coinsurance	$20 copay PCP $35 copay Specialist 20% coinsurance in hospital or freestanding surgical center	20% coinsurance	40% coinsurance	40% coinsurance
Infertility Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Radiation Therapy (Infusion Therapy)	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital	20% coinsurance	40% coinsurance	40% coinsurance
Chemotherapy	20% coinsurance	20% coinsurance	20% coinsurance if performed in a hospital or freestanding facility	20% coinsurance	40% coinsurance	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital or dialysis center	20% coinsurance	40% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	20% coinsurance for items rented or purchased from an in-network provider	20% coinsurance	40% coinsurance	40% coinsurance
MENTAL HEALTH AND CHEMICAL DEPENDENCY						
Inpatient Mental Health Care	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance for all hospital based services	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)
Alternative Mental Health Center	50%** (max of 30 days per year)	50%** (max of 30 days per year)	20% coinsurance for all hospital based services	50%** (max of 30 days per year)	50%** (max of 30 days per year)	50%** (max of 30 days per year)
Outpatient Mental Health Care Visit	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)	$35 copayment	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)
Marriage Counseling	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

2009 American Eagle Medical Plan Comparison Chart

2009 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
Detoxification (considered a medical condition)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Chemical Dependency*** Inpatient Rehabilitation	20% coinsurance if approved by EAP (max $5,000 benefit)	20% coinsurance if approved by EAP (max $5,000 benefit)	20% coinsurance for all hospital based services if approved by EAP	20% coinsurance if approved by EAP (max $5,000 benefit)	40% coinsurance if approved by EAP (max $5,000 benefit)	40% coinsurance if approved by EAP (max $5,000 benefit)
Chemical Dependency*** Outpatient Rehabilitation	50%** if approved by EAP	50%** if approved by EAP	$35 copayment* per visit if approved by EAP (max copayment of $350 per person per year)	50%** if approved by EAP	50%** if approved by EAP	50%** if approved by EAP
PRESCRIPTION MEDICATIONS						
Retail Pharmacy* (up to a 30 day supply)	**Retail Card Program** **Generic:** 20% ($10 Min/$50 Max) **Brand:** (no generic available) 30% ($25 Min/$75 Max) **Brand**:(if generic available) 50% ($40 Min/$100 Max)	**Retail Card Program** **Generic:** 20% ($10 Min/$50 Max) **Brand:** (no generic available) 30% ($25 Min/$75 Max) **Brand**:(if generic available) 50% ($40 Min/$100 Max)	**Retail Card Program** **Generic:** 20% ($10 Min/$50 Max) **Brand:** (no generic available) 30% ($25 Min/$75 Max) **Brand**:(if generic available) 50% ($40 Min/$100 Max)	**Retail Card Program** **Generic:** 20% ($10 Min/$50 Max) **Brand:** (no generic available) 30% ($25 Min/$75 Max) **Brand**:(if generic available) 50% ($40 Min/$100 Max)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)
Mail Service Pharmacy* (up to a 90 day supply)	**Generic:** 20% ($25 Min/$125 Max) **Brand:** (no generic available) 30% ($60 Min/$185 Max) **Brand:** (if generic available) 50% ($100 Min/$250 Max)	**Generic:** 20% ($25 Min/$125 Max) **Brand:** (no generic available) 30% ($60 Min/$185 Max) **Brand:** (if generic available) 50% ($100 Min/$250 Max)	**Generic:** 20% ($25 Min/$125 Max) **Brand:** (no generic available) 30% ($60 Min/$185 Max) **Brand:** (if generic available) 50% ($100 Min/$250 Max)	**Generic:** 20% ($25 Min/$125 Max) **Brand:** (no generic available) 30% ($60 Min/$185 Max) **Brand:** (if generic available) 50% ($100 Min/$250 Max)	Not Applicable	Not Applicable
Retail Service Pharmacy* (up to a 90 day supply) **For Long-Term medications (taken for 3 months or more) begining with 4th fill.**	**Generic:** 40% ($10 Min/No-Max) **Brand:** (no generic available) 50% ($25 Min/No-Max) **Brand:** (if generic available) 75% ($40 Min/No-Max)	**Generic:** 40% ($10 Min/No-Max) **Brand:** (no generic available) 50% ($25 Min/No-Max) **Brand:** (if generic available) 75% ($40 Min/No-Max)	**Generic:** 40% ($10 Min/No-Max) **Brand:** (no generic available) 50% ($25 Min/No-Max) **Brand:** (if generic available) 75% ($40 Min/No-Max)	**Generic:** 40% ($10 Min/No-Max) **Brand:** (no generic available) 50% ($25 Min/No-Max) **Brand:** (if generic available) 75% ($40 Min/No-Max)	Not Applicable	Not Applicable
Oral Contraceptives (available only thru mail service)	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OTHER INFORMATION						
CheckFirst (predetermination of benefits via Aetna or Blue Cross Blue Shield)	Call your network/claim administrator to request the form. Complete it, and mail to the address provided.	Call your network/claim administrator to request the form. Complete it, and mail to the address provided.	Call your network/claim administrator to request the form. Complete it, and mail to the address provided.	Call your network/claim administrator to request the form. Complete it, and mail to the address provided.	Call your network/claim administrator to request the form. Complete it, and mail to the address provided.	Call your network/claim administrator to request the form. Complete it, and mail to the address provided.

*Deductibles, fixed copayments or payments for prescription drugs do not apply toward the annual out-of-pocket maximum

**50% coinsurance amounts do not apply toward the annual out-of-pocket maximum

***Rehabilitation for Chemical Dependency limited to one per lifetime and must be approved by EAP

Disclaimer: The American Eagle Employee Benefits Guide (EBG) is the legal plan document and the summary plan description (SPD) for American Eagle's Benefits Plans. If there is any discrepancy between the EBG and this chart, the EBG will

SUMMARY OF MATERIAL MODIFICATIONS FOR HEALTH AND WELFARE BENEFIT PLANS SPONSORED BY AMERICAN AIRLINES, INC.

June 30, 2008

This document serves as notice to **American Eagle Airlines, Inc.** active and Leave-of-Absence employees of changes to the Company sponsored health and welfare benefit plans listed below. This Summary of Material Modifications describes the changes that affect your benefit plans and updates your summary plan descriptions. This Summary of Material Modifications, together with the Employee Benefits Guide, makes up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in the Employee Benefit Guide ("EBG")). These changes are effective June 30, 2008, unless otherwise stated elsewhere in this document.**

These changes apply to all plans in the benefit program of American Eagle Airlines, Inc., including the

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798; referred to herein as the "Plan"), and
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503, EIN #13-1502798, referred to herein as the "Supplemental Medical Plan").

Modification to "Supplemental Medical Plan," "Enrollment," "Special Enrollment Rights" (page 4) of the SMM effective 3/15/06, the following sentence should be added to the end of the second paragraph:

If you miss the 60-day deadline, the enrollment will not be processed.

Modification to "Enrollment," "Making Changes During the Year, "Overview" (pages 26-27), the third bullet should be replaced by the following text:

Life Event changes must be made within the 60-day time frame. If you miss the 60-day deadline, your Life Event change will not be processed. You will have to wait until the next annual enrollment period to process your Life Event.

However, if your dependent(s) lose eligibility under the Plan, you must contact HR Services to remove the ineligible dependent(s) from coverage – even if you have missed the 60-day deadline. If you contact HR Services after the 60-day deadline you will be able to remove your dependent(s) from coverage, but the effective date of the removal will be the date you notified HR Services, and your resulting contribution rate changes, if any, will be effective as of the date you notified HR Services. You will not receive a refund of contributions paid between the date your dependent(s) became ineligible for coverage and the date you notified HR Services of their ineligibility. Keep in mind that if you do not notify HR Services of your dependent(s)' eligibility within the 60-day timeframe, the dependent(s) will lose their right to continue coverage under COBRA, so it is important that you are timely in registering your dependent(s)' removal from coverage within the 60-day timeframe.

END OF SUMMARY OF MATERIAL MODIFICATIONS

CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE FOR AMERICAN EAGLE AIRLINES EMPLOYEES
June 30, 2008

This document serves as notice to **American Eagle Airlines, Inc.** active and Leave-of-Absence employees of clarifications to the summary plan description – the American Eagle Employee Benefits Guide ("EBG"). These clarifications, together with the EBG, make up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in your EBG).**

These clarifications apply to all plans in the benefit program for American Eagle Airlines, Inc., including the

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798; referred to herein as the "Plan")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503, EIN #13-1502798; referred to herein as the "Supplemental Medical Plan")

In "Enrollment," "Special Enrollment Rights" (on page 2 of the SMM effective 3/15/06 and page 26 of the EBG), the following clarifications apply to the second paragraph:

> *As an employee, you may enroll yourself and your new spouse and any dependents within 60 days of your marriage, and a new child within 60 days of his or her birth, adoption or placement for adoption. If you miss the 60-day deadline, the enrollment will not be processed. You will have to wait until the next annual enrollment period to enroll your dependent. In addition, if you are not enrolled in the employee benefits as an employee, you also must enroll in the employee benefits when you enroll any of these dependents. And, if your spouse is not enrolled in the employee benefits, you may enroll yourself and/or him/her in the employee benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage, coverage will begin on the first day of the first calendar month after the completed enrollment form is received. In the case of birth, adoption or placement for adoption, coverage is retroactive to the date of birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact HR Services (see Contact Information).*
>
> *If you are in the Supplemental Medical Plan and miss the 60-day deadline, the enrollment will not be processed. You will not have another opportunity to enroll your spouse.*

In “Medical Benefits,” “Medical Benefits Options,” “Hospital Services” the text in the table on page 43 should be clarified as follows:

Features	***Amount You Pay Under …***			
	In-Network PPO-Deductible & Out-of-Area Coverage	***In-Network PPO-Copay***	***Minimum Coverage***	***Out-of-Network PPO-Deductible & PPO-Copay***
Newborn nursery care *is considered under the baby’s coverage, not the mother’s. Within 60 days of the birth, you must process a Life Event change online through Jetnet to enroll your baby in your health coverage, even if you already have other children enrolled in coverage. If you do not, you must wait until the next annual enrollment period to enroll your baby in coverage. Payment of maternity claims does not automatically enroll your baby*	*20% coinsurance*	*20% coinsurance for all hospital-based services* *($150 copayment for hospital admission does not apply to the baby)*	*20% coinsurance*	*40% coinsurance*

In “Medical Benefits,” “Covered Expenses” (page 61), the following clarification applies:

> ***Newborn nursery care:*** *Hospital expenses for a healthy newborn baby are considered under the baby’s coverage, not the mother’s.*
>
> *To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. If you miss the 60-day deadline you will not be able to add your baby to your coverage until the next annual enrollment period, even if you already have other children enrolled in coverage.*

In “Supplemental Medical Plan,” “Eligibility,” “Employees Married to Employees” (page 88), the following clarification applies to the first bullet:

> *If both you and your spouse are eligible for the Supplemental Medical Plan as employees, you must each make a separate election for participation in the Supplemental Medical Plan. If one of you leaves the Company, the spouse that continues employment with the Company may add the other to Supplemental Medical Plan coverage as a dependent spouse within 60 days of the spouse’s termination of employment. If you miss the 60-day deadline, you will not be able to add the terminated spouse to your coverage.*

In "Supplemental Medical Plan," "Enrollment" (on page 4 of the SMM effective 3/15/06, page 4 of Clarifications of the SMM effective 12/15/06, and page 90 of the EBG), the following clarification applies to the first paragraph:

> *You may enroll only as an active employee when you are first eligible, or, if you later marry or declare a Domestic Partner (you must enroll yourself and/or your spouse/Domestic Partner within 60 days of your marriage/declaration; otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan). If you elect to drop Supplemental Medical Plan coverage for yourself or for you and your spouse, you will not be able to re-enroll, unless you later marry or declare a Domestic Partner, while you are still an active employee. If you experience one of these events, and you wish to make a change in your Supplemental Medical Plan coverage, you must make the change within 60 days of the event. <u>If you miss the 60-day deadline, you will not be able to add your spouse/Domestic Partner to your coverage</u>. You pay Supplemental Medical Plan contributions by after-tax payroll deductions. To see more of the enrollment rules, see Life Events beginning on page 28.*

In "Life and Accident Insurance Benefits," "Spouse and Child Term Life Insurance Benefits" (page 120), the following text replaces the fourth paragraph on the page:

> *You may elect Child Term Life Insurance for your eligible dependent child when first eligible or at a later date, and no proof of good health is required. You may also elect Spouse Term Life Insurance for your spouse when first eligible, and no proof of good health is required. Coverage becomes effective only after you (the employee) pay the first contribution, either directly or through payroll deduction.*
>
> *However, if you later want to add or increase Spouse Term Life Insurance, your spouse must complete a Statement of Health form. You must then forward the completed form to MetLife for review. Upon approval from MetLife, Spouse Term Life Insurance will be added or increased for your spouse. Coverage that requires proof of good health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction.*

In "Life and Accident Insurance Benefits," "Accident Insurance Benefit" "Overview" (on page 10 of the SMM effective 12/15/06 and page 122 of the EBG), the first chart on the page should be revised as follows:

Family Covered	***Amount of Benefit***
Spouse only	*70% of <u>the employee's elected</u> benefit amount*
Spouse and children	*Spouse: 60% of <u>the employee's elected</u> benefit amount* *Each child: 15% of <u>the employee's elected</u> benefit amount, <u>not to exceed $75,000</u>*
Children only	*Each child: 25% of <u>the employee's elected</u> benefit amount, <u>not to exceed $125,000</u>*

In "Plan Administration," "Claims," "Appealing a Denial" (page 171), the following paragraph replaces the fifth paragraph on the page:

> *This two-tiered appeal process is mandatory for all claims, unless otherwise stated in this document. The one exception to this mandatory two-tiered process is an appeal for an urgent care claim – for urgent care claim appeals, only Second Level Appeals are required – no First Level Appeals are necessary. Employees must use both levels of appeal (or the Second Level Appeal for urgent care claims) and must exhaust all administrative remedies to resolve any claim issues.*

END OF CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE

SUMMARY OF MATERIAL MODIFICATIONS FOR HEALTH AND WELFARE BENEFIT PLANS SPONSORED BY AMERICAN AIRLINES, INC.

December 15, 2007

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of changes to the Company sponsored health and welfare benefit plans listed below. This Summary of Material Modifications describes the changes that affect your benefit plans and updates your summary plan descriptions. This Summary of Material Modifications, together with the Employee Benefits Guide, makes up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in the Employee Benefit Guide ("EBG")). These changes are effective January 1, 2008, unless otherwise stated elsewhere in this document.**

These changes apply to the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798; referred to herein as the "Plan").

Changes to the Medical Options' Prescription Drug Coverage (page 66) under "Prescription Drug Benefits," "Retail Drug Coverage," replace second paragraph with the following:

There are three categories of covered drugs with three different co-payments: generic drugs, formulary brand-name drugs and non-formulary brand-name drugs. You will pay the lowest co-payment for generic drugs.

A "formulary" is a preferred list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. An independent committee of physicians and pharmacies brought together by Medco updates this list regularly based on continuous evaluation of medications. If a drug you are taking is not on the formulary, you may want to discuss alternatives with your doctor or pharmacist.

If you are taking a non-formulary drug, you have a choice – you can pay the higher co-payment for it or you can talk with your doctor about the possibility of switching to a formulary brand-name drug.

Contact Medco at (800) 988-4125 to determine if the brand-name drug you are taking is on the formulary list. You can also locate this information at www.medco.com.

Drug Type	Retail Prescriptions	Mail Order Prescriptions
Generic Drug	You pay 20%, with a minimum of $10 and a maximum of $50 per prescription	You pay 20% for a 90-day supply, with a minimum of $25 and a maximum of $125 per prescription
Formulary Brand Drug	You pay 30%, with a minimum of $25 and a maximum of $75 per prescription	You pay 30% for a 90-day supply, with a minimum of $60 and a maximum of $185 per prescription
Non-Formulary Brand Drug	You pay 50%, with a minimum of $40 and a maximum of $100 per prescription	You pay 50% for a 90-day supply, with a minimum of $100 and a maximum of $250 per prescription

If the actual cost of your prescription is less than the minimum shown above, then you pay just the actual cost.

On page 68 under "Mail Service Prescription Drug Option," replace the second paragraph with the following:

To encourage you to take advantage of American Eagle's mail order prescription drug program, you may only get an initial purchase and two refill purchases of a maintenance medication at a retail pharmacy. After that, you should consider filling your remaining maintenance medication prescriptions through the mail order prescription drug program to avoid paying higher amount for refills, as shown in the chart below.

Drug Type	If you use a retail pharmacy for your initial Rx purchase and two refill Rx purchases . . .	If you use a retail pharmacy for refills of maintenance medication beyond the two-refill limit . . .
Generic Drug	You pay 20%, with a minimum of $10 and a maximum of $50 per prescription	You pay 40%, with a minimum of $10 and an unlimited maximum per refill
Formulary Brand Drug	You pay 30%, with a minimum of $25 and a maximum of $75 per prescription	You pay 50%, with a minimum of $25 and an unlimited maximum per refill
Non-Formulary Brand Drug	You pay 50%, with a minimum of $40 and a maximum of $100 per prescription	You pay 75%, with a minimum of $40 and an unlimited maximum per refill

Contribution Rate Change for TriCare Supplement in the section "Addition of TriCare Supplement Insurance Option as a Medical Benefit Option for Active and Leave of Absence Employees," "TriCare Supplement Insurance Option" (page 2) of the SMM effective 1/1/06, the following paragraph should be added at the end of that section:

In compliance with federal law, effective January 1, 2008, American Airlines will no longer provide any employer subsidy for employees who elect the TriCare

Supplement Option. Premiums for this option must be 100 percent employee-paid.

END OF SUMMARY OF MATERIAL MODIFICATIONS

CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE FOR AMERICAN EAGLE AIRLINES EMPLOYEES

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of clarifications to the summary plan description – the American Eagle Employee Benefits Guide ("EBG"). These clarifications, together with the EBG, make up the official plan documents and Summary Plan Descriptions. **Please read this notice carefully, and place this notice with your Summary Plan Description(s) (the Summary Plan Descriptions are contained in your EBG).**

These clarifications apply to:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798; referred to herein as the "Plan")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503, EIN #13-1502798; referred to herein as the "SMP")

In "Life Events," "Benefit Coverages Not Affected by Life Events" (page 34 of EBG and page 1 of SMM effective 1/1/07), the second sentence in the last paragraph titled "Medical Options" is revised as follows:

> *You may change medical options only if you relocate (see the chart beginning on page 28). However, if you are enrolled in either the PPO-Copay, PPO-Deductible, Minimum Coverage, Out-of-Area Option or Tricare Supplement Insurance Option, you may not change from one of these options to another due to relocation, unless the option you were enrolled in previously is no longer available in your new location.*

In "COBRA Continuation of Coverage for Your Dependents Only – Qualifying Events" (on page 6 of the SMM effective 1/1/07 and on page 81 of the EBG), it should read:

> *You are eligible to elect Extended Continuation of Coverage when you:*
>
> - *Retire as an American Eagle Pilot at the FAA mandated retirement age. (Pilots retiring prior to the FAA mandated retirement age are not eligible for Extended Continuation of Medical Coverage).*
> - *Elect and maintain Medical coverage under COBRA Continuation of Coverage for the maximum continuation period when first eligible at the time of retirement.*

Dependents will not be eligible for Extended Continuation of Coverage.

In "COBRA Continuation of Coverage for Your Dependents Only – Qualifying Events" (on page 6 of the SMM effective 1/1/07 and on page 81 of the EBG), the second bullet should read:

- *Your Domestic Partner relationship ends*[1]

In "Flexible Spending Accounts," "Health Care FSA," "Receiving Reimbursement" the chart added in the SMM effective 1/1/06 (pages 7-8) is deleted in its entirety and replaced with the following chart:

Type of Expense	Can You Use FSA Consumer Account Card?	Can You Use Automatic Rollover?	Must You File FSA Claims Manually?
Medical Expenses – PPO Copay Option			
Co-payments, deductibles, co-insurance at a UHC network provider	**Yes**	**Yes**	**No**
Deductibles and co-insurance at an out-of-network (or non-UHC) provider	**No**	**Yes**	**No**
Retail Prescription Drugs (network pharmacies)	**Yes**	**Yes**	**No**
Mail Order Prescription Drugs (Medco by Mail)	**Yes**	**Yes**	**No**
Medical Expenses – PPO Deductible and Minimum Coverage Options			
Deductibles and co-insurance at a UHC network provider	**Yes**	**Yes**	**No**
Deductibles and co-insurance at an out-of-network (or non-UHC) provider	**No**	**Yes**	**No**
Retail Prescription Drugs	**No**	**Yes**	**No**
Mail Order Prescription Drugs (Medco by Mail)	**Yes**	**Yes**	**No**
Medical Expenses – HMOs			
Co-payments	**Yes**	**No**	**No**
Co-insurance and deductibles	**No***	**No**	**Yes**
Dental Expenses, including Orthodontia			
Co-insurance and deductibles	**No***	**Yes**	**No**
Vision Expenses			

Type of Expense	Can You Use FSA Consumer Account Card?	Can You Use Automatic Rollover?	Must You File FSA Claims Manually?
Co-payments, deductibles, co-insurance at a Spectera or UHC network provider	**Yes**	**Yes**	**No**
Vision expenses incurred with an out-of-network provider or if you are not enrolled in the Spectera Vision Plan	**No**	**No**	**Yes**
Over-the-Counter (OTC) Drugs purchased retail or online			
Walgreens – in-store purchases only	**Yes**	**No**	**No**
Drugstore.com – online only	**Yes**	**No**	**No**
Any Other FSA-Eligible Expenses not filed with your AMR Health Coverages	**No**	**No**	**Yes**
Dependent Day Care			
Some providers – check locally	**Yes**	**No**	**No**

* *The Consumer Account Card (CAC) is designed to work for any United Healthcare (UHC) provider since it is set up through UHC. If your HMO doctor or health care provider is in the UHC network, your card may work for these expenses as well. Likewise, if your dentist is in the UHC network (not the MetLife dental network used by the AMR health plan), your card may work for FSA-eligible dental expenses as well. To see if your dentist is a participating UHC dentist, go to http://www.myuhcdental.com and search for Dental Options PPO or check with your dentist. PLEASE NOTE: This is not the MetLife dental network for the AMR dental plan. This is only an option that may allow you to use your CAC at the dentist, but it may be out of network under your MetLife dental plan.*

In "Benefits at a Glance," "Supplemental Medical Plan" (page 6), the following paragraph replaces the third paragraph:

> *If you elect coverage under the Supplemental Medical Plan, there are three circumstances under which this Plan would pay a benefit:*
>
> - *When you or your covered spouse exhausts your maximum medical benefit under your selected Medical Benefit Option (for active employees) or Retiree Medical Benefit under the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (collectively, "Company-sponsored Medical Benefit Option(s)"), or*
> - *If you are the surviving spouse of an active or retired employee who dies while you are both covered under this Plan and you have*

exhausted your maximum medical benefits under your selected Company-sponsored Medical Benefit Option, or

- *If a surviving spouse continues coverage under the Supplemental Medical Plan once coverage under one of the Company-sponsored Medical Benefit Options ends (for any reason other than failure to pay contributions).*

In "Eligibility," "Dependent Eligibility" (page 14), the following clarifications apply:

The first bullet of that page or 4th bullet of that section should read as follows:

- *Unmarried child age 19 through 22, if the child is registered as a full-time student at a school/educational institution in a program of study leading to a degree or certification (proof of continuing eligibility will be required from time to time) and 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.*

If, for medical reasons, the child is required to reduce or terminate his or her studies, coverage will be continued for up to nine months. The child must be under a physician's care, and statements must be provided from the attending physician and school/educational institution to UnitedHealthcare. After nine months, coverage will end unless the child returns to school/educational institution full time or meets the definition of an incapacitated child. If you are enrolled in an HMO, you must contact your individual HMO to determine eligibility requirements and when coverage will be terminated.

In "New Employee Enrollment" (page 19), the text box should be clarified as follows:

Proof of good health is required if you wish to enroll in the above coverages later (if/when you are eligible) or to increase life insurance coverage levels. You must submit (postmarked) a completed, dated, and signed proof of health (a Statement of Health form to add or increase Life Insurance coverage or an Enrollment Form for OSTD coverage) within 30 days after your enrollment deadline. If your statement of health is not

postmarked within 30 days after the close of annual enrollment, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.

In "Enrollment," "Making Changes During the Year," "Life Events" (page 33), the following additions should be made to the list of qualified events that allow participants to make changes to their benefit elections outside the annual enrollment period:

If . . .	Then, You Can . . .
Benefit coverages are significantly improved, lowered or lessened by the Company *(Plan Administrator/Sponsor will determine whether or not a change is "significant")*	• **Make changes to the applicable benefit coverages:** The Company will notify you of the allowable benefit changes, the time limits for making election changes and how to make changes at that time.
You are subject to a court order resulting from a divorce, legal separation, annulment, guardianship or change in legal custody (including a QMSCO) that requires you to provide health care coverage for a child	• **Medical and Dental Options and Vision Insurance Benefit:** Start or add coverage for the dependent(s) and yourself. You cannot change benefit options at this time.
You, your spouse or your dependent enroll in Medicare or Medicaid	• **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for the applicable person. You cannot change benefit options at this time. • **Supplemental Medical Plan:** Stop coverage for you or your spouse.

In "Medical Benefit Options," "Additional Rules," "Coordination of Benefits/Other Plans" (page 78), add the following bullet to the list of other plans:

- *Other individual insurance policies*

In "Medical Benefit Options," "Additional Rules/Coordination with Medicare/Benefits for Individuals Who Are Entitled to Medicare" (page 80), the following paragraph replaces the current second paragraph:

The AMR Corporation plan is the primary payer – in other words, your claims go to the AMR Corporation plan first – if you are currently working for a participating AMR Corporation subsidiary.

If you become eligible for Medicare due to you (or your dependent) having end-stage renal disease, then AMR Corporation is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer.

If you become eligible for Medicare due to becoming eligible for Social Security disability and if your coverage under this plan is due to the current employment status of the employee, then this plan (the AMR Corporation plan) pays primary.

If you are covered by both Tricare and an AMR group health plan, the AMR plan pays primary. If you participate in the Tricare Supplement Option and Tricare, then Medicare is secondary.

In "Medical Benefit Options," "Additional Rules," "Coordination with Medicare" (page 80), the following clarification applies to the section titled "Benefits for Disabled Individuals:"

The Medicare-eligible person must apply for Medicare Parts A, B and D (or Parts C and D), whichever is applicable.

In "Medical Coverage," under "Continuation of Coverage," all references to "Extended Continuation of Coverage" (pages 81-84) should read "Extended Continuation of Medical Coverage".

In "How to Elect COBRA Continuation of Coverage," under "Solicitation Following a Qualifying Event" (page 82), the first sentence in that paragraph should read:

In the event of a Qualifying Event (as shown above as for your dependents only) (divorce, legal separation, the end of a Domestic partner relationship[1], your entitlement to or enrollment in Medicare, a dependent reaching the limiting age of coverage, or your Domestic Partner's death[1],) you must notify the Company by processing a Life Event change within 60 days of the event.

In "Medical Benefit Options," "Additional Rules," "Continuation of Coverage" (page 87), the following paragraphs should be added at the end of the "Certificate of Coverage" section:

> ***HIPAA Certificate of Creditable Coverage***
> *If you lose your coverage (or when you notify Employee Services of your dependent's loss of coverage), you will automatically be sent a certificate of creditable coverage showing how long you had been covered under the Plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's pre-existing medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will receive another certificate of coverage within the 24 months after your coverage has ended. You may also request a certificate of creditable coverage within the 24 months after your coverage has ended.*
>
> *To request a certificate of creditable coverage, contact HR Employee Services (see* Contact Information *on page 1), either by phone or by email, or by mail and ask for a HIPAA certificate of creditable coverage.*

In "Supplemental Medical Plan," "Overview" (page 88), the following paragraph replaces the second paragraph:

> *If you elect coverage under the Supplemental Medical Plan, there are <u>three</u> circumstances under which this Plan would pay a benefit:*
>
> - *When you or your covered spouse exhausts your maximum medical benefit under your selected Medical Benefit Option (for active employees) or Retiree Medical Benefit under the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (collectively, "Company-sponsored Medical Benefit Option(s)"), or*
> - *If you are the surviving spouse[1] of an active or retired employee who dies while you are both covered under this Plan and you have exhausted your maximum medical benefits under your selected Company-sponsored Medical Benefit Option, or*
> - *<u>If a surviving spouse continues coverage under the Supplemental Medical Plan once coverage under one of the Company-sponsored Medical Benefit Options ends (for any reason other than failure to pay contributions)..</u>*

In "Supplemental Medical Plan," under "Eligibility" (page 89), the following paragraph replaces the paragraph at the top of the page:

> *You and your spouse may join the Supplemental Medical Plan only when:*
>
> - *You are first eligible for benefits*
> - *You both are enrolled in one of the Company-sponsored Medical Benefit Options*
> - *You later marry or declare a Domestic Partner, after you are first eligible for benefits.*

In "Supplemental Medical Plan," under "Eligibility" (page 90), the following sentence should be added to the end of the paragraph at the top of page 90:

> *If interested in COBRA, contact Employee Services at 1-800-447-2000.*

In "Life and Accident Insurance Benefits," "Spouse and Child Term Life Insurance Benefit" (page 120), the following sentence replaces the one immediately following the first chart:

> *Benefit amounts for Employee and Spouse coverage are rounded to the next nearest $100 (if not already an even multiplier). Benefit amounts may increase (or decrease) during the year if you experience a pay increase (or decrease).*

In "Accident Insurance Benefit," "Special AD&D Benefit Features" (page 123), the following paragraph is inserted immediately preceding "Child care benefit":

> **Airbag benefit:** *If a participant dies as the result of a motor vehicle accident and his/her safety airbag deployed during the accident, the participant will receive an additional 10 percent of the AD&D principal sum benefit, up to a maximum of $10,000. A Seat Belt benefit must be payable in order for the Airbag benefit to be payable*

In "Optional Short Term Disability (OSTD) Insurance Benefit," "Filing a Claim (page 137)," the following paragraph replaces the first paragraph in this section:

> *If your disability (as defined in this insurance benefit) continues for eight or more days, you should file your disability claim*

immediately. Do not wait until your sick pay is used up; ***file by the eighth day of your disability****. The sooner you file, the sooner your claim can begin processing. However, the latest you can file your claim is six (6) months after your disability began. If you are covered under a state-mandated short-term disability plan, and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim beyond the six (6) month deadline (or the state-mandated deadline, if sooner), your claim will not be accepted, and you will not be eligible for benefits.*

In "Long Term Disability Plan," "Duration of Benefits" (page 141), the chart showing duration of benefits should be replaced with the following chart:

Age at Which Disability Begins	Maximum Duration of Benefits
Under age 60 or the day you turn age 60	To age 65
After your 60th birthday	5 years

In "Plan Administration," "Claims," "Appealing a Denial" (pages 169-172), the following clarifications apply:

The following sentence should be added to the second paragraph on page 169: *For urgent care claims, only Second Level Appeals are required – no First Level Appeals are necessary.*

Delete the third bullet on page 170 regarding urgent care claims

The following sentence should be added to the fourth bullet on page 170: *For disability claims, this process may also be referred to as a First Level Review.*

The third bullet on page 171 should read: *For urgent care claims, within the 72-hour time period allotted for completion of your appeal.*

In "Glossary" (page 192), the following clarification applies:

Under "Medical necessity or medically necessary", the third paragraph should read as follows: *A service or supply for an illness or injury must meet the above conditions to be considered medically necessary. A service is not considered*

medically necessary if it is educational, experimental, or unproven in nature.

In "Glossary" (page 194), the following clarification applies:

Under "Proof of Good Health, Statement of Good Health," the text should read as follows:

Some benefit plans require you to provide "proof of good health" when you enroll for coverage at a later date (if you do not enroll when you are first eligible), or when you increase levels of coverage. Proof of good health (via a Statement of Health for Life Insurance and an Enrollment Form for OSTD and LTD Insurance) is a form you must complete and return to the appropriate benefit Plan Administrator when you:

- *Increase levels of Life Insurance*
- *Add Long Term Disability Plan or Optional Short Term Disability Insurance Benefit (for work groups that offer this Plan and/or benefit), or*
- *Add Supplemental Medical Plan coverage if you marry or declare a Domestic Partner (and are part of a work group that offers this coverage).*

Coverage amounts will not increase nor will you be enrolled in these coverages until the Plan Administrator approves your proof of good health.

If a death or accident occurs before your enrollment for coverage or increase in coverage is processed, the amount of Life Insurance and Accidental Death and Dismemberment coverage that will be payable is your current amount of coverage or default coverage (if you have not enrolled following your eligibility).

You may obtain a Statement of Health or Enrollment Form from MetLife for each benefit plan or online through Jetnet under the Forms menu.

In "Glossary" (page 196), the following clarification applies:

Under "School", the term should be changed to "School/ Educational Institution."

END OF CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the following employee benefit plans:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (referred to as the "Plan", the "Eagle Plan", the "Retiree Medical Benefit")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries
- TWA Retiree Health and Life Benefits Plan.

These plans provide coverage for reconstructive surgery, as follows:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery or reconstruction of the other breast to produce a symmetrical appearance;
- Services in connection with other complications resulting from a mastectomy, such as treatment of lymphademas; and
- Prostheses.

This information is also available in your Employee Benefits Guide – in both the CD-ROM version (if applicable to your work group) sent to you in July – August, 2005, and on *Jetnet*.

END OF ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

SUMMARY OF MATERIAL MODIFICATIONS
American Eagle Airlines Inc. – Health and Welfare Benefit plans

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of changes to the Company sponsored health and welfare benefit plans listed below. This Notice and Summary of Material Modifications describes the changes that affect your benefit plans, and updates your summary plan descriptions. This Summary of Material Modifications, together with the Employee Benefits Guide, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s) (the Summary Plan Descriptions are contained in the Employee Benefit Guide ("EBG"). These changes are effective January 1, 2007, unless otherwise stated elsewhere in this document.**

- These changes apply to the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798 referred to herein as the "Plan").

Eagle Group Life and Health Benefits Plan

- Under "Health Maintenance Organizations (HMOs)" (page 6), first sentence in the third paragraph is revised as follows:

  HMOs are offered only in Puerto Rico, and St. Thomas and St. Croix USVI.

- Under "Employees Married to Other Employees" (page 11) the first paragraph of this section is deleted and replaced as follows:

  If both you and your spouse are Company employees you have a choice to be covered as single employee or enrolled as dependent under your spouse's plan. If you decide to be covered under you spouse's plan you will not receive company provided AD&D and basic life insurance which you would receive if you were covered as single employee.

- Under "Spouse on leave of absence:" (page 11) last paragraph of this section is deleted and replaced as follows:

  Company-provided coverage may continue for a period of time for employees on leave of absence, dependent upon receipt of your payment.

- Under "Life Events" the first bullet of the second Life Event listed (page 29) is revised as follows:

If…	***Then, You Can…***
You or your spouse becomes pregnant	**Contact:** UHC at 800-592-3048 before the 16th week of pregnancy, if you are covered by the Out-of-Area, Minimum Coverage, PPO-Deductible or PPO-Copay Options

- Under "Life Events", "Benefit Coverages Not Affected by Life Events" (page 34), the second sentence in the last paragraph titled "Medical Options" is revised as follows:

  However, if you are enrolled in either the PPO-Copay, PPO-Deductible, Minimum Coverage, or Out-of-Area Options when you relocate, you may not change from one of these options to another due to relocation, unless the option you were enrolled in previously is no longer available in our new location.

- Under "Medical Benefits", "Overview" (page 36), the third paragraph, is revised as follows:

  Employee residing in Puerto Rico, St. Thomas and St. Croix, USVI will have the choice between HMOS and the Out-of-Area Coverage options. All other employees will be eligible to participate in either the Out-of-Area Coverage Plan, or have a choice between the PPO-Deductible, the PPO-Copay, or Minimum Coverage Options. This determination is based on whether your home zip code falls within a PPO service area. Each year, an analysis is done to be sure that each PPO service area provides reasonable access to physicians, specialist, hospitals and pharmacies for our members. If you live within a PPO service area you have a choice of either, the PPO-Deductible Option, the PPO-Copay Option or the Minimum Coverage Option. If you do not live within a PPO service area you will be eligible for the Out-of-Area Coverage.

- Under "Medical Benefits", "Overview" (page 36), the first sentence in the fourth paragraph, is revised as follows:

  Under the Out-of-Area Coverage you will receive the PPO in-network level of coverage.

- Under "Medical Benefits", "Key Features of the Medical Options" , "Family annual deductible" (page 37), this paragraph is revised as follows:

Under the Out-of-Area Coverage, PPO-Deductible and Minimum Coverage Options, once the family annual deductible has been satisfied, all member of your family are eligible for reimbursement of eligible medical expenses, regardless of whether they have satisfied individual annual deductibles. The family annual deductible is available if three or more family members are covered.

- Under "Medical Benefits", "Key Features of the Medical Options" , "Annual out-of-pocket maximum" (page 37), the second bullet in this paragraph is revised as follows:

  - For network services under the PPO-Deductible, PPO-Copay and Minimum Coverage Options, coinsurance amounts for hospital-based services apply to the annual network out-of-pocket maximum.

- Under "Medical Benefits", "Key Features of the Medical Options" , "Prescription drug benefits" (page 38), the first sentence of the second paragraph is revised as follows:

  The PPO-Deductible, PPO-Copay, Minimum Coverage and Out-of-Area Options cover medically necessary prescriptions with copayments or coinsurance when purchased at a participating retail pharmacy (up to a 30 day supply).

Eliminate $3,500 restoration to the maximum medical benefit

- Under "Key Features of the Medical Options" under "Lifetime medical maximum benefit" (page 38), the third and fourth sentence of the first paragraph

  Effective January 1 of each year, part of your Lifetime Medical Maximum benefit is automatically restored. The amount restored is $3,500, or the amount necessary to restore your full $5,000,000, whichever is less.

  are deleted in their entirety.

- Under "Maximum Medical Benefit" (page 39), the second paragraph

  Effective January 1 of each year, part of your Lifetime Medical Maximum benefit is automatically restored. The amount restored is $3,500, or the amount necessary to restore your full $5,000,000, whichever is less.

  is deleted in its entirety.

- Under "Medical Benefits Options", "Medical Benefit Options Comparison" (page 40), the second sentence in the second paragraph is revised as follows:

  If you are covered under Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options or you use out-of-network services or network hospital based service under the PPO-Deductible, PPO-Copay or Minimum Coverage Options, you must satisfy any individual annual deductibles before the options pays benefits for Eligible Expenses.

Changes to the Medical Benefit Options Comparison table

- Replace the Medical Benefits Options Comparison table on pages 40-47 with the table contained in the attached appendix.

Provider Networks for the Medical Benefit Options

- Under "Benefits at a Glance", "Out-of-Area Coverage, Minimum Coverage and PPO Deductible Options" (page 5) the second sentence in the second paragraph is revised as follows:

  When you use a network provider under the PPO-Deductible Option and the Minimum Coverage Option, you receive a higher level of benefits.

- Under "Benefits at a Glance" (page 6) the following section is added immediately following "PPO-Copay Option" section, before the last sentence on this section "To see comparison of your benefits under the Medical Options, see page 40":

  Provider Networks for the Medical Options

  The Medical Benefit Option you select determines the provider network you access. UnitedHealthcare. When you access UnitedHealthcare's website, your ID and password enables UnitedHealthcare to know which Medical Benefit Option you've elected, and to select the appropriate provider network for your elected Medical Benefit Option—thus, you will have access to the provider network corresponding to your medical coverage. The following chart references the specific provider network and network usage requirements for each of the self-funded Medical Options:

Medical Benefit Option	Type of Network Provider	Voluntary Choice of In vs. Out of Network?	Benefit Level Reduction for Out of Network?
Out-of-Area Coverage	UnitedHealthcare Options	Yes	Not Applicable

Option	PPO Network		
Minimum Coverage Option	UnitedHealthcare Choice Plus Network	Yes	Yes, from 80% / 20% to 60% / 40%
PPO-Deductible Option	UnitedHealthcare Choice Plus Network	Yes	Yes, from 80% / 20% to 60% / 40%
PPO-Copay Option	UnitedHealthcare Choice Plus Network	Yes	Yes, from 80% / 20% to 60% / 40%

Choice Plus provider network for participants in Maine, Massachusetts, and New Hampshire: UnitedHealthcare has introduced the Harvard Pilgrim healthcare provider network to its Choice Plus network participants residing in Maine, Massachusetts, and New Hampshire. Participants residing in these three states and who elect coverage that utilizes the Choice Plus network, will have access to the Harvard Pilgrim network for services rendered in these three states. If these participants access medical care outside Maine, Massachusetts, and New Hampshire, they will access the Choice Plus network.

- Under "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options", "How the medical Options Work" (page 48), the first paragraph is revised as follows:

  Only employees who do not have adequate access to PPO providers will have the Out-of-Area Coverage as an option. The PPO-Deductible and the Minimum Coverage Options provide different levels of benefits based on whether or not you use a network or out-of-network provider.

- Under "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options", "How the medical Options Work" (page 48), the third sentence of the second paragraph is revised as follows:

  When you use a network provider under the Out-of-Area Coverage Option, you save and the company saves.

- Under "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options", "How the medical Options Work" (page 48), the third paragraph is revised as follows:

  After meeting the annual deductible under the Out-of-Area Coverage and in-network under the PPO-Deductible and Minimum Coverage Options, the plans pays 80% of most eligible expenses up to usual and prevailing fee limits for most medically necessary services. Your coinsurance is 20%. When using non-network provider under the PPO-Deductible and Minimum Coverage Options, the plan pays 60% of most eligible expenses up to usual and prevailing fee limits for most medically necessary services and your coinsurance is 40%. After you meet the annual out-of-pocket maximum, eligible medical services are covered at 100% for the remainder of the year. Outpatient mental health care is covered at 50% and does not count toward the annual out-of-pocket maximum.

- Under "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options", "How the medical Options Work" (page 48), a new paragraph is added under the third paragraph as follows:

  Under the PPO Deductible and Minimum Coverage Options, you may decide whether to use in-network or out-of-network providers each and ever time you need care. You also have the option of seeing any specialist physician without a referral. However, when you use network providers, you receive a higher level of benefit, called in-network benefits. If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact UnitedHealthcare for approval to visit an out-of-network specialist. Provided you have obtained approval from UnitedHealthcare, your out-of-network care will be covered at the network benefit level. If an approval is not obtained prior to the visit to the specialist, the visit will be covered out-of-network.

Introduce Out-of-Network deductibles under the Minimum Coverage Option

- Under "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options", "Special provisions", "Deductibles" (page 48), the third sentence in this paragraph is revised as follows:

  Under the Minimum Coverage Option, you pay an annual deductible of $1,000 per person or $2,000 per family for network services and an annual deductible of $2,000 per person or $4,000 per family for services received by out-of-network providers.

Individual Annual Out-of-Pocket Maximum under the Out-of-Area, Minimum Coverage and PPO-Deductible Options

- Under "Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options", "Special Provisions", bellow "Deductibles" (page 48), a paragraph is added as follows:

  Individual Annual Out-Pocket-Maximum: Under the PPO-Deductible Option, you pay a $2,000 Individual Annual Out-of-Pocket Maximum for in-network services, and a $4,000 Individual Annual Out-of-Pocket Maximum for out-of-network services. Under the Minimum Coverage Option, you pay a $3,000 Individual Annual Out-of-Pocket Maximum for in-network services, and a $5,000 Individual Annual Out-of-Pocket Maximum for out-of-network services. Under the Out-of-Area Coverage Option you pay a $2,000 Individual Annual Out-of-Pocket Maximum for in or out-of-network services.

Add preventive care coverage to the Minimum Coverage, PPO Deductible and Out-of-Area Options

- Under "Special Provisions" section "Preventive Care" (page 49) each bullet reads as follows (see December 15, 2005 SMM):
  - Under the Minimum Coverage and PPO Deductible Options, in-network preventive care will be covered at 80%, without having to meet the annual deductible. (See Medical Benefits Options Comparison Table for details).
  - Under the Out-of-Area Coverage Option preventive care will be covered at 80% in-network or out-of-network, without having to meet the annual deductible. (See Medical Benefits Options Comparison Table for details).
- Under "Covered Expenses", "Preventive Care" (page 62), this paragraph is revised as follows:

  The PPO-Copay, PPO-Deductible, Minimum Coverage, and Out-of-Area Options cover preventive care, including well-child care, mammograms, pap smears, male health screenings, and annual routine physical exams for participants of all ages when you use network providers. Non-routine tests for certification, sports, or insurance are not covered unless medically necessary. Preventive care will not be covered out-of network under any of the Plans, except the Out-of-Area Option.

Change in copayments and coinsurance amounts in the PPO-Copay Plan

- Under "Special Provisions" section "Hospital out-of-pocket maximum" (page 52), the first sentence in this paragraph is revised as follows:

  You pay 20% coinsurance for network hospital-based services up to an annual out-of-pocket maximum of $2,000 per covered person per year after you satisfy the $150 annual copayment.

Bariatric – surgeries covered in-network only

- Under "Covered Expenses", below "Assistant Surgeon" (page 58), add a section as follows:

Bariatric surgeries: Bariatric surgeries (including but not limited to Gastric bypass, LAP Band, etc.) will be covered in-network only.

- Under "Excluded Expenses", below "Alternative and/or Complementary medicine" (page 70), add a section as follows:

  Bariatric surgeries: Bariatric surgeries (including but not limited to Gastric bypass, LAP Band, etc.) will not be covered out-of-network.

Eliminate Plan Coverage for Sexual Performance Medications, Devices, and/or Treatment

- Under "Excluded Expenses" below "Sex changes" (page 72) a bullet is added as follows:
  - **Sexual Performance Treatment:** Prescription medications (including but not limited to, Viagra, Levitra, or Cialis), procedures, devices, or other treatments prescribed, administered, or recommended to treat erectile dysfunction or other sexual dysfunction, or for the purpose of producing, restoring, or enhancing sexual performance/experience.

Introduce generic coinsurance and minimum copayments under the prescription drug benefit

- Under "Retail Drug Coverage" (page 66) the second paragraph is deleted in its entirety and replaced with the following paragraph and chart:

  Under the Retail Prescription Drug Option, you may order up to a 30-day supply of any medically-necessary covered prescription, including psychotherapeutics. If cost of the drug is less than the minimum then participant pays the cost of the drug.

Retail Prescription Drug	Coverage:
Generic	20% coinsurance, with $10 Minimum and $50 Maximum per prescription/refill
Brand Drug (no generic available)	30% coinsurance, with $20 Minimum and $100 Maximum per prescription/refill
Brand Drug (if generic available)	50% coinsurance, with $20 Minimum and no Maximum per prescription/refill

- Under "Mail Service Prescription Drug Option" (page 68) the second paragraph is revised as follows:

Under the Mail Service Prescription Drug Option, you may order up to a 90-day supply of your prescription drug (but no more than the number of days prescribed by your physician). You pay a coinsurance (with no annual deductible) for each prescription or refill.

- Under "Mail Service Prescription Drug Option" (page 68) the two bullets are deleted in their entirety and replaced with the following chart:

Mail Service Prescription Drug	Coverage:
Generic	20% coinsurance, with $20 Minimum and $125 Maximum per prescription/refill
Brand Drug (no generic available)	30% coinsurance, with $40 Minimum and $250 Maximum per prescription/refill
Brand Drug (if generic available)	50% coinsurance, with $40 Minimum and no Maximum per prescription/refill

- Under "Continuation of Coverage" (page 81) this section is deleted in its entirety and replaced with the following

Continuation of Coverage

Overview

If your employment terminates for any reason (i.e., furlough, resignation, etc), your health benefits are cancelled, along with your other benefits. You may elect to continue your health benefits as part of your COBRA Continuation of Coverage options (see page 5) available through CONEXIS, the COBRA administrator. CONEXIS will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your medical coverage through COBRA, claims incurred after the date of your termination are not payable.

Several of American Eagle Airlines, Inc. benefits, options or plans (Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, Dental Benefit, HMOs, Vision Insurance Benefit, HCFSA Benefit and the Supplemental Medical Plan) provide for COBRA Continuation of Coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain qualifying events. If you and/or your dependents have coverage at the time of the qualifying event, you may be eligible to elect COBRA Continuation of Coverage under the following:

- Medical Benefits
- Dental Benefit
- Vision Insurance Benefit
- Supplemental Medical Plan
- Health Care Flexible Spending Account Benefit, for the remainder of the calendar year in which you became eligible for COBRA Continuation of Coverage. (Although you would not be able to make contributions on a before-tax basis, by electing COBRA Continuation of Coverage for this account, you would still have the opportunity to file claims for reimbursement based on your account balance for the year).

The coverage under COBRA is identical to coverage provided under the benefits or plans for similarly situated employees or their dependents[1], including future changes.

Effective January 1, 2005, if you retire from a Pilot position at American Eagle Airlines, Inc. or Executive Airlines, Inc. at the FAA-mandated retirement age (age 60), you may be eligible for Extended Continuation of Medical Coverage until such time as you become eligible for Medicare. The Pilot who elects Extended Continuation of Medical Coverage will not be able to elect Dental Benefits, Vision Insurance Benefits, and Supplemental Medical. The Pilot may not elect an HMO as his/her Medical option for the Extended Continuation of Medical Coverage. If you do not elect Extended Continuation of Medical Coverage, claims incurred after the expiration date of your initial COBRA Continuation of Coverage period are not payable.

COBRA Continuation

Eligibility
Eligibility for COBRA 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 COBRA Continuation of Coverage and the circumstances that result in eligibility for this coverage continuation.

[1] Although a Domestic Partner and his/her children do not have rights to COBRA Continuation of Coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur, however this may change. The current voluntary extension of COBRA Continuation of Coverage to Domestic Partners does not apply to the Supplemental Medical Plan and is not available under COBRA to surviving Domestic Partners.

COBRA Continuation of Coverage for You and Your Dependents – Qualifying Events
Change in job status (layoff or termination of employment): You may elect COBRA Continuation of Coverage for yourself and your eligible dependents, including a Domestic Partner and his/her children, for a maximum period of 18 months, if your coverage would otherwise end because of layoff or termination of your employment for any reason (except in the event of termination for gross misconduct).

If you are disabled when you lose coverage due to change in job status: If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you (or any eligible dependent) are disabled at any time during the first 60 days of COBRA Continuation of Coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself and your dependents, including a Domestic Partner and his/her children. *To qualify for this additional coverage, the Qualified Beneficiary must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (CONEXIS) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.*

COBRA Continuation of Coverage for Your Dependents Only – Qualifying Events

Your covered dependents may continue coverage for a maximum period of 36 months if coverage would otherwise end because of:

- Your divorce or legal separation
- Your Domestic Partner relationship ends[2]
- You become entitled to (enrolled in) Medicare benefits
- Loss of eligibility because the dependent, including children of a covered Domestic Partner, no longer meets the Plan's definition of a dependent (for example, if a child reaches the Plan's limiting age)
- Your death
- Your Domestic Partner's death[1]

If you experience more than one of these qualifying events, your maximum COBRA Continuation of Coverage is the number of months allowed by the event that provides the longest period of continuation.

Eligibility for Extended Continuation of Medical Coverage for Qualifying Pilots

Eligibility
You are eligible to elect Extended Continuation of Medical Coverage when you:

- Retire as an American Eagle Pilot at the FAA mandated retirement age (Pilots retiring prior to the FAA mandated retirement age are not eligible for Extended Continuation of Medical Coverage).
- Elect and maintain medical coverage under COBRA Continuation of Coverage for the maximum continuation period when first eligible at the time of retirement.

Dependents will not be eligible for Extended Continuation of Medical Coverage.

How to Elect COBRA Continuation of Coverage

Solicitation for COBRA Continuation of Coverage

Solicitation following layoff or termination: In the event that your employment ends through layoff or termination, you will automatically receive information from CONEXIS, the COBRA administrator, about electing COBRA Continuation of Coverage through COBRA.

Solicitation following a qualifying Life Event: In the event of a Qualifying Event (as shown above as for your dependents only) (divorce, legal separation, the end of a Domestic Partner relationship[1], your entitlement to or enrollment in Medicare, a dependent reaching the limiting age for coverage, or your Domestic Partner's death[3]), you must notify the Company by processing a Life Event change *within 60 days of the event.* You can process most Qualifying Events that are also Life Events online through *Jetnet*; however, in some instances, you must call HR Employee Services at 800-447-2000 to process the change. For example, in the event of your death, your supervisor or a dependent must call HR Employee Services to make the appropriate notification. If the Qualifying Event is also a Life Event that involves your Domestic Partner, you must call HR Employee Services to process the change.

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[3] Your Domestic Partner and his/her covered dependents will be eligible to purchase COBRA Continuation of Coverage if they lose benefits as a result of the termination of your Domestic Partner relationship, your partner's child's loss of eligibility under the Plan, or the death of your Domestic Partner or yourself.

If you fail to notify the Company of a dependent's loss of eligibility *within 60 days* after the qualifying life event, the dependent will not be eligible for COBRA Continuation of Coverage, *and* you will be responsible for reimbursing the Company for any benefits paid for the ineligible person. You are also required to repay the Company for premium amounts that were overpaid for fully insured coverages.

Enrolling in COBRA Continuation of Coverage
Following notification of any of Qualifying Event (see page 82), HR Employee Services will advise CONEXIS, who in turn will notify you or your dependents of the right to COBRA Continuation of Coverage. When you process your Life Event, you should provide your dependent's address (if different from your own) where CONEXIS can send solicitation information.

You (or your dependents) must provide written notification of your desire to elect to purchase COBRA Continuation of Coverage within 60 days of the date postmarked on the notice in order to purchase COBRA Continuation of Coverage. (See the contact list for information on CONEXIS' address for sending the written notice).

You and your dependents may each independently elect COBRA Continuation of Coverage. Once you elect COBRA 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.

Federal laws require the Company to provide a Certificate of Group Health Plan Coverage outlining your coverage under the Plan and showing the dates you were covered by this Plan. This certificate is sent to you by CONEXIS.

If you waive COBRA 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 CONEXIS before your 60-day election period expires.

Refund of Premium Payments for COBRA Continuation of Coverage
If you elect COBRA Continuation of Coverage and later discover that you do not meet the eligibility requirements for coverage, for example, if you become entitled to (enrolled in) Medicare benefits, you must contact CONEXIS at 877-902-9207 immediately, but no later than three months after you make your first premium payment in order for you to be eligible for a refund. No payments will be refunded after this three-month period, regardless of the reason.

If claims have been paid during this three-month time period, the Plan will request reimbursement from you. If the amount of your premium payments for COBRA Continuation of Coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the plan receives reimbursement for your claim, the Plan will refund your premiums.

This time limit for refunds for COBRA Continuation of Coverage also applies if the Company discovers that COBRA Continuation of Coverage has been provided to you or your dependents in error.

Processing Life Events After COBRA Continuation of Coverage is in Effect

Please note: The Pilot who elects Extended Continuation of Medical Coverage will not be able to process Life Events.

If you elect COBRA Continuation of Coverage for yourself and later marry or *declare a Domestic Partner*, give birth, or adopt a child while covered by COBRA Continuation of Coverage, you may elect coverage for your newly-acquired dependents after the qualifying event. To add your dependents, contact CONEXIS, the COBRA administrator, at 877-902-9207, *within 60 days* of the marriage, Domestic Partner relationship, birth, or adoption.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29, or 36 months, depending on the qualifying event). This new dependent will not have the right to continue coverage on his or her own if there is a divorce, end of Domestic Partner relationship, or another event that causes loss of coverage**.** You may add a newborn child or a child newly placed for adoption to your COBRA Continuation of Coverage. You should notify CONEXIS and the Plan Administrator of the newborn or child newly placed for adoption within 60 days of the child's birth or placement for adoption. All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to COBRA Continuation of Coverage.

If you have questions regarding COBRA Continuation of Coverage, contact CONEXIS at 877-902-9207.

Paying for or Discontinuing COBRA Continuation of Coverage
To maintain COBRA Continuation of Coverage, you must pay the full cost of COBRA Continuation of Coverage on time, including any additional expenses permitted by law. Your first payment is due within 45 days after you elect COBRA 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 COBRA Continuation of Coverage, you will receive a payment invoice from CONEXIS indicating when each payment is due. Payments are due even if you have not received your payment coupons. Failure to make the required payment 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. All checks shall be made payable to CONEXIS and sent to **CONEXIS, P.O. Box 14225, Orange, CA 92863-1225.**

Solicitation For, Enrollment In, and Payment For, Extended Continuation of Medical Coverage for Qualifying Pilots
CONEXIS, the COBRA administrator, will mail a COBRA expiration notice to your home address (or to the address you provide CONEXIS) 60 days prior to the end of your COBRA Continuation of Coverage. Included in this letter will be instructions on how you can elect Extended Continuation of Medical Coverage. To take advantage of this extended coverage, you must respond in writing to CONEXIS within 30 days of the date postmarked on the notice. Failure to respond timely will result in forfeiture of this extended coverage option.

Paying for or Discontinuing Extended Continuation of Medical Coverage
To maintain Extended Continuation of Medical Coverage, you must pay the full cost of Extended Continuation of Medical Coverage on time, including any additional expenses permitted by law. Premiums for the Extended Continuation of Medical Coverage are due on the first day of each month for that month's coverage. If you elect Extended Continuation of Medical Coverage, you will receive a payment invoice from CONEXIS indicating when each payment is due. Payments are due even if you have not received your payment coupons. Failure to make the required payment on or before the due date, or by the end of the grace period will result in termination of Extended Continuation of Medical Coverage, without the possibility of reinstatement. All checks shall be made payable to CONEXIS and sent to **CONEXIS, P.O. Box 14225, Orange, CA 92863-1225.**
If you have questions regarding Extended Continuation of Medical Coverage, contact CONEXIS at 877-902-9207.

When COBRA Continuation of Coverage Begins/Ends
When COBRA Continuation of Coverage begins: If you or your dependents elect COBRA Continuation of Coverage within 60 days of the date postmarked on your notice, the coverage becomes effective on the date your other coverage would otherwise end. Thus, the first premium for COBRA Continuation of Coverage includes payment for this retroactive coverage period.

When COBRA Continuation of Coverage ends: COBRA Continuation of Coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29, or 36 months) expires (See also *Eligibility for COBRA Continuation of Coverage* on page 5).
- Payment for COBRA Continuation of Coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the participant is entitled to COBRA Continuation of Coverage
- up to the maximum time period.
- The Plan participant continuing coverage becomes entitled to Medicare
- The Company no longer provides the coverage for any of its employees or their dependents

See also *Dependents of Deceased Employees* on page 16.

When Extended Continuation of Medical Coverage for Qualifying Pilots Begins/Ends
When Extended Continuation of Medical Coverage begins: If you elect Extended Continuation of Medical Coverage within 30 days of the date postmarked on the notice, the coverage becomes effective on the date your COBRA Continuation of Coverage would otherwise end. The Pilot must have maintained medical coverage under COBRA Continuation of Coverage for the maximum COBRA continuation period when first eligible at the time of retirement.

When Extended Continuation of Medical Coverage ends: Extended Continuation of Medical Coverage automatically ends on the earliest of the following dates:

- The Pilot electing Extended Continuation of Medical Coverage becomes entitled to Medicare. In the event that the Medicare-eligible age is changed by law, the Extended Continuation of Medical Coverage may be extended up to but not exceeding 3 additional years beyond the date at which the Pilot could become eligible for Medicare based on the laws in effect on January 1, 2005
- Payment for Extended Continuation of Medical Coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement
- The Pilot who elects Extended Continuation of Medical Coverage becomes covered under any other group medical plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the Pilot is entitled to Extended Continuation of Medical Coverage up to the maximum time period
- The Company no longer provides this Extended Continuation of Medical Coverage

COBRA Continuation of Coverage for Employees in the Uniformed Services
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your medical coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of COBRA Continuation of Coverage available to you and your eligible dependents is the lesser of 24 months **(for elections of coverage on or after December 10, 2004)** or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any period of COBRA Continuation of Coverage for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days. The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Employee Policy Guide

COBRA Continuation of Coverage While on a Family and Medical Leave
Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition

Depending on your state of residence, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Other Employees Obligations
In order to protect you and your family's rights, you should keep both CONEXIS and the Company informed of any changes in the addresses of your family members.

Other Special Rules
If your event that qualified you for COBRA coverage was either a Company-mandated reduction in hours or termination of employment and your employment termination or reduction was due to reduced sales due to increased imports and it was certified by the U.S. Department of Labor so that you are a Trade Adjustment Act (TAA)-eligible individual, then you may be eligible for a second chance to elect COBRA Continuation of Coverage. You are only eligible for the second chance to elect COBRA coverage if all of the events described in this paragraph occurred within six (6) months of your loss of coverage. If you are a TAA-eligible individual, you must elect coverage within six (6) months of the date you lost coverage, or you lose the right to elect COBRA coverage as a TAA-eligible individual.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA Continuation of Coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Impact of Failing to Elect COBRA Continuation of Coverage on Future Coverage
In considering whether to elect COBRA Continuation of Coverage, and Pilots considering whether to elect Extended Continuation of Medical Coverage should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA Continuation of Coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA Continuation of Coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law when enrolled in COBRA Continuation of Coverage. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Plan coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of your COBRA Continuation of Coverage if you get COBRA Continuation of Coverage for the maximum time available to you.

Additional Questions
If you have any additional questions about COBRA Continuation of Coverage or if you are a Pilot who has questions about electing Extended Continuation of Medical Coverage, you should contact CONEXIS (see *Contact Information* on page 1).

Certificate of Coverage
If you lose your coverage (or when you notify Employee Services of your dependent's loss of coverage) you will automatically be sent a certificate of coverage showing how long you had been covered under the Plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's preexisting medical condition limitation period that might otherwise apply to you. If you elect COBRA Continuation of Coverage, or if you are a Pilot who elects Extended Continuation of Medical Coverage, when that coverage ends, you will receive another certificate of coverage within the 24 months after your coverage has ended. You may also request a certificate of coverage within the 24 months after your coverage has ended.

Changes to the Spectera Vision Insurance Benefit

- Under "Vision Benefits" (page114), the first paragraph is revised as follows:

  The Company offers a Vision Discount Program and the Spectera Vision Insurance Benefit (optional). When you enroll in any of the medical plans, you are automatically registered as a member of the Vision Discount Program, which is offered through EyeMed. Also, all employees have the option of purchasing more comprehensive vision coverage through Spectera, which provides coverage for eyeglass lenses, frames, contact lenses, and sundry items.

- Under "Vision Benefits", "Spectera Vision Insurance Benefits", "Spectera Vision Insurance Network Provider Benefits" (page115), the "Covered Services / You Pay…" chart is deleted and replaced with the following:

Covered Services	You Pay. . .
Contact lenses (in lieu of lenses and frames)	
Selection contact lenses	$25 copayment
Selection contact lenses, disposable	$25 copayment (for up to 6 boxes per year)
Non-selection contact lenses or Special contact lenses (gas permeable, bifocal, astigmatism lenses, etc).	$150 allowance toward the evaluation, fitting fees, and contact lenses
Patient Options	
Progressive lenses and tints, etc.	No additional charge (is included in the $25 copayment for lenses)
Scratch-coating protection for lenses	No additional charge (is included in the $25 copayment for lenses

VPAI coverage for children

- Under "Accident Insurance Benefit", "Overview", (page 122), third bullet after "VPAI coverage also includes the following features" is revised as follows:

  - You may select coverage in $10,000 increments up to $500,000. If you elect family coverage the amount of insurance for your family members is a percentage of the amount elected, and is based on the composition of your family at the time of loss, as shown in the table below:

Family Covered	Amount of Benefit
Spouse only	70% of benefit amount
Spouse and Children	Spouse: 60% of benefit amount Each child: 15% of benefit amount
Children only	Each child: 25% of benefit amount

Enhancements to Accidental Death and Dismemberment Insurance Benefit (AD&D)

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” (page 123), the following paragraph is inserted immediately preceding “Child care benefit”:

  Air bag benefit: If a participants is involved in a motor vehicle accident and his/her safety airbag is deployed as a result of such accident, the participant will receive a benefit equivalent to 10% of his/her principal sum benefit, up to a maximum of $10,000.

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” “Counseling and bereavement benefits” (page 124), the second sentence’s reference to “$50 per session” is deleted and replaced with the following:

  . . .at a maximum of $100 per session. . . .

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” (page 124), the following paragraph is inserted immediately following “Double benefit for dismemberment of children”:

  Home/Vehicle modification benefit: If, as the result of an accident, the participant’s covered injury(ies) require use accommodations to his/her home or motor vehicle, the participant will receive a benefit equivalent to 10% of his/her principal sum benefit, up to a maximum benefit of $10,000.

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” (page 125), the following paragraph is inserted immediately preceding “Seat belt benefit”:

  This coverage applies only to accidents that occur on or after the January 1, 2001. It is subject to all of the provisions, limitations and exclusions of the Policy except as they are specifically modified by this coverage.

  Rehabilitation Benefit: If a covered person suffers an accidental loss for which benefits are payable under the policy, we will reimburse the covered person for covered rehabilitative expenses that are due to the injury causing the loss. The covered rehabilitative expenses must be incurred within two years after the date of the accident causing the loss and will be payable up to a maximum of $2,500 for all injuries caused by the same accident.

  Hospital means a facility that: (1) is operated according to law for the care and treatment of injured people; (2) has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis; (3) has 24 hour nursing service by registered nurses (R.N).; and (4) is supervised by one or more physicians. A hospital does not include: (1) a nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care; (2) a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing, or other section of the hospital that is used for such purposes; or (3) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

  Medically Necessary Rehabilitative Training Service – as used in this coverage, means any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that: (1) is essential for physical rehabilitative training due to the injury for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) is ordered by a doctor.

  Covered Rehabilitative Expense(s) means an expense that: is charged for a medically necessary rehabilitative training service of the covered person performed under the care, supervision or order of a physician (2) does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a hospital room and board charge, does not exceed the most common charge for hospital semi-private room and board in the hospital where the expense is incurred); and (3) does not include charges that would not have been made if no insurance existed.

  Exclusions: In addition to the exclusions in the general exclusion section of the policy, covered rehabilitative expenses do not include any expenses for or resulting from any condition for which the covered person is entitled to benefits under (1) any Workers Compensation Act or similar law; or (2) the accident medical expense Benefit coverage.

- Under “Accident Insurance Benefit”, “Special AD&D Benefit Features” (page 125), the following two paragraph is inserted immediately following “Spouse retraining benefit”:

  Uniplegia benefit: If a participant is involved in an accident resulting in the loss of use of only one arm or one leg, the participant will receive a benefit equivalent to 50% of his/her principal sum benefit.

- Under “Flexible Spending Account”, “Receiving Reimbursement”, (page 151) add three bullets before the first paragraph as follows:

  You might receive reimbursement from your HCFSA through 3 different methods:

  - File your claims by mail directly with UnitedHealthcare, and UnitedHealthcare will mail your reimbursement check to you (or will deposit the reimbursement amount into your bank account, if you have elected to receive reimbursement via direct deposit)

- Use the automatic rollover feature – certain expenses will be submitted to UnitedHealthcare automatically, and UnitedHealthcare will mail your reimbursement check to you (or will deposit the reimbursement amount into your bank account, if you have elected to receive reimbursement via direct deposit)

- Use your UnitedHealthcare Consumer Account Card to pay the service provider directly from your HCFSA at the time you receive the service or product

- Under "Flexible Spending Account", "Receiving Reimbursement", "Automatic Reimbursement Feature" or "Automatic Rollover Feature" (page 152) at the end of first paragraph add a sentence as follows:

  UnitedHealthcare will process these claims and make reimbursement payment to you (either by mailing you a check or by making a direct deposit to your bank account, if you have elected to receive reimbursement via direct deposit).

- Under "Flexible Spending Account", "Receiving Reimbursement", "Automatic Reimbursement Feature" or "Automatic Rollover Feature" (page 152) add a second paragraph as follows:

  The Automatic Rollover Feature is automatically activated for all participants on January 1 of each year. However, there may be situations where you cannot or do not wish to use this feature.

- Under "Flexible Spending Account", "Receiving Reimbursement", "Automatic Reimbursement Feature" or "Automatic Rollover Feature" (page 152) under "You should stop the Automatic Rollover Feature if:" a third bullet is added as follows:

  - You cover dependents under your health care benefits as the result of a Qualified Medical Child Support Order.

- Under "Flexible Spending Account", before "Filling Claims", under section entitled "Using the UnitedHealthcare Consumer Card" (page 152) add three paragraphs before the chart as follows (see December 15, 2005 SMM):

  Effective January 1, 2005, all FSA enrollees began receiving the UnitedHealthcare Consumer Account Card – this is different than your regular medical ID card. This Consumer Account Card (also referred to as the "FSA Card") carries information about your FSA account(s) (both your HCFSA and your DDFSA, if applicable), including your account balance(s). Your FSA Card can be used at any provider, pharmacy, mail order pharmacy, or other medical provider that accepts MasterCard to pay for certain FSA-eligible expenses at the time and point of service. When you receive your FSA Card, you must activate it (similar to activating a credit card – instructions for activation are on the card). Each year that you participate in an HCFSA, your existing FSA card will be updated with your selected HCFSA amount, and you need not reactivate your card unless you are issued a new card (keep in mind that any newly issued/reissued card must be activated after January 1, and you must wait three business days after activating the card before you may use it). After you have activated your FSA Card, each year that you participate in an HCFSA, your FSA Card will be updated ("reloaded") with your selected HDFSA amount, and will be ready for use on January 1 of the year to which your election applies.

  When you incur an HCFSA –eligible expense (for example, when you incur an expense for a doctor's office visit under the Copay Plan), simply present your FSA Card to the provider. The doctor's office will bill a change for your $20 PCP or $35 Specialist copayment, and run this charge against your FSA Card – the FSA Card will pay your copayment directly from your HCFSA to the doctor's office; thus, you don't have to pay the copayment from your own funds, you don't have to submit the HCFSA claim to the FSA administrator, and you don't have to wait for HCFSA reimbursement. You are not required to use the FSA Card if you prefer to use the automatic rollover feature or file your claims manually. Keep in mind however, that when you use the FSA Card, the provider of service must bill/run the charge to your FSA Card as credit card, since the FSA Card cannot be assigned a PIN (Personal Identification Number) that is required for debit card transactions.

  Any unauthorized transaction (any ineligible HCFSA expense) will be denied at the point of service, and you will be required to pay out of pocket for the portion of the expense that would have been paid by the FSA Card, had the expense been HCFSA-eligible. The card will also be denied at the point of service if the charge exceeds the remaining account balance; however, your HCFSA has the full amount of your elected amount available at the first of the year, as soon as you have made the first deduction from your paycheck. The following chart outlines which HCFSA-eligible expenses can be paid with the FSA Card, which are subject to automatic rollover, and which must be submitted manually to the FSA administrator:

END OF SUMMARY OF MATERIAL MODIFICATIONS

CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE FOR AMERCAN EAGLE AIRLINES EMPLOYEES

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employee of clarifications to the summary plan description—the American Eagle Employee Benefits Guide ("EBG"). These clarifications, together with the EBG, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s) (the Summary Plan Descriptions are contained in your EBG).**

These clarifications apply to the following plans:

Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798; referred to herein as the "Plan")

Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503, EIN #13-1502798; referred to herein as "SMP")

American Airlines, Inc. Long Term Disability Plan (Plan 509, EIN #13-1502798; herein referred to as "LTD")

- Under "Eligibility", under "Eligibility During Leaves of Absence and Disability" (pages 13), this subsection is deleted in its entirety and replaced with the following subsection:

  Subject to the specific rules governing leaves of absence, you may be eligible to continue benefits for yourself and your eligible dependents for a period of time during a leave. The type of leave you take determines the cost of your benefits (i.e., whether you and the company share the cost of benefits or pay the full cost of benefits). In order to continue your benefits during a leave of absence, you must timely pay the required monthly contributions during your leave.

  When you begin a leave of absence (when your payroll transaction record is changed to reflect that you're on a leave of absence), HR Employee Services sends you a letter acknowledging your leave, instructing you to access Jetnet to register your Leave of Absence Life Event, and requesting that you decide whether or not to continue your benefits while on your leave. Register your Life Event and benefit elections of Jetnet, and it will display for you a confirmation statement reflecting your choices, the monthly cost of benefits, etc. If you have not received HR Employee Services' letter within 10 days of being placed on a leave, contact HR Employee Services immediately, so that you may continue your benefits while on leave.

  IMPORTANT: If you elect not to continue your benefits while on your leave, or if you fail to timely pay the required monthly contributions for coverage, your benefits will terminate for the duration of your leave of absence. When you return to active status, you may reactivate most of your benefits; however, some benefits will require that you supply proof of good health in order to reactivate them (i.e., Long Term Disability Plan, Optional Short Term Disability Insurance Benefits, Contributory Term Life Insurance Benefit).

  With respect to your reactivating your Contributory Term Life Insurance Benefit— if, for example, your prior-leave amount of life insurance was 4 times your annual salary, and you elected not to pay for your benefit while you were on leave, once you've returned from your leave and provided proof of good health satisfactory to MetLife, you are allowed to reactivate your life insurance ONLY to one level greater than the Basic Life Insurance Benefit (which is one level greater than 1 time your annual salary)

  If your leave is an FMLA or military leave, special rules govern your rights to continue or resume your benefits, which are based on federal law.

  During the first year (12 months) of an unpaid sick or unpaid injury on duty leave of absence, you may keep the same benefits you had while actively working. You are responsible for timely paying your share of the cost for coverage during your leave. After this 12-month period, your coverage ends, at that time you may elect continuation of coverage under COBRA.

  For a detailed description of each Leave of Absence, refer to the Employee Policy Guide, located under Policies and Procedures on Jetnet, or consult with your supervisor.

- Under "Life Events" (page 28), under "You get married or declare a Domestic Partner", in the bullet describing Supplemental Medical Plan coverage, the following parenthetical statement is added to the end of the existing sentence, as follows:

  (you must enroll yourself and/or your new spouse/Domestic Partner within 60 days of your marriage/declaration; otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan).

- Under "Life Events" (page 29), under "You divorce or legally separate, or your Domestic Partner relationship ends", the bullet entitled, "Medical and Dental Options and Vision Insurance Benefit" is revised to reflect the following:

  Stop coverage for your spouse. Add coverage for yourself and/or your eligible dependents (dependent coverage may be subject to QMCSO—see page 74-75). You cannot change benefit options at this time.

- Under “Special Provisions” below “Deductibles” (page 52), a paragraph is added as follows:

  Individual Out-of-Pocket Maximum: Under the PPO-Copay you pay a $2,000 Individual Annual Out-of-Pocket Maximum for in-network services, and a $4,000 Individual Annual Out-of-Pocket Maximum for out-of-network services.

- Under “Covered Expenses” (page 57), the entry entitled, “Acupuncture” is deleted in its entirety and replaced with the following:

  Acupuncture: Medically necessary treatment (performed by a Certified Acupuncturist) for diagnosed illness or injury, only when acupuncture treatment has been proven both safe and effective treatment for such diagnosed illness or injury. (Coverage does not include acupuncture treatment for conditions in which the treatment has not been proven safe and effective—such as glaucoma, hypertension, acute low back pain, infectious disease, allergy, and the like).

- Under “Supplemental Medical Plan”, under “Eligibility”, “Active Employees” (page 88), the following parenthetical statement is added at the end of the second bullet:

  (you must enroll yourself and/or your new spouse/Domestic Partner within 60 days of your marriage/declaration; otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan).

- Under “Supplemental Medical Plan”, “Enrollment” (page 90), the following parenthetical statement is added to the end of the first sentence in the first paragraph:

  (you must enroll yourself and/or your new spouse/Domestic Partner within 60 days of your marriage/declaration; otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan).

- Under “Supplemental Medical Plan, “Enrollment” (page 90), the following statement is added to the end of the third sentence in the second paragraph:

  . . . otherwise, you cannot enroll in/add your spouse/Domestic Partner to the Supplemental Medical Plan.

- Under “Dental Benefits”, under “Covered Expenses” (page 111), the subsection entitled “Periodontal treatment” is clarified as follows:

  Medically necessary periodontal treatment of the gums and supporting structures of the teeth, and related anesthetics, with the frequency of treatment based on generally accepted standards of good periodontal care.

- Under “Vision Benefits”, “How the Spectera Vision Insurance Benefit Works” (page 114), the third paragraph is deleted and replaced with the following:

  ID cards are not necessary under the Spectera Vision Insurance Benefit—the “unique ID number” you need to access your Spectera benefits is your Social Security number. The provider’s office is responsible for obtaining the pre-authorization to perform the services and provide glasses, frames, etc., and will request the covered employee’s Social Security number, in addition to the patient’s name and date of birth.

- Under “Spectera Vision Insurance Benefits”, (page 114), the first paragraph is revised as follows:

  If you use a network provider, the Spectera Vision Insurance Benefit covers the following services, with the benefit available every 12 months based on the last date of service, for each covered member. (The insurance also offers access to discounted laser eye surgery procedures).

- Under “Disability Benefits”, “Optional Short Term Disability Insurance Benefit”, “Exclusions and Limitations” (page 138), the following is added as the tenth bullet under the Exclusions and Limitations:

  • **Preexisting Conditions Exclusion:** You are not covered under this benefit for a disability if you received medical care or treatment for the disability within the three months before the effective date of this coverage. However, after you have been covered for twelve months, this limitation on disability no longer applies, and you may receive benefits. (Also see the Glossary for the OSTD insurance benefit definition of a preexisting condition).

- Under “Dependent Day Care Flexible Spending Account”, “Receiving Reimbursement”, under “Using the UnitedHealthcare Consumer Account Card” (page 156), the last sentence in the first paragraph is deleted in its entirety and replaced with the following:

  Each year that you participate in an DDFSA, your existing FSA card will be updated with your selected DDFSA amount, and you need not reactivate your card unless you are issued a new card (keep in mind that any newly issued/reissued card must be activated after January 1, and you must wait three business days after activating the card before you may use it).

- Under “Flexible Spending Accounts”, “Dependent Day Care Flexible Spending Account”, “Filing Claims” (page 156), in the second paragraph, after the first sentence a sentence is added as follows:

Claims not postmarked by June 15 are ineligible for reimbursement.

- Under "Flexible Spending Accounts", "Health Care FSAs", "Receiving Reimbursement", the chart added on the SMM effective date 01/01/06 (pages 7-8) is deleted in its entirety and replaced with the following chart:

Type of Expense	Can You Use FSA Card?	Can You Use Automatic Rollover?	Must You File FSA Claim Manually?
Medical Expenses — PPO Copay Option			
Copayments	Yes	Yes	No
Deductibles (UHC network providers)	Yes	Yes	No
Coinsurance Amounts (UHC network providers)	Yes	Yes	No
Retail Prescription Drugs (network pharmacies)	Yes	Yes	No
Mail Order Prescription Drugs (Medco by Mail)	Yes	Yes	No
Medical Expenses — PPO-Deductible and Minimum Coverage Options			
Coinsurance (UHC network providers)	Yes	Yes	No
Deductibles (UHC network providers)	Yes	Yes	No
Mail Order Prescription Drugs (Medco by Mail)	Yes	Yes	No
HMOs			
Copayments	Yes	No	No
Coinsurance and Deductibles (UHC network provider)	Yes	Yes	No
Dental Expenses, Including Orthodontia			
Coinsurance and Deductibles (for a dental provider in the UHC network)	Yes	Yes	No
Coinsurance and Deductibles (for a dental provider in both the MetLife PDP network and the UHC network)	Yes	Yes	No
Coinsurance and Deductibles (for a dental provider in only the MetLife PDP network)	No	Yes	No
Vision Expenses			
Copayments	Yes	Yes	No
Coinsurance and Deductibles (for a Spectera or UHC network provider)	No	Yes	No
Eligible Over-the-Counter Drugs (OTC) purchased Retail or Online			
Walgreens — in store purchases only	Yes	No	No
Drugstore.com — online only	Yes	No	No
Any Other FSA-Eligible Expenses Not Filed with your Health Coverages	No	No	Yes
Dependent Day Care			
Some providers — check locally	Yes	No	No

- Under the Glossary, under the definition for "Proof of Good Health, Statement of Health" (page 194), the third bullet in the definition (regarding the addition of Supplemental Medical Plan) is deleted in its entirety.

END OF CLARIFICATIONS TO THE EMPLOYEE BENEFITS GUIDE

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the following employee benefit plans:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (referred to as the "Plan", the "Eagle Plan", the "Retiree Medical Benefit")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries
- TWA Retiree Health and Life Benefits Plan

These plans provide coverage for reconstructive surgery, as follows:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery or reconstruction of the other breast to produce a symmetrical appearance;
- Services in connection with other complications resulting from a mastectomy, such as treatment of lymphademas; and
- Prostheses

This information is also available in your Employee Benefits Guide—in both the CD-ROM version (if applicable to your work group) sent to you in July-August, 2005, and on *Jetnet*.

Questions? Contact HR Employee Services at PO Box 619616, MD 5141, DFW Airport, TX 75261-9616 or on Jetnet, by clicking on Chat with HR Services on the Benefit and Pay page or call 800-447-2000.

END OF ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

SMM for 2007, American Eagle Airlines EBG, 120406

2007 American Eagle Medical Plan Comparison Chart

2007 Plan Features

0	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
DEDUCTIBLES / MAXIMUMS						
Individual Annual Deductible	$250	$250	None	$1,000	$500	$2,000
Family Annual Deductible	$750	$750	None	$2,000	Not Applicable	$4,000
Individual Annual Out-of-Pocket Maximum*	$2,000	$2,000	$2,000	$3,000	$4,000	$5,000
Individual Lifetime Medical Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
PREVENTIVE CARE						
Annual Routine Physical Exam	20% coinsurance without deductible waived	20% coinsurance without deductible waived	$20 copayment*	20% coinsurance without deductible waived	Not Covered	Not Covered
Pap Test	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
Screening Mammogram according to age guidelines, (Age 35 thru 39- one every 1-2 years. Age 40 thru 49 as recommended by physician. Age 50 and beyond- once every year)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
PSA screening and colorectal screening (according to age guidelines - routine coverage begins at age 50)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	No cost if part of office visit 20% coinsurance if in at a outpatient hospital	20% coinsurance without deductible waived	Not Covered	Not Covered
Well Child office visits and immunizations (Birth to age 18, initial hospitalization, all immunizations. Up to 7 well child visits, birth to age 2)	20% coinsurance without deductible waived	20% coinsurance without deductible waived	$20 copayment*	20% coinsurance without deductible waived	Not Covered	Not Covered
MEDICAL SERVICES						
Primary Care Physician's Office Visit	20% coinsurance	20% coinsurance	$20 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	20% coinsurance	$35 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Gynecological Care Visit	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	$20 copayment* (for preventive visits) $35 copayment* (if not a preventive diagnosis)	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Diagnostic Mammogram	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)
Pregnancy - Physician Services	20% coinsurance	20% coinsurance	$35 copayment* per visit $350 max copayment per pregnancy (includes prenatal/postnatal/delivery)	20% coinsurance	40% coinsurance	40% coinsurance
PSA and colorectal diagnostic exam (according to age guidelines - routine coverage begins at age 50) Diagnostic	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	20% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)	40% coinsurance (if medically necessary)
Second Surgical Opinion	20% coinsurance	20% coinsurance	$20 copay PCP $35 copay Specialist	20% coinsurance	40% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	20% coinsurance	$25 copayment*	20% coinsurance	40% coinsurance	40% coinsurance
Chiropractic Care Visit	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	$35 copayment* (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	20% coinsurance	$35 copayment* per visit (max copayment of $350 per person per year)	20% coinsurance	40% coinsurance	40% coinsurance
Allergy Care	20% coinsurance	20% coinsurance	$35 copayment* per visit (max copayment of $350 per person per year)	20% coinsurance	40% coinsurance	40% coinsurance

2007 American Eagle Medical Plan Comparison Chart

2007 Plan Features

0	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
Diagnostic X-ray and Lab	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office or a network laboratory/radiology center	20% coinsurance	40% coinsurance	40% coinsurance
OUTPATIENT SERVICES						
Outpatient Surgery in Physician's Office	20% coinsurance	20% coinsurance	$20 copay PCP $35 copay Specialist	20% coinsurance	40% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
HOSPITAL SERVICES						
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	20% coinsurance	$150 copayment* per year, plus 20% coinsurance for all other hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via Jetnet within 60 days or these charges will not be covered.)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance for all hospital based services (hospital admission copayment of $150 does not apply to baby)	20% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office	20% coinsurance	40% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance	No Cost	20% coinsurance	40% coinsurance	40% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% coinsurance	$75 copayment* (Waived if admitted to the hospital) plus 20% coinsurance	20% coinsurance	40% coinsurance	40% coinsurance
OUT-OF-HOSPITAL CARE						
Convalescent and Skilled Nursing facility, following hospitalization	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance	20% coinsurance	$20 copayment	20% coinsurance	40% coinsurance	40% coinsurance
Hospice Care	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital; $20 copayment per day if home care	20% coinsurance	40% coinsurance	40% coinsurance
OTHER SERVICES						
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance	20% coinsurance	$20 copay PCP $35 copay Specialist 20% coinsurance in hospital or freestanding surgical center	20% coinsurance	40% coinsurance	40% coinsurance
Infertility Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

2007 Plan Features

2007 American Eagle Medical Plan Comparison Chart

0	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
Radiation Therapy or Chemotherapy	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital	20% coinsurance	40% coinsurance	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital or dialysis center	20% coinsurance	40% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	20% coinsurance for items rented or purchased from an in-network provider	20% coinsurance	40% coinsurance	40% coinsurance
MENTAL HEALTH AND CHEMICAL DEPENDENCY						
Inpatient Mental Health Care	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance for all hospital based services	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)
Alternative Mental Health Center	50%** (max of 30 days per year)	50%** (max of 30 days per year)	20% coinsurance for all hospital based services	50%** (max of 30 days per year)	50%** (max of 30 days per year)	50%** (max of 30 days per year)
Outpatient Mental Health Care Visit	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)	$35 copayment	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)	50%** (up to max of 60 visits per year in-network and out-of-network combined)
Marriage Counseling	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Detoxification (considered a medical condition)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance	40% coinsurance
Chemical Dependency*** Inpatient Rehabilitation	20% coinsurance if approved by EAP (max $5,000 benefit)	20% coinsurance if approved by EAP (max $5,000 benefit)	20% coinsurance for all hospital based services if approved by EAP	20% coinsurance if approved by EAP (max $5,000 benefit)	40% coinsurance if approved by EAP (max $5,000 benefit)	40% coinsurance if approved by EAP (max $5,000 benefit)
Chemical Dependency*** Outpatient Rehabilitation	50%** if approved by EAP	50%** if approved by EAP	$35 copayment* per visit if approved by EAP (max copayment of $350 per person per year)	50%** if approved by EAP	50%** if approved by EAP	50%** if approved by EAP
PRESCRIPTION MEDICATIONS						
Retail Pharmacy* (up to a 30 day supply)	**Retail Card Program** **Generic:** 20% ($10 Min/$50 Max) **Brand:** (no generic available) 30% ($20 Min/$100 Max) **Brand**:(if generic available) 50% ($20 Min/No-Max)	**Retail Card Program** **Generic:** 20% ($10 Min/$50 Max) **Brand:** (no generic available) 30% ($20 Min/$100 Max) **Brand**:(if generic available) 50% ($20 Min/No-Max)	**Retail Card Program** **Generic:** 20% ($10 Min/$50 Max) **Brand:** (no generic available) 30% ($20 Min/$100 Max) **Brand**:(if generic available) 50% ($20 Min/No-Max)	**Retail Card Program** **Generic:** 20% ($10 Min/$50 Max) **Brand:** (no generic available) 30% ($20 Min/$100 Max) **Brand**:(if generic available) 50% ($20 Min/No-Max)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)
Mail Service Pharmacy* (up to a 90 day supply)	**Generic:** 20% ($20 Min/$125 Max) **Brand:** (no generic available) 30% ($40 Min/$250 Max) **Brand:** (if generic available) 50% ($40 Min/No-Max)	**Generic:** 20% ($20 Min/$125 Max) **Brand:** (no generic available) 30% ($40 Min/$250 Max) **Brand:** (if generic available) 50% ($40 Min/No-Max)	**Generic:** 20% ($20 Min/$125 Max) **Brand:** (no generic available) 30% ($40 Min/$250 Max) **Brand:** (if generic available) 50% ($40 Min/No-Max)	**Generic:** 20% ($20 Min/$125 Max) **Brand:** (no generic available) 30% ($40 Min/$250 Max) **Brand:** (if generic available) 50% ($40 Min/No-Max)	Not Applicable	Not Applicable
Oral Contraceptives (available only thru mail service)	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OTHER INFORMATION						

2007 American Eagle Medical Plan Comparison Chart

2007 Plan Features

0	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	In-Network Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay	Out-of-Network Minimum Coverage
CheckFirst (predetermination of benefits via United HealthCare)	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail

*Deductibles, fixed copayments or payments for prescription drugs do not apply toward the annual out-of-pocket maximum

**50% coinsurance amounts do not apply toward the annual out-of-pocket maximum

***Rehabilitation for Chemical Dependency limited to one per lifetime and must be approved by EAP

Disclaimer: The American Eagle Employee Benefits Guide (EBG) is the legal plan document and the summary plan description (SPD) for American Eagle's Benefits Plans. If there is any discrepancy between the EBG and this chart, the EBG will

SUMMARY OF MATERIAL MODIFICATIONS
American Eagle Airlines, Inc. – Health and Welfare Benefit Plans

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of changes to the Company-sponsored health and welfare benefit plans listed below. This Summary of Material Modifications describes the changes that affect your benefit plans, and updates your summary plan descriptions. This Summary of Material Modifications, together with the Employee Benefit Guide, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s) (the Summary Plan Descriptions are contained in the Employee Benefit Guide ("EBG"). These changes are effective January 1, 2006, unless otherwise stated elsewhere in this document.**

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798)

Eagle Group Life and Health Benefits Plan

Change the Plan's medical management/QuickReview administrator to UnitedHealthcare (UHC)

- Effective January 1, 2006 SHPS will no longer provide medical management services to American Eagle, including the QuickReview process. If an employee has a surgery or a hospitalization planned on or after January 1, 2006 the employee or his/her physician should contact UHC for QuickReview.
- Any references throughout the EBG to "Health International", "SHPS" or "HI" are replaced with **UHC**.
- In the "Contact Information" section of the EBG (page 1), the following information is revised as follows:

QuickReview (Pre-authorization fro hospitalization)		
Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options and Supplemental Medical Plan	**UnitedHealthcare** **AMR Medical Claim Unit** **P.O.Box 30551** **Salt Lake City, UT 84130-0554**	**(800) 592-3048** (Select QuickReview at the prompt)

Establish a new contact number for UnitedHealthcare

- All references to phone number (800) 638-9599 throughout the EBG are replaced with (800) 592-3048.

Change in copayments and coinsurance amounts in the PPO-Copay Option

- Under "Special Provisions**"** section "Co-payments vs. coinsurance" (page 52), the first sentence in the second paragraph is revised as follows:

  For services received in a network hospital-based setting, you pay a $150 annual copayment, and then you pay the 20% coinsurance (a percentage of the cost).

- Under "Special Provisions" section "Hospital out-of-pocket maximum" (page 52), the first sentence is revised as follows:

  You pay 20% coinsurance for network hospital-based services up to an annual out-of-pocket maximum of $1,500 per covered person per year after you satisfy the $150 annual copayment.

Increase deductible amounts in the PPO-Deductible Option

- Under "Special Provisions" section "Deductibles" (page 48) the paragraph is revised as follows:

  You pay an annual $250 per person deductible under the Out-of-Area Coverage option with a family deductible of $750. Under the PPO-Deductible option, you pay an annual $250 per person, $750 family deductible for

network services and an annual $500 per person deductible for services received by out-of-network providers. Under the Minimum coverage option, you pay an annual deductible of $1,000 per person or $2,000 pr family.

Add preventive care coverage in the Out-of-Area Option

- Under "Special Provisions" section "Preventive Care" (page 49) remove the sentence and replace with the following two bullets as follows:

  - **Under the Minimum Coverage and PPO-Deductible Options, well-child care (for children up to age 2) and periodic mammograms are covered.**

  - **Under the Out-of-Area Coverage Option annual routine physical exams, well-woman exams, and well-child exams provided by your network PCP or a network obstetrician/gynecologist are covered after satisfying the annual deductible**.

Eliminate the pre-existing condition exclusion in the PPO-Copay, PPO-Deductible, Minimum Coverage, and Out-of-Area Options

- The pre-existing condition section, including the header and all related paragraphs found on pages 39 & 40 should be deleted in its entirety

Increase maximum member coinsurance amounts in the Prescription Drug Benefit

- Under "Retail Drug Coverage" (page 66) the second paragraph is revised as follows:

  When you use network pharmacies, you pay $10 for generic drugs or 30% of the cost for brand name drugs (up to a maximum of $100) if no generic is available, or 50% of the cost of a brand drug when there is a generic available, for up to a 30-day supply of any medically-necessary covered prescription, including psychotherapeutics.

- Under "Mail Service Prescription Drug Option" (page 68) replace the two bullets with a paragraph as follows:

  Brand name drugs: 30% of the cost of the drug, up to $250 maximum per prescription or refill if no generic is available or 50% of the cost of the brand drug when there is a generic available.

Changes to the Medical Benefit Options Comparison table

- Replace the Medical Benefits Options Comparison table on pages 40-47 with the table contained in the attached appendix.

Addition of TriCare Supplement Insurance Option as a Medical Benefit Option for Active and Leave of Absence Employees

- In the "Contact Information" section of the EBG, (page 1), the following information is added:

TriCare Supplement Insurance Option *Enrollment, member services, etc. inquiries*	***ASI*** *2301 Research Blvd., Ste 300* *Rockville, MD 20850-6265*	***(800) 638-2610, Ext. 255*** ***(800) 311-3124 (fax)*** ***Web site:*** *www.asicorptricaresupp.com* ***Email:*** *custsvc@asicorporation.com*
TriCare Supplement Insurance Option *Claim inquiries*	***ASI*** *PO Box 2510* *Rockville, MD 20847*	***(800) 638-2610, Ext. 255*** ***(800) 310-5514 (fax)***
DEERS *(Eligibility for TriCare)*	***Defense Manpower Data Center Support Office (DMDC)*** *Attn: COA* *400 Gigling Road* *Seaside, CA 93955-6771*	***(800) 538-9552*** ***(800) 866 363-2883*** *(for TTY/TTD)* ***(831) 655-8317*** *(Attn: CSO) (fax)* ***Email:*** *addrinfo @osd.pentagon.mil* ***Online:*** *https://www.dmdc.osd*

In the "Benefits at a Glance" section, "Medical Benefit Options" (page 5); a sixth bullet is added to the list of medical benefit options:

- *TriCare Supplement Insurance*

In the "Benefits at a Glance" section, "Medical Benefit Options" (page 6), the following text is added:

TriCare Supplement Insurance Option

Military retirees under age 65, retired military reservists under age 65, and their eligible dependents may be eligible for TriCare health coverage sponsored by the federal government. TriCare-enrolled employees may elect to enroll in TriCare Supplement Insurance Option as a new Medical Benefit Option for 2006. TriCare Supplement Insurance Option coordinates with your TriCare coverage and reimburses many out-of-pocket expenses not paid by TriCare. For more details about the TriCare Supplement Insurance Option, see page 74.

In the "Eligibility" section, "Common Law Spouse/Domestic Partners" (page 17), a fourth bullet is added to the statement, "Domestic Partners **ARE NOT** eligible to participate in", as follows;

- *TriCare Supplement Insurance Option*

To determine your TriCare eligibility, contact the Defense Manpower Data Center Support Office (see Contact Information section in this Guide).

In the "Enrollment" section, "Paying for Coverage, "Company-Provided Benefits" (page 22), "Medical Benefits", the first bullet is revised as follows:

- *Medical Benefits. You can choose from Out-of-Area Coverage, PPO-Deductible, PPO-Copay, Minimum Coverage or an HMO option (if available in your area), or the TriCare Supplement Insurance Option (if you are eligible for TriCare). .*

In the "Enrollment" section, "Taxation of Benefits" (page 24), the chart outlining options, taxability, etc., "Medical Benefit Options" is revised as follows:

Type of Benefits	*Before Tax?*	*May Waive?*
Medical Benefit Options	*Yes*	*Yes*
• *Out-of-Area Coverage Option* • *PPO-Deductible Option* • *PPO-Copay Option* • *Minimum Coverage Option* • *Health Maintenance Organizations Option (HMOs)* • *TriCare Supplement Insurance Option (not available to DomesticPartners)*		

In the "Life Events" chart (page 28), the first bullet under "You get married or declare a Domestic Partner" is revised as follows:

Medical and Dental Options: *Add coverage for your spouse and eligible dependents; stop coverage for a dependent or yourself. Although you can add or drop coverage for dependents or yourself, you cannot change benefit options at this time. Domestic Partners and their dependents are not eligible for the TriCare Supplement Insurance Option. You may add or drop dental coverage.*

In the "Life Events" chart (page 31) the first bullet under "You move to a new home address" is revised as follows:

Medical Option: *May select from medical options available in new location if you are covered under the PPO-Copay Option, PPO-Deductible Option or an HMO and you moved out of the service area to any area with different options available. Contact HR Employee Services for more information.*

Under "Special Life Event Considerations" (page 33) the "Relocation" first paragraph is revised as follows:

If you are enrolled in the PPO-Deductible or PPO-Copay Option and you move to a location where PPO providers are not available, you must choose another medical option or you may waive coverage. If you are enrolled in an HMO and you move out of that plan's service area, you may choose another medical option or you may wave coverage. If you are enrolled in the Out-of-Area Coverage Option and move to an area where the PPO network is available, you will no longer be eligible for the Out-of-Area Option. However, if you change to another medical option, your deductibles and out-of-pocket maximums do not transfer to the new option. If you are enrolled in the Minimum Coverage Option or in the TriCare Supplement Insurance Option, you may stay in that option or elect PPO-Copay Option, PPO-Deductible Option or an HMO, if available. You may not choose between the Minimum Coverage Option and TriCare Supplement Insurance Option because of relocation.

Under "Benefit Coverages Not Affected by Life Events" (page 34), the "Medical Options" paragraph is revised as follows:

Medical Options: *You may change medical options only if you relocate (see the chart beginning on page 28). However, if you are enrolled in either the PPO-Copay, PPO-Deductible, Out-of-Area Options or TriCare Supplement Insurance Option, you may not change from one of these options to another due to relocation, unless the option you were enrolled in previously is no longer available in your new location.*

Under the "Medical Benefit Options", "Overview" (page 36), a fourth bullet is added, as follows:

TriCare Supplement Insurance Option is a fully insured option with covered services insured and underwritten by Hartford Life and Accident Insurance Company and administered by the Association and Society Insurance Corporation (ASI). This Option is available to employees who are eligible for TriCare.

In the “Maximum Medical Benefit” section (page 39), the last sentence of the first paragraph is revised as follows:

All benefits paid under the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options and Prescription Drug Benefits (both retail and mail order), HMO Options, and TriCare Supplement Insurance Option are included in the maximum medical benefit.

In the “Maximum Medical Benefit” section (page 39) the fifth paragraph is revised as follows:

If your selected medical coverage (for both the employee and covered eligible dependents) is one of the self-funded medical coverages (Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or PPO-Copay Options), and you and/or your covered eligible dependents exhaust the maximum medical benefit under the self-funded medical coverage, neither you nor your covered eligible dependents who exhaust the maximum medical benefit can elect any other medical coverage (including an HMO or TriCare Supplement Insurance Options) under the Plan.

Immediately following the “Additional Rules for HMOs” section (page 54), the following section is added:

TriCare Supplement Insurance Option

For those employees who are eligible for TriCare medical coverage,

- *Spouse or surviving spouse of an active-duty member,*
- *Retirees of the uniformed services or their spouses and surviving spouses,*
- *Spouses of reservists who are ordered up to active duty for more than 30 days (they are covered only during the reservist’s active-duty tour), or a reservist who died while on active-duty tour,*
- *Former spouses of active-duty or retired military who were married to a service member or former service member who had performed at least 20 years of creditable service for retirement purposes at the time a divorce or annulment occurred,*
- *Spouses or surviving spouses of 100% disabled veterans. Such spouses would be eligible for CHAMP/VA), and*
- *Unmarried dependent children of TriCare-eligible employees,*

TriCare medical coverage (offered through the federal government) may be a preferred option for you and your family. If you (or you and your family) are enrolled in TriCare, you have the option of electing the TriCare Supplement Insurance Option as your Medical Benefit Option under the Plan. TriCare Supplement Insurance Option, insured by the Hartford Life and Accident Insurance Company and administered by ASI, is designed to coordinate with your federal government-sponsored TriCare medical coverage, and may provide an overall richer coverage than the Out-of-Area Coverage Option, the PPO-Deductible Option, the PPO-Copay Option, the Minimum Coverage Option or the Health Maintenance Organizations Option (HMOs)

TriCare and the TriCare Supplement Insurance Option include a network of physicians, hospitals, and other medical service providers; TriCare and the TriCare Supplement Insurance Option determine your medical coverage. If you elect TriCare Supplement Insurance Option, your TriCare Supplement Insurance Option replaces medical coverage offered through the Out-of-Area Coverage Option, the PPO-Deductible Option, the PPO-Copay Option, the Minimum Coverage Option or the Health Maintenance Organizations Option (HMOs). Your benefits, including prescription drugs prescribed by physicians and dentists, as well as mental health care, treatment for alcohol/chemical dependency, are determined according to the terms and provisions of TriCare and the TriCare Supplement Insurance Option. Some of the TriCare Supplement Insurance Option features are:

- *No preexisting condition exclusion*
- *No plan deductibles*
- *Protection from excess charges*
- *Guaranteed acceptance in the TriCare Supplement Insurance*
- *Freedom of choice to utilize any TriCare authorized civilian doctor or specialist*
- *Comprehensive coverage*
- *Prompt processing of claims*
- *Portability—you may choose to continue your TriCare Supplement Insurance if you leave your employment for any reason*
- *No claim forms required*
- *Administration services provided by Association and Society Insurance Corporation (ASI)*
- *No separate precertification or preauthorization requirement*
- *Between TriCare and TriCare Supplement Insurance, most eligible charges are reimbursed in full*

TriCare Supplement Insurance Option is completely independent of American Eagle Airlines, Inc. and as such, American Eagle Airlines, Inc. cannot influence or dictate the coverage provided under this option. While this section of the Guide has provided you with overview information about the TriCare Supplement Insurance Option, you must carefully review the ASI/Hartford TriCare Supplement Insurance documents to determine the provisions, limitations, and exclusions of this insurance, as those documents govern your coverage and benefits under the TriCare Supplement Insurance Option. If you elected this as your Medical Benefit Option, ASI/Hartford will provide you with the plan document/summary plan description that will detail the coverages, terms, and provisions of the TriCare Supplement Insurance Option. (See Contact Information for ASI and Hartford.)

Domestic Partners are not eligible to participate in the TriCare Supplement Insurance Option.

In the "Additional Rules" section (page 74), the first sentence is revised as follows:

The following sections apply to the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, HMOs, Dental Benefits, Vision Insurance Benefit, TriCare Supplement Insurance Option, HCFSA Benefit and the Supplemental Medical Plan (except as noted).

In the "Qualified Medical Child Support Order" section (page74), a seventh bullet is added after the third paragraph, as follows:

TriCare Supplement Insurance Option

In the "Continuation of Coverage" section (page 81), the second paragraph is revised as follows:

Several of the benefits or plans (Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, Dental Benefit, HMOs, Vision Insurance Benefit, TriCare Supplement Insurance Option, and the HCFSA Benefit and the Supplemental Medical Plan) provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain qualifying events. . . .

In the "Continuation of Coverage" section (page 81), the following subsection is added:

Portability of the TriCare Supplement Insurance

You have the ability to continue your TriCare Supplement Insurance after you separate from the Company. For information on portability, contact ASI/Hartford (see Contacts Information).

In the "Plan Administration" section (page 159), "Plan Information", a sixth bullet is added to the chart for the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries, and "Medical Benefits" is revised as follows:

- *Medical Benefits*
  - *Out-of-Area Option*
  - *Minimum Coverage Option*
  - *PPO-Deductible Option*
  - *PPO-Copay Option*
  - *Health Maintenance Organizations*
  - *TriCare Supplement Insurance Option*

In the "Appealing a Denial" section (page 169), the "Procedures for Appealing an Adverse Benefit Determination", the second group of bullets is revised as follows:

With respect to adverse benefit determination made on fully insured benefits, as follows:

- *TriCare Supplement Insurance Option*
- *Employee Term Life Insurance Benefit (Employee, Spouse, and Child)*
- *Accidental Death and Dismemberment Insurance Benefits (Employee, Spouse, Child, VPAI, and all Company-provided accident insurance benefits)*
- *HMOs*
- *Long Term Insurance Care Plan*
- *Optional Short Term Disability Insurance Benefit.*

In the "Compliance with Privacy Regulations" section (page 173),

TriCare Supplement Insurance Option

is added to the parenthetical statement at the end of the first sentence of the second paragraph.

Introduction of Maximum Non-Network Reimbursement Program ("MNRP") for Assessing Eligible Out-of-Network Charge Amounts in the PPO-Copay Option, PPO-Deductible Option, and Minimum Coverage Option.

In the "Medical Benefit Options" section, "Key Features of the Medical Options" (page 37), a new paragraph is added after the "Usual and prevailing fee limits" paragraph, as follows:

MNRP Fee Limits: *Effective January 1, 2006, the PPO-Copay Option, PPO-Deductible Option, and Minimum Coverage Option will determine the eligible charge amount for out-of-network expenses by using the Maximum Non-Network Reimbursement Program ("MNRP"). The eligible amount will be the actual billed fee, up to 140% of the Medicare allowable charge. MNRP fee limits will apply to all medical services and supplies, including but not limited to, hospital charges, physician's fees, lab fees, radiology fees, and all other covered medically necessary out-of-network*

expenses. For the following types of out-of-network claims, the eligible charge will be determined according to the following rules:

- *If the claim represents care rendered in a life/limb endangering emergency (e.g., chest pain, respiratory distress, head injury, severe hemorrhage, etc.), the PPO-Copay Option, PPO-Deductible Option, and Minimum Coverage Option will allow the provider's full billed fee as eligible expense*

- *If the claim represents care pre-authorized by UHC rendered in a "network gap" (where the nearest source of appropriate medical treatment is 30 or more miles away), the PPO-Copay Option, PPO-Deductible Option, and Minimum Coverage Option will allow the full billed charge as eligible expense*

- *If the claim represents services for which no MNRP data exist, the PPO-Copay Option, PPO-Deductible, and Minimum Coverage Option will allow 50% of the provider's billed charge as eligible expense*

In the "Medical Benefit Options Comparison section (page 40), the second sentence of the first paragraph is revised, as follows:

Benefits are available for Eligible Expenses that are medically necessary and within the usual and prevailing fee limits for the Out-of-Area Option or within the MNRP Fee Limit the PPO-Copay, PPO-Deductible, or Minimum Coverage Options.

In the "Excluded Expenses" section (page70), the following paragraph is added between "Lenses" and "Massage therapy":

MNRP (Maximum Non-Network Reimbursement Program): *Any portion of fees for physicians, hospitals, and other medical providers that exceeds the MNRP Fee Limit. (Applies to out-of-network providers under the PPO-Copay Option, PPO-Deductible Option, and the Minimum Coverage Option).*

In the "Excluded Expenses" section (page 73), the "Usual and prevailing" paragraph is revised as follows:

Usual and prevailing: *Any portion of fees for physicians, hospitals, and other providers that exceeds the usual and prevailing fee limits. (Applies to the Out-of-Area Option)*

In the "PPO-Copay Option" section, "Out-of-Network Services" (page 49), the second paragraph is revised, and a new sentence is added, as follows:

At the out-of-network benefit level, you pay an annual $500 per person per year deductible and higher out-of-pocket coinsurance amounts—for most services, the plan pays 60% and you pay 40% of covered out-of-network charges, after you satisfy the annual per person deductible. Additionally, you must pay any amount of the provider's billed fee that exceeds the MNRP Fee Limit. Each time you or your covered dependent needs medical care, you choose whether to use a network or out-of-network provider.

In the "Glossary" (page 187), a new entry is added, as follows:

Term	***Definition***
Maximum Non-Network Reimbursement Program (MNRP)	*This program is based upon federal Medicare reimbursement limits; that is, the Medicare-allowable (what the federal Medicare program would allow as covered expense) charge for all types of medical services and supplies. Under the PPO-Copay Option, the PPO-Deductible Option, and the Minimum Coverage Option the Eligible Expense for out-of-network services and supplies is not to exceed 140% of the Medicare allowable charge. This is referred to as the MNRP Fee Limit. Most health care facilities and medical providers accept MNRP as a valid reimbursement resource. MNRP applies to all out-of-network medical services and supplies, including, but not limited to, hospital, physician, lab, radiology, and medical supply expenses.*

Medicare Part D for Non Retiree Participants with Medicare

In the "Coordination with Medicare" section, "Benefits for Individuals Who are Entitled to Medicare" (page 80), the following paragraph is added immediately following the two bullet points:

Effective January 1, 2006, the federal Medicare program activates the Medicare Part D Benefit—Medicare benefits for prescription drug expenses. If you (or your dependent(s)) are entitled to Medicare benefits—including Medicare Part D—the aforementioned rules apply.

In the "Coordination with Medicare" section, "Benefits for Disabled Individuals" (page 80) , the first paragraph is revised as follows:

If you stop working for a participating AMR Corporation subsidiary because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you must apply for Medicare Parts A, B, and D. Medicare Part A provides inpatient hospitalization benefits, Medicare Part B provides outpatient medical benefits, such as doctor's office visits, and Medicare Part D provides prescription drug benefits. Medicare is the primary plan payer for most disabled persons.

In the "Coordination with Medicare" section, "Benefits for Disabled Individuals" (page 80), the last sentence of the second paragraph—

"Services not covered by Medicare include prescription drugs."

is deleted.

2 ½ Month Carryover of Unused Flexible Spending Account Funds

In the "Benefits at a Glance" section, "Flexible Spending Accounts Benefits", "Health Care Flexible Spending Account" (page 09), the following sentence is added to the second paragraph:

However, effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your HCFSA as of December 31—and you may use these carryover funds to reimburse eligible medical and dental expenses incurred not only in the year these funds were deposited, but also for eligible medical and dental expenses incurred from January 1 through March 15 of the following year.

In the "Benefits at a Glance" section, "Flexible Spending Accounts Benefits", "Dependent Day Care Flexible Spending Account" (page 10), the following sentence is added to the fifth paragraph:

However, effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your HCFSA as of December 31—and you may use these carryover funds to reimburse eligible medical and dental expenses incurred not only in the year these funds were deposited, but also for eligible medical and dental expenses incurred from January 1 through March 15 of the following year.

In the "Flexible Spending Accounts" section (pages 147-157), all references to the claim filing deadline of April 30 (page 153, fourth paragraph; page 157, last paragraph) are revised to reflect a new deadline date, as follows:

"June 15"

In the "Flexible Spending Accounts" section, "Overview" (page 147), the following is added to the end of the second paragraph:

However, effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your FSA as of December 31—and you may use these carryover funds to reimburse not only eligible expenses incurred in the same year in which the funds were deposited, but also for eligible expenses incurred from January 1 through March 15 of the following year.

In the "How the Health Care FSA Works" section, "Eligible Expenses" (page 149), the second paragraph is revised as follows, and a new paragraph is added immediately after the second paragraph:

Prior to November 1, 2005, you received reimbursement from your HCFSA only for eligible expenses incurred during the same year in which you deposited money into your account. For example, if you deposited money into your 2004 HCFSA to help pay for a surgical procedure, you must have undergone that surgical procedure and incurred the related expenses by December 31, 2004.

Effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your HCFSA as of December 31—and you may use these carryover funds to reimburse eligible expenses incurred not only during the same year in which you deposit money into your account, but also for eligible expenses incurred from January 1 through March 15 of the following year. For example, if you deposited money into your 2005 HCFSA to help pay for a surgical procedure, you must have undergone that surgical procedure and incurred the related expenses during the 2005 calendar year or between January ,1 2006 and March 15, 2006, inclusive. For purposes of the HCFSA, your are deemed to have incurred expenses for a service or supply at the time the service of supply is provided (rendered).

In the "How the Health Care FSA Works" section, before "Filing Claims", (page 152), the following subsection is added at the end of "Automatic Reimbursement Feature" subsection

"Using the UnitedHealthcare Consumer Account Card" (Page 152)

Type Of Expense	*Can You Use FSA Card?*	*Can You Use Automatic Rollover?*	*Must You File FSA Claim Manually?*
Medical Expenses—PPO-Copay Option			
Copayments	*Yes*	*Yes*	*No*
Deductibles (UHC network providers)	*Yes*	*Yes*	*No*
Coinsurance Amounts (UHC network providers)	*Yes*	*Yes*	*No*
Retail Prescription Drugs (network pharmacies)	*Yes*	*Yes*	*No*
Mail Order Prescription Drugs (Medco by Mail)	*Yes*	*Yes*	*No*
Medical Expenses—PPO-Deductible and Minimum Coverage Options			
Coinsurance (UHC network providers)	*Yes*	*Yes*	*No*
Deductibles (UHC network providers)	*Yes*	*Yes*	*No*

Retail Prescription Drugs (network pharmacies)	*Yes*	*Yes*	*No*
Mail Order Prescription Drugs (Medco by Mail)	*Yes*	*Yes*	*No*
HMOs			
Copayments	*Yes*	*No*	*No*
Coinsurance and Deductibles (UHC network provider)	*Yes*	*Yes*	*No*
Dental Expenses, Including Orthodontia			
Coinsurance and Deductibles (network provider)	*Yes*	*Yes*	*No*
Vision Expenses			
Copayments	*Yes*	*Yes*	*No*
Coinsurance and Deductibles (network provider)	*Yes*	*Yes*	*No*
Eligible Over-the-Counter (OTC) Drugs Purchased Retail or Online			
Walgreens—in store purchases only	*Yes*	*No*	*No*
Drugstore.com—online only	*Yes*	*No*	*No*
Any Other FSA-Eligible Expense Not Filed With Your Health Coverages	*No*	*No*	*Yes*
Dependent Day Care			
Some providers—check locally	*Yes*	*No*	*No*

In "Filing Claims", immediately following the chart (page 152), the following subsection is added at the end of this section:

2 ½ Month Carryover of Unused HCFSA Funds

Effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your HCFSA as of December 31—and you may use these carryover funds to reimburse eligible expenses incurred not only in the year in which the funds were deposited, but also eligible expenses incurred between January 1 and March 15, inclusive, of the following calendar year. For example, if you still have $300 of unused funds in your 2005 HCFSA on December 31, 2005, that $300 can be carried over into 2006, and you have until March 15, 2006 to incur the eligible expense to be reimbursed from this carryover amount of $300. However, you must have incurred the eligible expense on or before March 15, 2006, and you must submit the carryover claim for reimbursement by June 15, 2006.

IMPORTANT—this new June 15 filing deadline applies to BOTH claims submitted for expenses incurred during the year in which you deposited the funds, AND claims incurred during the 2 ½ carryover period.

If you plan to submit claims for reimbursement of the carryover amount, it will be necessary for you to file such claims with UnitedHealthcare using the special claim form available on Jetnet—UnitedHealthcare's Grace Period Extension form. You cannot use your UnitedHealthcare Consumer Account Card to pay for expenses incurred in the carryover period. Likewise, you cannot use automatic rollover to pay for expenses incurred in the carryover period. If you have questions or need further information, contact HR Employee Services or UnitedHealthcare (see Contact Information).

In the "Dependent Day Care Flexible Spending Account", "How the DDFSA Works" (page 153), the following paragraphs are added as the second and third paragraphs:

Prior to November 1, 2005, you received reimbursement from your DDFSA only for eligible expenses incurred during the same year in which you deposited money into your account. For example, if you deposited money into your 2004 DDFSA to help pay for child care, you must have incurred the child care expenses by December 31, 2004. For the purposes of the DDFSA, you are deemed to have incurred expenses for a service at the time the service is provided (rendered).

Effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your DDFSA as of December 31—and you may use these carryover funds to reimburse eligible expenses incurred not only during the same year in which you deposit money into your account, but also for eligible expenses incurred from January 1 through March 15 of the following year. For example, if you deposited money into your 2005 DDFSA to help pay for child care, you must have incurred the child care expenses during the 2005 calendar year or between January 1, 2006 and March 15, 2006, inclusive. For purposes of the DDFSA, your are deemed to have incurred expenses for a service at the time the service is provided (rendered).

In "Filing Claims" (page 156), the following paragraphs are added at the end of this section:

2 ½ Month Carryover of Unused DDFSA Funds

Effective November 1, 2005, you may carry over into the next calendar year any unused funds remaining in your DDFSA as of December 31—you may use these carryover funds to reimburse eligible expenses incurred not only in the year in which the funds were deposited, but also eligible expenses incurred between January 1 and March 15, inclusive, of the following calendar year. For example, if you still have $300 of unused funds in your 2005 DDFSA on December 31, 2005, that $300 can be carried over into 2006, and you have until March 15, 2006 to incur the eligible expense to be reimbursed from this carryover amount of $300. However, you must have incurred the eligible expense on or before March 15, 2006, and you must submit the carryover claim for reimbursement by June 15, 2006.

IMPORTANT—this new June 15 filing deadline applies to BOTH claims submitted for expenses incurred during the year in which you deposited the funds, AND claims incurred during the 2 ½ carryover period.

If you plan to submit claims for reimbursement of the carryover amount, it will be necessary for you to file such claims with UnitedHealthcare using the special claim form available on Jetnet—UnitedHealthcare's Grace Period Extension form. You cannot use your UnitedHealthcare Consumer Account Card to pay for expenses incurred in the carryover period. Likewise, you cannot use automatic rollover to pay for expenses incurred in the carryover period. If you have questions or need further information, contact HR Employee Services or UnitedHealthcare (see Contact Information).

Method of Contribution Payment for Employees on Leaves of Absence

In the "Eligibility" section, "Eligibility During Leaves of Absence and Disability" (page 13), the first two paragraphs are revised as follows:

Subject to the specific rules governing leaves of absence, you may be eligible to continue benefits for yourself and your eligible dependents for a period of time during a leave. The type of leave you take determines the cost of those benefits. In order to maintain your benefits while on a leave, you must timely pay the required contributions for your benefits during the time you are on a leave of absence. Your failure to timely remit the required contributions may result in termination of your benefits. If you do not wish to maintain your benefits while on a leave, you may waive/suspend coverage for the duration of the leave. You may be able to reinstate your benefits upon your return from your leave to active employee status, subject to the conditions and requirements explained in the leave of absence information provided to you at the beginning of your leave.

When you begin a leave of absence, HR Employee Services will send you a leave of absence information packet providing information about continuing your benefits while on a leave how to register your benefit elections for the duration of your leave, how to pay for those benefits while on your leave, the determinations of cost, requirements for timely payment, the results of your electing to waive/suspend your benefits while on a leave, etc. You will also be able to access leave of absence information on Jetnet. ***It is most important that you review all of this information carefully and completely, and contact HR Employee Services if you have any questions or need additional information. If you have not received your leave of absence packet within 10 days of being placed on a leave of absence, contact HR Employee Services at 800-447-2000 immediately to be sure you are able to continue coverage during the leave.***

Restatement of the Employee Benefits Management Structure

In the "Plan Amendments" section (pages 161-172), the first paragraph is revised as follows:

The Benefits Strategy Committee ("BSC"), as appointed by the Chief Executive Officer, has the sole authority to adopt new employee benefit plans ("Plans") and terminate existing Plans. The Pension Benefits Administration Committee ("PBAC"), as appointed by the Chief Executive Officer, has the sole authority to interpret, construe, and determine claims under the Plans. The PBAC also has the authority to amend the Plans or make recommendations to the BSC for material amendments to the Plans.

Coverage Changes and Clarifications in the Plan's OSTD Insurance Benefit

The Optional Short Term Disability Insurance Benefit ("OSTD") is a disability benefit wholly insured and underwritten by MetLife. MetLife has made some changes and modifications to OSTD, and these changes are incorporated into the EBG as set forth below.

In the Glossary section (page 187) the following entry is added:

Term	***Definition***
Appropriate Care and Treatment (Applies to OSTD Insurance Benefit and LTD Plan)	*Medical care and treatment that is:* *1. Given by a Physician whose medical training and clinical specialty are appropriate for treating your disability,* *2. Consistent in type, frequency, and duration of treatment with relevant guidelines of national medical research, health care coverage organizations, and governmental agencies,* *3. Consistent with a Physician's diagnosis of your disability, and* *4. Intended to maximize your medical and functional improvement.*

In the Glossary section (page 193) the following entry is added:

Term	***Definition***
Preexisting condition (Applies to OSTD Insurance Benefit)	*A sickness or accidental injury for which you received medical treatment, consultation, care, or service; or took prescription medication or had medications prescribed three (3) months before your insurance or any increase in the amount of insurance under the OSTD Insurance Benefit.*

In the Glossary section (page 197), the following entry is added:

Term	*Definition*
Third-party Recovery (Applies to OSTD Insurance Benefit)	*Recovery amounts that you receive for loss of income as a result of claims filed against a third party by judgment, settlement, or otherwise, including future earnings. Such recovery amount may be an offset to your OSTD benefit.*

In the "Optional Short Term Disability Insurance Benefit" section, "Filing a Claim" (page 137), the following shall be added as the second paragraph:

Effective January 1, 2006, claims for disabilities incurred on or after this date must be filed within six (6) months after your disability began.

Under the "When Benefits End" section (page 138), the existing language is deleted and the following new language is inserted, as follows:

Your OSTD Insurance Benefit payments end automatically on the earliest of the following dates:

- *The date the claims processor determines you are no longer disabled (e.g., you no longer meet the definition of total disability; you are no longer receiving Appropriate Care and Treatment, etc.)*
- *The date you become gainfully employed in any type of job for any employer, except under the Return to Work Program*
- *The end of the maximum benefit period of 26 weeks*
- *The date you die . . . .*

Under the "Definition of Total Disability" subsection (page 136), the following is added as the second paragraph:

Under the OSTD Insurance Benefit, you will be required to receive Appropriate Care and Treatment (during your disability). Appropriate Care and Treatment means medical care and treatment that is:

- *given by a Physician whose medical training and clinical specialty are appropriate for treating your disability;*
- *consistent in type, frequency, and duration of treatment with relevant guidelines of national medical research, health care coverage organizations, and governmental agencies;*
- *consistent with a Physician's diagnosis of your disability; and*
- *intended to maximize your medical and functional improvement.*

Under the "Exclusions and Limitations" (page 138), the eighth bullet is revised as follows:

- *Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling condition from a duly qualified physician*

Immediately following the "Filing a Claim" section (page 137), the following new subsection is added:

Return to Work Program

You will collect 50% OSTD insurance benefit that is adjusted for income from other sources, a 10% Return to Work ("RTW") Program incentive, and the amount you earn from participating in the voluntary RTW Program while you are disabled. Your OSTD benefit will be adjusted to reflect income from other sources (such as state disability, income from another employer, no-fault auto, third party recovery) and any amount of your work earnings while participating in the RTW Program that causes your income from all sources to exceed 100% of your pre-disability earnings. In no event can the total amount you collect from all sources or income to exceed 100% of your pre-disability earnings while you are disabled.

Your pre-disability earnings are determined as of the date you become disabled. For part-time employees, pre-disability earnings are based on a 20-hour workweek.

Following the new "Return to Work Program" section (page 137), the following new section is added:

Family Care Incentive

If you work part-time or participate in a Return to Work Program while you are disabled, MetLife will reimburse you for up to $100 for weekly expenses you incur for each child or family member incapable of independent living.

To provide care for your or your spouse's child, legally adopted child, or child for whom you or your spouse are legal guardian and who is

- *Living with you as part of your household;*
- *Dependent on your for support; and*
- *Under age 13.*

The child care must be provided by a licensed child care provider who may not be member of your immediate family or living in your residence.

This benefit also includes care for your family member who is living with you as part of your household and who is

- *Chiefly dependent on your for support; and*
- *Incapable of independent living, regardless of age, due to mental or physical handicap as defined by applicable law.*

Care to your family member may not be provided by a member of your immediate family.

In the "When Benefits Begin" section (page 138), the second paragraph is revised and a new paragraph added, as follows:

There is no limit to the number of times you may receive these benefits for different periods of disability. Prior to January 1, 2006, successive periods of disability separated by less than one week of full-time active work were considered a single period of disability. The only exception was if the later disability was unrelated to the previous disability and began after you returned to full-time active work for at least one full day.

Effective January 1, 2006, a single period of disability will be considered continuous if separated by 60 days or less. Such disability will be considered to be a part of the original disability. MetLife will use the same pre-disability earnings and apply the same terms, provisions, and conditions that were used for the original disability. This is of benefit to you in that if you become disabled again due to the same or related sickness or accidental injury, you will not be required to meet a new elimination period.

Immediately following the "When Benefits Begin" section (page 138), the following new section is added:

Benefits from Other Sources

If you qualify for disability benefits from other sources, your OSTD benefits are reduced by the amount of the following periodic benefits. Your OSTD benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- ***No-Fault Auto Laws:*** *Periodic loss of income payments you receive under no-fault auto laws. Such payments will become an offset to your OSTD benefit.*
- ***Third Party Recovery:*** *Recovery amounts that you receive from loss of income as a result of claims against a third party by judgment, settlement, or otherwise including future earnings may be an offset to your OSTD benefit.*

Clarification of the LTD Plan's "Appropriate Care and Treatment" Provision

Under the "When Benefits End" section (page 142), the first paragraph/bullet listing is revised as follows:

Your LTD benefits automatically end of the earliest of the following dates:

- *The date your benefits expire, as explained in Duration of Benefits;*
- *The date you reach age 65 (unless disabled after age 60);*
- *The date you are no longer disabled (e.g., you no longer meet the definition of total disability; you are no longer receiving Appropriate Care and Treatment, etc.);*
- *The date you become gainfully employed in any type of job, except under the Return to Work Program (see page 137);*
- *The date you die; or*
- *The date benefits end, if disability is due to a mental health disorder or neuromuscular, musculoskeletal, or soft tissue disorder—subject to the Exclusions and Limitations described below . . . .*

In the "Definition of Total Disability" section (page139), the following language is added as the second paragraph:

Under the LTD Plan, you will be required to receive Appropriate Care and Treatment during your disability. Appropriate Care and Treatment means medical care and treatment that is

- *given by a Physician whose medical training and clinical specialty are appropriate for treating your disability;*
- *consistent in type, frequency, and duration of treatment with relevant guidelines of national medical research, health care coverage organizations, and governmental agencies;*
- *consistent with a Physician's diagnosis of your disability; and*
- *intended to maximize your medical and functional improvement.*

In the "Exclusions and Limitations" section (page 143), the seventh bullet is revised as follows:

- Benefits are not payable unless you are receiving Appropriate Care and Treatment for your disabling condition from a duly qualified physician

Addition of a Maximum Benefit Duration Limit in the LTD Plan for Neuromuscular, Musculoskeletal, and Soft Tissue Disorder Disabilities

The following section is added to the "Exclusions and Limitations" section (page 143) as the last bullet:

- *If you are disabled due to a neuromuscular, musculoskeletal, and/or soft tissue disorder disability, the disability benefits under the LTD Plan will end when you have received a maximum of 24 months of disability benefits for the entire time you are covered under the LTD Plan. This 24-month maximum benefit applies to the duration of your participation in this coverage. Neuromuscular, musculoskeletal, and/or soft tissue disorders include, but are not limited to, any disease, injury, or disorder of the spine, the vertebra(ae), their supporting structures, muscles, and/or soft tissue; bones, nerves, supporting body structures, muscles, and/or soft tissue of all joints, extremities, and/or major body complexes of movement; sprains/strains of all joints and muscles. This 24-month maximum benefit does not apply to disabilities if such disabilities have documented objective clinical evidence of*

  - *Seropositive arthritis (inflammatory disease of the joints), supported by clinical findings of arthritis AND positive serological tests for connective tissue disease;*
  - *Spinal (referring to the bony spine and/or spinal cord tumor(s) [abnormal growths] whether benign or malignant), malignancy, or vascular malformations (abnormal development of blood vessels);*
  - *Radiculopathies (disease of the peripheral nerve roots) supported by objective clinical evidence of nerve pathology;*
  - *Myelopathies (disease of the spinal cord and/or nerves) supported by objective clinical evidence of spinal cord/nerve pathology;*
  - *Traumatic spinal cord necrosis (injury or disease of the spinal cord) resulting from traumatic injury with paralysis; or*
  - *Musculopathies (disease of the muscle/muscle fibers) supported by objective pathological evidence on muscle biopsy or electromyography.*

  Disabilities caused by the aforementioned conditions—provided objective evidence confirms the diagnosis—will not be subject to this 24-month limitation, but will be benefited according to all other applicable LTD Plan provisions.

END OF SUMMARY OF MATERIAL MODIFICATIONS

ANNUAL BENEFITS NOTICE UNDER THE WOMEN'S CANCER RIGHTS ACT

In compliance with the Women's Cancer Rights Act, this annual notice provides you with information about the coverages available to participants and their eligible dependents under the following employee benefit plans:

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (referred to as the "Plan", the "Eagle Plan", the "Retiree Medical Benefit")
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries
- TWA Retiree Health and Life Benefits Plan

These plans provide coverage for reconstructive surgery, as follows:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery or reconstruction of the other breast to produce a symmetrical appearance;
- Services in connection with other complications resulting from a mastectomy, such as treatment of lymphademas; and
- Prostheses

This information is also available in your Employee Benefits Guide—in both the CD-ROM version (if applicable to your work group) sent to you in July-August, 2005, and on *Jetnet*.

Questions? Contact HR Employee Services at PO Box 619616, MD 5141, DFW Airport, TX 75261-9616 or on Jetnet, by clicking on Chat with HR Services on the Benefit and Pay page or call 800-447-2000.

2006 American Eagle Medical Plan Comparison Chart

2006 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
DEDUCTIBLES / MAXIMUMS					
Individual Annual Deductible	$250	$250	None	$1,000	$500
Family Annual Deductible	$750	$750	None	$2,000	Not Applicable
Individual Annual Out-of-Pocket Maximum*	$1,500	$1,500	$1,500	$3,000	$4,000
Individual Lifetime Medical Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
PREVENTIVE CARE					
Annual Routine Physical Exam	Not Covered	20% coinsurance after satisfying annual deductible	$20 copayment*	Not Covered	Not Covered
Well Child Care	20% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)	20% coinsurance after satisfying annual deductible	$20 copayment*	20% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)	40% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)
MEDICAL SERVICES					
Primary Care Physician's Office Visit	20% coinsurance	20% coinsurance	$20 copayment*	20% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	20% coinsurance	$30 copayment*	20% coinsurance	40% coinsurance
Gynecological Care Visit	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	$20 copayment* (for preventive visits) $30 copayment* (if not a preventive diagnosis)	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Pap Test	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	No cost if part of office visit 20% coinsurance if performed at a hospital	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Mammogram	20% coinsurance if medically necessary (routine coverage begins at age 35)	20% coinsurance after satisfying annual deductible	No cost if part of office visit 20% coinsurance if outpatient hospital	20% coinsurance if medically necessary (routine coverage begins at age 35)	40% coinsurance if medically necessary (routine coverage begins at age 35)
Pregnancy - Physician Services	20% coinsurance	20% coinsurance	$30 copayment* per visit $300 max copayment per pregnancy (includes prenatal/postnatal/delivery)	20% coinsurance	40% coinsurance
Second Surgical Opinion	20% coinsurance	20% coinsurance	$20 copay PCP $30 copay Specialist	20% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	20% coinsurance	$25 copayment*	20% coinsurance	40% coinsurance
Chiropractic Care Visit	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	$30 copayment* (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)

2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	20% coinsurance	$30 copayment* per visit (max copayment of $300 per person per year)	20% coinsurance	40% coinsurance
Allergy Care	20% coinsurance	20% coinsurance	$30 copayment* per visit (max copayment of $300 per person per year)	20% coinsurance	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office or a network laboratory/radiology center	20% coinsurance	40% coinsurance
OUTPATIENT SERVICES					
Outpatient Surgery in Physician's Office	20% coinsurance	20% coinsurance	$20 copay PCP $30 copay Specialist	20% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance
HOSPITAL SERVICES					
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	20% coinsurance	$150 copayment* per year, plus 20% coinsurance for all other hospital based services+E58	20% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via Jetnet within 60 days or these charges will not be covered.)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance for all hospital based services (hospital admission copayment of $150 does not apply to baby)	20% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office	20% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance	No Cost	20% coinsurance	40% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% coinsurance	$75 copayment* Waived if admitted to the hospital	20% coinsurance	40% coinsurance

2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
OUT-OF-HOSPITAL CARE					
Convalescent and Skilled Nursing facility, following hospitalization	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance	20% coinsurance	$20 copayment	20% coinsurance	40% coinsurance
Hospice Care	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital; $20 copayment per day if home care	20% coinsurance	40% coinsurance
OTHER SERVICES					
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance	20% coinsurance	$20 copay PCP $30 copay Specialist 20% coinsurance in hospital or freestanding surgical center	20% coinsurance	40% coinsurance
Infertility Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Radiation Therapy or Chemotherapy	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital	20% coinsurance	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital or dialysis center	20% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	No cost if rented or purchased from Network Provider	20% coinsurance	40% coinsurance
MENTAL HEALTH AND CHEMICAL DEPENDENCY					
Inpatient Mental Health Care	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance for all hospital based services	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)
Alternative Mental Health Center	50%** (max of 30 days per year)	50%** (max of 30 days per year)	20% coinsurance for all hospital based services	50%** (max of 30 days per year)	50%** (max of 30 days per year)
Outpatient Mental Health Care Visit	50%** (up to max of 50 visits per year)	50%** (up to max of 50 visits per year)	$20 copayment	50%** (up to max of 50 visits per year)	50%** (up to max of 50 visits per year)
Marriage Counseling	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Detoxification (considered a medical condition)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance

2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Chemical Dependency*** Inpatient Rehabilitation	20% coinsurance if approved by EAP (max $5,000 benefit)	20% coinsurance if approved by EAP (max $5,000 benefit)	20% coinsurance for all hospital based services if approved by EAP	20% coinsurance if approved by EAP (max $5,000 benefit)	40% coinsurance if approved by EAP (max $5,000 benefit)
Chemical Dependency*** Outpatient Rehabilitation	50%** if approved by EAP	50%** if approved by EAP	$30 copayment* per visit if approved by EAP (max copayment of $300 per person per year)	50%** if approved by EAP	50%** if approved by EAP
PRESCRIPTION MEDICATIONS					
Retail Pharmacy* (up to a 30 day supply)	**Retail Card Program** $10 - Generic 30% (max $100) - Brand (if no generic available) 50% - Brand (if generic available)	**Retail Card Program** $10 - Generic 30% (max $100) - Brand (if no generic available) 50% - Brand (if generic available)	**Retail Card Program** $10 - Generic 30% (max $100) - Brand (if no generic available) 50% - Brand (if generic available)	**Retail Card Program** $10 - Generic 30% (max $100) - Brand (if no generic available) 50% - Brand (if generic available)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)
Mail Service Pharmacy* (up to a 90 day supply)	$20 - Generic 30% (max of $250) - Brand 50% - Brand (if generic available)	$20 - Generic 30% (max of $250) - Brand 50% - Brand (if generic available)	$20 - Generic 30% (max of $250) - Brand 50% - Brand (if generic available)	$20 - Generic 30% (max of $250) - Brand 50% - Brand (if generic available)	Not Applicable
Oral Contraceptives (available only thru mail service)	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OTHER INFORMATION					
CheckFirst (predetermination of benefits via United HealthCare)	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail

*Deductibles, fixed copayments or payments for prescription drugs do not apply toward the annual out-of-pocket maximum

**50% coinsurance amounts do not apply toward the annual out-of-pocket maximum

***Rehabilitation for Chemical Dependency limited to one per lifetime and must be approved by EAP

Index of benefit plan information dated March 15, 2006:
(Click on the links below to view the sections of this document.)

NOTICE AND DOCUMENTATION OF TECHNICAL CORRECTIONS TO THE EMPLOYEE BENEFITS GUIDE FOR American Eagle Airlines, Inc, CORRECTIONS TO THE DECEMBER 15, 2005 SUMMARY OF MATERIAL MODIFICATIONS, AND TRIENNIAL HIPAA NOTICE OF PRIVACY PRACTICES (March 15, 2006)

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of technical corrections and summary of material modifications made to your summary plan descriptions. This Notice and Summary of Material Modifications, together with the Employee Benefit Guide and Summaries of Material Modifications, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s). The Summary Plan Descriptions are contained in the Employee Benefit Guide for American Eagle, Inc. ("EBG").**

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798)
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503, EIN #13-1502798)
- Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 510-EIN #13-1502798)
- American Airlines Inc. Long Term Disability Plan (Plan 509, EIN #13-1502798)

Eagle Group Life and Health Benefits Plan

I. TECHNICAL CORRECTIONS TO THE EMPLOYEE BENEFIT GUIDE

- All references to the "Benefits and Pay" page on Jetnet throughout the EBG are replaced with "Benefits".
- Under "Medical Benefits Options" (page 5) first paragraph is revised as follows:

  Some Medical Options are not offered in all locations. The PPO Options are offered in most locations, but if you live outside the UnitedHealthcare access area, you are not eligible for the PPO Options and may choose the Out of Area Option for medical coverage. The enrollment section on Jetnet will reflect which Options are available to you.

- Under "Dependents of Deceased Employees" (page 16) the first sentence of the third paragraph is revised as follows:

  Your Covered dependents can elect to continue Dental Benefits and certain other benefits (if applicable) under COBRA at the full COBRA rate, if they had Dental Benefits at the time of your death.

- Under "Enrollment" section, "When Coverage Begins" (page 21) the first sentence of the first paragraph is revised as follows:

  If you enroll by the enrollment deadline, your selected coverage (if different from default coverage) is retroactive to the date you are first eligible for benefits and your paycheck is adjusted as necessary.

- Under "Taxation of Benefits" (page 24) change the last entry at the end of the chart is revised as follows:

Type of Benefits	Before Tax?	May Waive?
Long Tern Care Insurance Plan	**No**	**Yes**

- Under "Benefit ID Card" (page 25) first sentence of the first paragraph is revised as follows:

  If you have elected to participate in a Medical Benefits Option (other than an HMO), or if you are a new participant to a Medical Benefit Option, UnitedHealthcare will mail your benefit ID cards to you.

- Under “Special Enrollment Rights” (page 26) the last phrase of the first sentence is revised as follows:

  …you have 60 days from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option.

- Under “Special Enrollment Rights” (page 26) under the existing three bullets after the first paragraph, four additional bullets are added as follows:

  - **You and/or one of your dependents exhaust a lifetime maximum in another employer’s health plan or in other health insurance coverage.**
  - **Your employer and/or your dependent’s employer ceases to offer health benefits to the class of employees through which you (or one of your dependents) have coverage.**
  - **You and/or one of your dependents were enrolled under an HMO or other group or individual plan or coverage arrangement that will no longer cover you and/or one of your dependents) because you and/or your dependent no longer reside, live, or work in its service area.**
  - **You have a new dependent as a result of your marriage, your child’s birth, adoption, or placement for adoption with you.**

- Under “Special Enrollment Rights” (page 26) second paragraph is revised as follows:

  As an employee, you may enroll **yourself and your new spouse and any dependents** within 60 days of your marriage and a new child within 60 days of his or her birth, adoption or placement for adoption. In addition, if you are not enrolled in the employee benefits as an employee, you also must enroll in the employee benefits when you enroll any of these dependents. And, if your spouse is not enrolled in the employee benefits, you may enroll **yourself and/or** him or her in the employee benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage, coverage will begin on the first day of the first calendar month after the completed enrollment form is received. In the case of birth, adoption or placement for adoption coverage is retroactive to the date of birth, adoption or placement for adoption. **To request special enrollment or obtain more information, HR Employee Services (see Contact Information).**

- Under “Life Events” the first Life Event at the top (page 31) is revised as follows:

If…	***Then, You Can…***
Change in spouse’s employment or other health coverage, or *Your spouse’s employer no longer contributes toward health coverage, or* *Your spouse’s employer no longer covers employees in your spouse’s position*	• **Medical and Dental Options and Vision Insurance Benefit**: Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time, **if you were already enrolled. If you were not enrolled, you may enroll yourself and your spouse and eligible dependents in any Medical Benefit Option** • **Supplemental Medical Plan**: Stop coverage for your spouse, yourself, or you and your spouse • **Optional Short Term Disability Insurance Benefit**: Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan: Start or stop coverage**; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit**: Start or stop coverage • **Voluntary Personal Accident Insurance Benefit**: Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits**: Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

- Under “Life Events” (page 31) add a new category under the first Life Event as follows:

If…	***Then, You Can…***
You or your dependent exhausts a lifetime limit in another medical plan ***You or your dependents were enrolled in an HMO or another arrangement that will no longer cover you due to your failure to live, work or reside in the arrangement’s service area***	• **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your spouse and eligible dependents in any Medical Benefit Option • **Supplemental Medical Plan**: Stop coverage for your spouse, yourself, or you and your spouse • **Optional Short Term Disability Insurance Benefit**: Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan: Start or stop coverage**; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit**: Start or stop coverage • **Voluntary Personal Accident Insurance Benefit**: Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits**: Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

- Under “Maximum Medical Benefit” (page 39) third paragraph, first sentence, a comma is added after the first phase of the sentence as follows:

  When you have exhausted your maximum medical benefit, your medical coverage terminates.

- Under “Medical Benefit Options Comparison” (page 40) first paragraph, second sentence is revised as follows:

  Benefits are available for Eligible Expenses that are medically necessary and within the usual and prevailing fee limits for the Out-of-Area Coverage Option (or within 140% of MNRP under the PPO Copay, PPO Deductible, Minimum Coverage Options).

- Under “Medical Benefit Options Comparison” (page 40) second sentence of first bullet is revised as follows:

  The out-of-pocket maximum does not include deductibles or copayment amounts, amounts not covered, amounts exceeding the usual and prevailing fee limits for the Out-of-Area Coverage Option (or 140% of MNRP under the PPO Copay, PPO Deductible, Minimum Coverage Options), or services covered at 50%.

- Under “Leaving the service area:” (page 52) second paragraph, the last sentence is replaced with:

  If you do not notify HR Employee Services of your election, you will be enrolled in a plan offered in your new location. (See table on page 20, under Default Coverage)

- Under “Filling Claims” (page 74) the final two sentences are replaced as follows:

  If you have questions about your coverage or your claim, call UnitedHealthcare or Medco.

- Under “Continuation of Coverage” section “Enrolling for Coverage” (page 83) replace the first sentence of second paragraph with the following sentence:

  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. You must elect to continue coverage within 60 days of the date post marked on the notice, or you lose your right to elect to continue coverage. (See Contact Information for CONEXIS’ address for sending your written notice.)

- Under “Supplement Medical”, “Enrollment” (page 90) add at the end of the first paragraph a sentence as follows:

  To see more on the enrollment rules, see Life Events beginning on page 28.

- Under “Enrollment” (page 90) the following section is added immediately after “Enrollment”

  Special Enrollment Rights

  The following special enrollment rights are available and apply to participants in the Supplemental Medical Plan. These enrollment rights apply after satisfaction of, and subject to the eligibility requirements the Supplemental Medical Plan beginning on page 88.

  If you or your spouse declined coverage under the Supplemental Medical Plan because you or they have medical coverage elsewhere and one of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your dependents in Supplemental Medical Plan coverage.

  - **You and your spouse lose the other medical coverage because eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).**
  - **The employer contributions for the other coverage have stopped.**
  - **The other coverage was COBRA and the maximum COBRA coverage period ends.**
  - **You and/or your spouse exhaust a lifetime maximum in another employer’s health plan or other health insurance coverage**
  - **Your employer and/or your spouse’s employer ceases to offer benefits to the class of employees through which you (or one of your dependents) had coverage**
  - **You and/or your spouse were enrolled under a HMO or other group or individual plan or arrangement that will no longer cover you (and/or your spouse) because you and/or your spouse no longer reside, live, or work in its service area.**
  - **You have a new spouse as a result of your marriage.**

  In addition, if you are not enrolled in the employee benefits as an employee, you also must enroll in the employee benefits when you enroll your spouse. And, if your spouse is not enrolled in the employee benefits, you may enroll yourself, and/or him/her in the employee benefits. In the case of marriage, coverage will begin on the first day of the first calendar month after the completed enrollment form is received. To request special enrollment or obtain more information, HR Employee Services (see Contact Information).

  If you are adding a new spouse to your benefits during the special enrollment rights period, keep in mind that you must submit to HR Employee Services proof that your spouse qualifies as your eligible dependent. Proof that the spouse you enroll qualifies as your eligible dependent includes (but is not limited to) official government-issued birth certificates, marriage licenses, joint income tax returns, etc. The proof of eligibility requirements is listed on Jetnet, under Benefits, under “Dependent, Benefit Eligibility”, or you may contact HR Employee Services for proof of eligibility requirements (see Contact Information).

- Under “Covered Orthodontia Expenses” (page 111) change first sentence in first paragraph to read as follows:

  The Dental Benefit plan covers orthodontic treatment for an eligible dependent child only and covers 50% of eligible and necessary expenses, to a maximum orthodontia benefit of $1,500 during the entire time the child is covered by the Plan.

- Under "Covered Orthodontia Expenses" section "Payment of claims" (page 111) change the second sentence in the first bullet to read as follows:

  The Dental Benefit will pay up to the maximum orthodontia benefit of $1,500, in one lump sum, based upon the orthodontist's lump sum billing for orthodontia treatment (provided the treatment is determined to be an eligible expense under the Dental Benefit).

- Under "Covered Orthodontia Expenses" section "Payment of claims" (page 112) change the second sentence in the second bullet to read as follows:

  If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the $1,500 maximum orthodontia benefit.

- Under "Travel Assistance Services" (page 126) the ninth bullet, last sentence is revised as follows:

  Children do not have to be covered under VPAI for this benefit.

- Under "Insurance Policy" (page 128) the first sentence of the second paragraph is revised as follows:

  Other accident insurance, including Special Risk Accident Insurance and Special Purpose Accident Insurance, is provided under group insurance policies issued by LINA (see Other Accident Insurance below).

- Under "Assignment of Benefits" (page 134) the last four paragraphs of this section are grouped together under a subheading entitled as follows:

  "Total Control Account"

- Under "Optional Short Term Disability Insurance Benefit", "OSTD Insurance Benefits" (page 136) the first sentence of the first paragraph is revised as follows:

  If you have a qualifying disability, the OSTD benefit covers the difference between any state-provided benefit and 50% of your adjusted monthly salary on your last day worked.

- Under "How the Health Care FSA Works", "HCFSA Funds Availability" (page 148) the following sentence is deleted:

  In addition, the Company maintains some limits on reimbursements for items such as orthodontia.

- Under "Receiving Reimbursement", section "Automatic Reimbursement Feature" (page 152) the last paragraph of this section is deleted and replaced with the following paragraph:

  To stop the Automatic Rollover Feature, access UnitedHealthcare's web site at www.myuhc.com (click on "Manage My Accounts") or call UnitedHealthcare (see Contact Information).

- All references to "Automatic Reimbursement Feature" (pages 151-153) are deleted and replaced with:

  "Automatic Rollover Feature"

- Under "Filling Claims", under "You must file a claim for reimbursement from your HCFSA in the following circumstances:" (page 152) the third bullet:

  "Retail prescription drug copayments and all mail order prescription drug copayments must be submitted to the claims administrator with a claim for reimbursement" is deleted.

- Under "Collective Bargaining Agreement" (page 163) the first sentence of the paragraph is revised as follows:

  The types of benefits (medical and dental benefit, life insurance benefits) described in this Guide are maintained subject to a collective bargaining agreement.

II. TECHNICAL CORRECTIONS TO THE SUMMARY OF MATERIAL MODIFICATION ("SMM") DATED DECEMBER 15, 2005

- In the Chart on page 7 of the 12/15/2005 SMM, under "Using the UnitedHealthcare Consumer Account Card", the text is revised as follows:

Type Of Expense	***Can You Use FSA Card?***	***Can You Use Automatic Rollover?***	***Must You File FSA Claim Manually?***
Medical Expenses—PPO-Copay Option			
Copayments	*Yes*	*Yes*	*No*
Deductibles (UHC network providers)	*Yes*	*Yes*	*No*
Coinsurance Amounts (UHC network providers)	*Yes*	*Yes*	*No*
*Retail Prescription Drugs (**Walgreens Retail Pharmacies ONLY**)*	*You can, but it's better if you don't (see footnote 1 below)*	*No*	*Is better if you do (see footnote 2 below)*
Mail Order Prescription Drugs (Medco by Mail)	*Yes*	*Yes*	*No*

1. If you pay for your Walgreens retail prescription with your FSA card, the entire cost will be charged to your HCFSA account, and the cost isn't reconciled against what your Medical Option's prescription drug coverage would pay. Thus, your HCFSSA is depleted at a greater rate, leaving you fewer HCFSA fund available for other health care expenses.

2. In this case, it's better for your HCFSA balance if you wait until your Medical Option pays its benefit, and then manually submit your out of pocket prescription drug expense to your HCFSA.

- On page 2 of the 2/15/05 SMM, under "Increase maximum member coinsurance amounts in the Prescription Drug Benefit", under "Mail Service Prescription Drug Option", (page 68 of EBG) the paragraph is replaced with two bullets that read as follows:

    - **Generic Drugs: $20 per prescription or refill for generic drugs (or the actual cost of the drug, if the prescription cost is less than $20)**

    - **Brand Name Drugs: 30% of the cost of the drug, up to a $250 maximum per prescription or refill if no generic is available or, 50 % of the cost of the brand drug when there is a generic available.**

- The attached "Medical Benefit Option Comparison Chart" replaces the appendix attached to the Summary of Material Modifications sent on 12/15/05.

2006 American Eagle Medical Plan Comparison Chart

2006 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
DEDUCTIBLES / MAXIMUMS					
Individual Annual Deductible	$250	$250	None	$1,000	$500
Family Annual Deductible	$750	$750	None	$2,000	Not Applicable
Individual Annual Out-of-Pocket Maximum*	$1,500	$1,500	$1,500	$3,000	$4,000
Individual Lifetime Medical Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000
PREVENTIVE CARE					
Annual Routine Physical Exam	Not Covered	20% coinsurance after satisfying annual deductible	$20 copayment*	Not Covered	Not Covered
Well Child Care	20% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)	20% coinsurance after satisfying annual deductible	$20 copayment*	20% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)	40% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)
MEDICAL SERVICES					
Primary Care Physician's Office Visit	20% coinsurance	20% coinsurance	$20 copayment*	20% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	20% coinsurance	$30 copayment*	20% coinsurance	40% coinsurance
Gynecological Care Visit	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	$20 copayment* (for preventive visits) $30 copayment* (if not a preventive diagnosis)	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Pap Test	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	No cost if part of office visit 20% coinsurance if performed at a hospital	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Mammogram	20% coinsurance if medically necessary (routine coverage begins at age 35)	20% coinsurance after satisfying annual deductible	No cost if part of office visit 20% coinsurance if outpatient hospital	20% coinsurance if medically necessary (routine coverage begins at age 35)	40% coinsurance if medically necessary (routine coverage begins at age 35)
Pregnancy - Physician Services	20% coinsurance	20% coinsurance	$30 copayment* per visit $300 max copayment per pregnancy (includes prenatal/postnatal/delivery)	20% coinsurance	40% coinsurance
Second Surgical Opinion	20% coinsurance	20% coinsurance	$20 copay PCP $30 copay Specialist	20% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	20% coinsurance	$25 copayment*	20% coinsurance	40% coinsurance
Chiropractic Care Visit	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	$30 copayment* (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)

Revised: 03/15/06
12-Eagle

2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	20% coinsurance	$30 copayment* per visit (max copayment of $300 per person per year)	20% coinsurance	40% coinsurance
Allergy Care	20% coinsurance	20% coinsurance	$30 copayment* per visit (max copayment of $300 per person per year)	20% coinsurance	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office or a network laboratory/radiology center	20% coinsurance	40% coinsurance
OUTPATIENT SERVICES					
Outpatient Surgery in Physician's Office	20% coinsurance	20% coinsurance	$20 copay PCP $30 copay Specialist	20% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance
HOSPITAL SERVICES					
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	20% coinsurance	$150 copayment* per year, plus 20% coinsurance for all other hospital based services	20% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via Jetnet within 60 days or these charges will not be covered.)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance for all hospital based services (hospital admission copayment of $150 does not apply to baby)	20% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office	20% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance	No Cost	20% coinsurance	40% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% coinsurance	$75 copayment* Waived if admitted to the hospital	20% coinsurance	40% coinsurance

Revised: 03/15/06
12-Eagle

2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
OUT-OF-HOSPITAL CARE					
Convalescent and Skilled Nursing facility, following hospitalization	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance	20% coinsurance	$20 copayment	20% coinsurance	40% coinsurance
Hospice Care	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital; $20 copayment per day if home care	20% coinsurance	40% coinsurance
OTHER SERVICES					
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance	20% coinsurance	$20 copay PCP $30 copay Specialist 20% coinsurance in hospital or freestanding surgical center	20% coinsurance	40% coinsurance
Infertility Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Radiation Therapy or Chemotherapy	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital	20% coinsurance	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital or dialysis center	20% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	No cost if rented or purchased from Network Provider	20% coinsurance	40% coinsurance
MENTAL HEALTH AND CHEMICAL DEPENDENCY					
Inpatient Mental Health Care	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance for all hospital based services	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)
Alternative Mental Health Center	50%** (max of 30 days per year)	50%** (max of 30 days per year)	20% coinsurance for all hospital based services	50%** (max of 30 days per year)	50%** (max of 30 days per year)
Outpatient Mental Health Care Visit	50%** (up to max of 60 visits per year)	50%** (up to max of 60 visits per year)	$30 copayment	50%** (up to max of 60 visits per year)	50%** (up to max of 60 visits per year)
Marriage Counseling	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Detoxification (considered a medical condition)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance

2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Chemical Dependency*** Inpatient Rehabilitation	20% coinsurance if approved by EAP (max $5,000 benefit)	20% coinsurance if approved by EAP (max $5,000 benefit)	20% coinsurance for all hospital based services if approved by EAP	20% coinsurance if approved by EAP (max $5,000 benefit)	40% coinsurance if approved by EAP (max $5,000 benefit)
Chemical Dependency*** Outpatient Rehabilitation	50%** if approved by EAP	50%** if approved by EAP	$30 copayment* per visit if approved by EAP (max copayment of $300 per person per year)	50%** if approved by EAP	50%** if approved by EAP
PRESCRIPTION MEDICATIONS					
Retail Pharmacy* (up to a 30 day supply)	**Retail Card Program** $10 - Generic 30% (max $100) - Brand (if no generic available) 50% - Brand (if generic available)	**Retail Card Program** $10 - Generic 30% (max $100) - Brand (if no generic available) 50% - Brand (if generic available)	**Retail Card Program** $10 - Generic 30% (max $100) - Brand (if no generic available) 50% - Brand (if generic available)	**Retail Card Program** $10 - Generic 30% (max $100) - Brand (if no generic available) 50% - Brand (if generic available)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)
Mail Service Pharmacy* (up to a 90 day supply)	$20 - Generic 30% (max of $250) - Brand 50% - Brand (if generic available)	$20 - Generic 30% (max of $250) - Brand 50% - Brand (if generic available)	$20 - Generic 30% (max of $250) - Brand 50% - Brand (if generic available)	$20 - Generic 30% (max of $250) - Brand 50% - Brand (if generic available)	Not Applicable
Oral Contraceptives (available only thru mail service)	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
OTHER INFORMATION					
CheckFirst (predetermination of benefits via United HealthCare)	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail

*Deductibles, fixed copayments or payments for prescription drugs do not apply toward the annual out-of-pocket maximum

**50% coinsurance amounts do not apply toward the annual out-of-pocket maximum

***Rehabilitation for Chemical Dependency limited to one per lifetime and must be approved by EAP

Disclaimer: The American Eagle Employee Benefits Guide (EBG) is the legal plan document and the summary plan description (SPD) for American Eagle's Benefits Plans. If there is any discrepancy between the EBG and this chart, the EBG will govern.

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12-Eagle

About This Guide

This American Eagle Employee Benefits Guide ("Guide") contains the legal plan documents and the summary plan descriptions (SPDs) for the following plans: the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (the "Group Life and Health Plan"), the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (the "Supplemental Medical Plan"), the American Eagle Airlines, Inc. Long Term Disability Plan (the "LTD Plan"), and the Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (collectively the "Plans").

The provisions of this Guide apply to eligible employees of American Eagle Airlines, Inc. ("American Eagle") and Executive Airlines, Inc. ("Executive") employees on the United States payroll, spouses, dependents, and surviving spouses who elect coverage.

In our efforts to provide you with full multi-media access to benefits information, American Eagle Airlines, Inc. and Executive Airlines, Inc. have created online versions of the Plans and SPDs. If there is any discrepancy between the online version and this Guide then the Plans contained in this Guide, plus the official notices of changes to the Plans will govern.

The Company reserves the right to modify, amend or terminate any of the Plans, any program described in this Guide, or any part thereof, at its sole discretion. Changes to the Plans, generally will not affect claims for services or supplies received before the change.

Only the Pension Benefits Administration Committee (PBAC) is authorized to change the Plans. From time to time, you may receive updated information concerning changes to the Plans. Neither this Guide nor updated materials are contracts or assurances of compensation, continued employment, or benefits of any kind.

In the event of a conflict between the Plans' provisions contained in this Guide and the provisions contained in any applicable collective bargaining agreement (and/or insurance policies for fully insured programs), the collective bargaining agreement (and/or insurance policy for fully insured programs) shall govern in all cases with respect to employees covered by such agreement.

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Contact Information

The following table lists the names, addresses, phone numbers, and Web sites (when available) for these important contacts.

For Information About:	Contact:	At:
Health and Welfare Benefits General questions, information updates, and request forms	**HR Employee Services** AMR Corporation MD 5141-HDQ P.O. Box 619616 DFW Airport, TX 75261-9616	**(800) 447-2000** **E-mail to:** Employee.Services@aa.com **Web site:** *Jetnet*.aa.com
Medical Coverage		
Out-of-Area Coverage , PPO-Deductible, PPO-Copay and Minimum Coverage Options	**UnitedHealthcare** AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**(800) 638-9599** For other information, visit: **Web site:** www.myuhc.com **Provider directories:** www.provider.uhc.com/american
Health Maintenance Organizations (HMOs) Option **Puerto Rico employees only**	**Triple S** **Humana**	**(787) 749-4777** **Web site:** www.ssspr.com **(787) 282-7900** **Web site:** www.humana.com
Supplemental Medical Plan	**HealthFirst TPA** P. O. Box 130217 Tyler, TX 75713-0217	**(800) 711-7083** **(903) 581-2600**
Maximum Medical Benefit Requests	**UnitedHealthcare** AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**(800) 638-9599**
Coverage for Incapacitated Child and Special Dependents (PPO-Deductible and PPO-Copay Options)	**UnitedHealthcare** Statement of Health Underwriting 1900 East Golf Road Suite 400 Schaumburg, IL 60173	**(800) 865-6098**
CheckFirst (Predetermination of Benefits)(Except HMOs)		
Out-of-Area Coverage , PPO-Deductible, PPO-Copay and Minimum Coverage Options	**UnitedHealthcare** AMR Medical Claim Unit P.O. Box 30551 Salt Lake City, UT 84130-0551	**(800) 638-9599**
Supplemental Medical Plan	**HealthFirst TPA** P. O. Box 130217 Tyler, TX 75713-0217	**(800) 711-7083** **(903) 581-2600**
QuickReview (Pre-authorization for hospitalization)		
Out-of-Area Coverage , PPO-Deductible, PPO-Copay and Minimum Coverage Options and Supplemental Medical Plan	**Health International** 14770 North 78th Way Scottsdale, AZ 85260	**(800) 638-9599** (Select QuickReview at the prompt.)

For Information About:	Contact:	At:
Prescription Drugs (Except HMOs)		
Mail Service Prescription Drug Option (Mail Order Pharmacy Service)	**Medco Health** P. O. Box 3938 Spokane, WA 99220-3938	**(800) 988-4125** **Web site:** www.medcohealth.com
Prescriptions – Prior Authorization	**Medco Health** 8111 Royal Ridge Parkway Suite 101 Irving, TX 75063	**(800) 841-5345** (Member Services)
Retail Prescriptions – Phone Inquiries	**Medco** Member Services	**(800) 988-4125** **Web site**: www.medcohealth.com
Filing Retail Prescription Claims	**Medco** P. O. Box 2160 Lee's Summit, MO 64063-2160	N/A
Employee Assistance Program		
Employee Assistance Program	**EAP at American Airlines**	**(800) 555-8810**
Dental Coverage		
Dental Benefit – Claims Processor	**MetLife** AMR Dental Claim Unit P.O. Box 981282 El Paso, TX 79998-1282	**(800) 638-9599** (Select Dental Benefit at the Prompt.) For claims tracking, to review your coverage options, or to locate a network dentist, visit the MetLife Web site at www.metlife.com/mybenefits. You will be prompted to enter a company name. Enter "AMR Corporation". To continue the sign-in process, enter your uniquely-created "User Name" and "Password". If you are a first-time visitor to the site, click on "register here" under "Welcome to MyBenefits" or click the "Register Now" icon on the left. Follow the prompts to establish your account. If you have problems accessing the site, please contact MetLife's technical help desk at 1-877-9MET-WEB (1-877-963-8932), or by e-mail: info@metlife.com.
Provider Listing – Participating Dentists	Preferred Dentist Program	(**800) 474-7371** **Web site:** www.metlife.com/dental
Vision Coverage		
Vision Discount Program	**EyeMed**	**(877) 226-1115** **Web site:** www.enrollwitheyemed.com
Vision Insurance Benefit	**Spectera, Inc**. 2811 Lord Baltimore Drive Baltimore, MD 21244	**(800) 638-3120** **Web site:** www.spectera.com

For Information About:	Contact:	At:
Life Insurance		
Term Life Insurance Benefit	**MetLife** American Airlines Customer Unit P.O. Box 3016 Utica, NY 13504-3016	**(800) 638-6420**
Accident Insurance		
Accidental Death & Dismemberment (AD&D) Insurance Benefit, Voluntary Personal Accident Insurance Benefit, and Other Accident Insurance Benefits	**CIGNA Group Insurance** (for Life Insurance Company of North America) P. O. Box 22328 Pittsburgh, PA 15222 **CIGNA Secure Travel**	**(800) 238-2125** From U.S. and Canada: **(800) 368-7878** From all other locations: **(202) 331-1596**
Disability Coverage		
Disability Benefits: Optional Short Term Disability Insurance Benefit Long Term Disability Plan	**MetLife DisAbility** American Airlines Claim Unit P. O. Box 14590 Lexington, KY 40511-4590	**(888) 533-6287** Web site access for claims tracking and coverage information: www.metlife.com/mybenefits
Flexible Spending Accounts (FSAs)		
Health Care and Dependent Day Care FSAs	UnitedHealthcare P. O. Box 981178 El Paso, TX 79998-1178	Telephone: (877) 311-7849 Facsimile: (915) 781-1085 **Web site:** www.myuhc.com
Long Term Care		
Long Term Care Insurance Benefit	**MetLife Long Term Care** 57 Greens Farms Road Westport, CT 06880	**(800) 438-6388**
Continuation of Coverage (COBRA)		
Continuation of Coverage (COBRA Administrator)	**CONEXIS** P. O. Box 223886 Dallas, TX 75222	**(877) 902-9207** **Web site:** www.conexis.org
Other Information		
Pension Benefits Administration Committee	**PBAC** American Airlines MD 5134-HDQ P.O. Box 619616 DFW Airport, TX 75261-9616	**ICS or (817) 967-1412**
Employee's Withholding Allowance Certificate Form W-4	**Payroll** **American Eagle** MD 790-TUL 7645 E. 63rd Street Tulsa, OK 74133	**ICS or (918) 254-7439** **E-mail to:** amr.Payroll Customer Service@aa.com

For Information About:	Contact:	At:
Other Options (Not Company Sponsored) The following program options are offered to eligible employees (and eligible dependents). However, American Eagle Airlines, Inc. does not sponsor these programs. For any information about these program options, please contact the sponsor(s) directly:		
Group Prepaid Legal Services	**Hyatt Legal Plans, Inc.** 1111 Superior Avenue Cleveland, OH 44114-2507	**(800) 438-6388**
Group Homeowners' and/or Automobile Insurance	**Metropolitan Property & Casualty Insurance Company** 477 Martinsville Road, 4th Floor Liberty Corner, NJ 07938	**(800) 438-6388**

Benefits at a Glance

Medical Benefits

The Company offers you the opportunity to enroll in medical coverage for you and your eligible dependents. The Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage options are self-funded by the Company and administered by UnitedHealthcare (UHC). HMOs are insured programs.

Medical Benefit Options

Generally, you may choose one of the following Plan options (collectively, the "Medical Benefits"):

- Out-of-Area Coverage Option
- Minimum Coverage Option
- PPO-Deductible Option
- PPO-Copay Option; and
- Health Maintenance Organization (HMO) Option (for Puerto Rico employees).

Some Medical Options are not offered in all locations. The Enrollment section on *Jetnet* will reflect which Options are available to you.

You may also waive coverage. Regardless of the Medical Option you choose, you also have the opportunity to participate in the Supplemental Medical Plan if you enroll for coverage when first eligible for benefits (as a new employee), or if you later marry or *declare a Domestic Partner*. Domestic Partners and their dependents are not eligible for coverage under the Health Maintenance Organizations.

Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options

Only employees who do not have adequate access to PPO providers will have the Out-of-Area Coverage as an option.

The Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options allow you to use any qualified licensed physician. When you use a network provider under the PPO-Deductible Option, you receive a higher level of benefits. Network providers have agreed to charge discounted fees for medical services. Generally, you pay a percentage of the cost for each visit or service and the plan pays the rest.

For details on the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, see page 48.

To see a comparison of your benefits under the Medical Options, see page 40.

PPO-Copay Option

You may decide whether to use network or out-of-network providers each time you need care under the PPO-Copay Option. When you use a network provider, you pay only a copayment or coinsurance for most services.

If you go to a provider who is not part of the network, you are still covered for eligible, medically necessary services, but at a lower level of benefits, called the out-of-network benefit level. At the out-of-network benefit level, you pay a deductible and higher out-of-pocket amounts. For most out-of-network services, the plan pays 60% and you pay the remaining 40% after you satisfy the $500 deductible.

For details on the PPO-Copay Option, see page 49.

To see a comparison of your benefits under the Medical Options, see page 40.

Health Maintenance Organizations (HMOs)

HMOs provide medical care through a network of physicians, hospitals and other medical service providers. You must use network providers to receive coverage under the HMO. Your expenses, including prescription drugs and mental health care, are covered according to the rules of the HMO you select.

Most HMOs require you to choose a primary care physician (PCP) to coordinate your medical care and to obtain a referral from your PCP before receiving care from a specialist.

HMOs are only offered in Puerto Rico. HMOs offered in your area appear as options in the Benefits Enrollment Center on *Jetnet* during enrollment. When you enroll in an HMO, you will receive detailed information directly from that HMO.

For more details about HMOs, see page 53.

Prescription Drug Coverage

If you are enrolled in an Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or PPO-Copay Option, you receive prescription drug coverage through the medical benefit. Coverage includes both retail pharmacy prescriptions (up to a 30-day supply) and mail order prescriptions (up to a 90-day supply). Refer to page 66 for details about this coverage.

If you participate in an HMO, contact the HMO for information about your prescription drug coverage.

Supplemental Medical Plan

The Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries is self-funded through employee contributions and is offered to eligible employees of participating subsidiaries of AMR Corporation and their eligible spouses (or Domestic Partners). The claims processor for this Plan is HealthFirst TPA.

The Supplemental Medical Plan is available only to employees who enroll when first eligible for this Plan (as a new employee) or, if you later marry or *declare a Domestic Partner*.

The Plan pays a benefit if:

- You or your covered spouse (or Domestic Partner) exhaust your medical maximum benefit under a Company-sponsored Medical Benefit Option; or
- You are the surviving spouse (or Domestic Partner) of an active employee who dies while you are both covered under this Plan and you have exhausted the maximum medical benefit under the Company-sponsored Medical Benefit Option

The Plan pays a percentage (see chart on page 92) of eligible expenses after you meet the annual out-of-pocket maximum for medically necessary care, treatment, and supplies up to the usual and prevailing fee limits. Once you've met the annual out-of-pocket maximum, the Plan pays 100% of eligible medical expenses for the remainder of the year. For details on this Plan, see page 88.

Dental Benefit

The Company offers you the opportunity to enroll in the Dental Benefit to help pay for covered dental services. The Dental Benefit is self-funded by the Company and administered by MetLife.

The Dental Benefit offers a Preferred Dentist Program (PDP) — a voluntary network of over 70,000 participating dentists nationwide who provide fee discounts to plan participants. You are not required to use a network dentist, but you will generally save money when you do. To access a list of network dentists in your area, log on to www.metlife.com/dental or call MetLife at 800-474-7371.

For details on the Dental Benefit, see page 109.

Vision Benefits

You have the opportunity to enroll in vision coverage, insured and administered by Spectera, a national vision care company. The Vision Benefit offers a network of providers, including retail chains such as Eyemasters, as well as independent providers. To locate participating providers, log on to www.spectera.com or contact Spectera at 800-638-3120.

You can elect to receive services from a network provider or from an out-of-network provider. Covered supplies and services include exams, glasses (frames and lenses), and contact lenses. For details on this insurance, see page 114.

In addition, you may take advantage of the Vision Discount Program offered through EyeMed. For details on this benefit, see page 114.

Term Life Insurance Benefit

When you enroll in a medical Plan, the Company provides Basic Employee Term Life Insurance, which pays a benefit to your designated beneficiary in the event of your death. Optional levels of Contributory Term Life Insurance coverage are also available to you. In addition, you can choose to enroll your eligible spouse and children in Spouse and Child Term Life Insurance, which pays you a benefit if your covered spouse or child dies.

Term Life Insurance pays a death benefit, but has no cash value and remains in effect only while premiums are being paid. The plans are insured by MetLife. You pay your share of any Contributory coverage you choose through payroll deduction.

Employee Term Life Insurance Benefit

When you enroll in a medical Plan, the Company provides Basic Employee Term Life Insurance coverage equal to one times your annual salary at no cost to you.

When you are first eligible for benefits, you may elect Contributory Term Life Insurance up to one level above the Company-provided basic coverage without providing proof of good health. You must submit a statement of health to MetLife if you wish to elect coverage in a greater amount. Contributory Term Life Insurance Coverage up to 6 times your pay is available, to a maximum of $350,000. After you enroll you may increase your Contributory Term Life Insurance coverage by one level per year with proof of good health.

You may not waive Basic Employee Term Life Insurance. For details on this insurance, see page 117.

Spouse and Child Term Life Insurance Benefit

You may purchase coverage for either your spouse or your children or for both spouse and children. Spouse Term Life Insurance is available in amounts up to 3 times your pay. To add or increase Spouse Term Life Insurance, your spouse must complete and submit a statement of health to MetLife. Child Term Life Insurance provides $15,000 coverage for each covered child, and proof of good health is not required.

You pay the entire cost of any Spouse and Child Term Life coverage you select on an after-tax basis. Your spouse's rate is based on his or her age, but coverage for your children is based on a flat rate, regardless of the number of children covered.

For details on this insurance, see page 120.

Accident Insurance

Accidental Death & Dismemberment Insurance (AD&D) and Voluntary Personal Accident Insurance (VPAI) Benefit

As an eligible employee enrolled in a Medical Benefit Option, you automatically receive Accidental Death & Dismemberment Insurance (AD&D) equal to one times your annual salary from the Company at no cost to you. You may also elect to purchase Voluntary Personal Accident Insurance (VPAI) for yourself and your family.

AD&D coverage pays a benefit to you if you are injured in an accident or to your beneficiary if you are killed in an accident. VPAI coverage pays additional benefits if you or your covered dependent is injured or killed as the result of an accident. See page 123 for these additional benefits.

You may select VPAI coverage in $10,000 increments up to a maximum of $500,000. The amount of VPAI coverage for your covered spouse is $10,000 up to $350,000. Child AD&D provides $10,000 coverage for each dependent child, regardless of the number of children covered.

VPAI includes Travel Assistance Services for you and your covered dependents. See page 125 for details.

Other Accident Insurance Benefits

The Company also provides other accident insurance under certain situations. These programs include Management Personal Accident Insurance (MPAI), Special Risk Accident Insurance (SRAI) and Special Purpose Accident Insurance (SPAI). Benefits from these insurance coverages are payable in addition to any benefits you may receive under the AD&D and VPAI insurance benefits.

MPAI provides coverage for management employees while traveling on Company business and for non-occupational accident including any land or water vehicle coverage is three times your salary up to a maximum of $200,000.

SRAI provides coverage for management, agent, support staff and TWU employees for accidental death and dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world. SRAI pays a benefit of five times your annual base salary up to a maximum of $500,000.

SPAI coverage applies to management, agent, support staff and TWU employees. It pays up to $100,000 to each employee who is injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.

For details on this insurance, see page 128.

Disability Benefits

The Company offers you the opportunity to purchase Optional Short Term Disability Insurance (OSTD), as well as Long Term Disability (LTD) Plan coverage in case you are unable to return to work when your sick pay ends.

Optional Short Term Disability Insurance (OSTD) Benefit

The OSTD insurance benefit is fully insured by MetLife and will pay up to 50% of your adjusted monthly salary if you are unable to work due to a non-occupational illness or injury. Benefits are payable only after you have used all of your accrued sick time or on the eighth day of your disability, whichever is later. Benefits end after a period of 26 weeks or when you recover, whichever is earlier.

You pay the cost of your OSTD insurance on an after-tax basis. The insurance is paid by employee contributions and administered by MetLife. For details on this insurance, see page 136.

Long Term Disability (LTD) Plan

LTD benefits replace a portion of your salary when you are unable to work as a result of a disability and you are continuously totally disabled for a period of four consecutive months (elimination period).

The monthly LTD benefit is calculated to equal 50% of your base monthly salary, up to the maximum allowed by federal law. Your benefit is reduced by any disability income payable during the same period, such as optional short term disability benefits or income from state disability programs, Social Security, or Workers' Compensation.

The minimum LTD benefit for all employees is 10% of your pre-disability base monthly salary or $100 per month, whichever is greater.

You pay the cost of your LTD coverage on an after-tax basis. The LTD Plan is self-funded through employee contributions and administered by MetLife.

For details on the LTD Plan, see page 139.

Flexible Spending Accounts Benefits

Health Care Flexible Spending Account

The Health Care Flexible Spending Account (HCFSA) allows you to set aside money on a before-tax basis to help pay for eligible health care expenses for yourself and eligible dependents. Paying for these expenses with before-tax money helps reduce your taxes.

You may deposit up to $5,000 per calendar year to your HCFSA. Because of IRS rules, you lose any money in your HCFSA that is not used during the year it was deposited.

Because of IRS rules, you lose any money in your HCFSA that is not used during the year it was deposited.

For details on this benefit, see page 147.

Dependent Day Care Flexible Spending Account

The Dependent Day Care Flexible Spending Account (DDFSA) allows you to set aside money on a before-tax basis to help pay for dependent day care expenses for your eligible dependents. Paying for these expenses with before-tax money helps reduce your taxes.

If you are married, you and your spouse must be employed or actively seeking employment to be eligible to receive reimbursement from your DDFSA. IRS rules limit the amount you may deposit and the type of expenses that may be paid from your DDFSA.

A single employee or an employee who files a joint income tax return with his or her spouse and both earn over $5,000 for the year, may deposit up to $5,000 per calendar year (a lower limit applies to employees who file separate returns and special rules apply if both spouses do not work).

Because of IRS rules, you lose any money in your DDFSA you do not use during the year it was deposited.

For details on this benefit, see page 153.

Long Term Care Insurance Plan

As an eligible employee, you may elect Long Term Care Insurance to help pay nursing home and home care costs if future illness, injury, or the effects of aging prevent you from living independently. This insurance is also available for your spouse, Domestic Partner, parents, parents-in-law, grandparents, and grandparents-in-law.

You may enroll in the Long Term Care Insurance Plan without providing proof of good health if you enroll within 60 days of your hire date. If you do not enroll for coverage when first eligible, you may add coverage at any time, but will be required to provide proof of good health.

Spouses, Domestic Partners, parents, parents-in-law, grandparents, and grandparents-in-law must provide proof of good health in order to be covered under this benefit. Children are not eligible for coverage under the Long Term Care Insurance Plan.

MetLife insures and administers this coverage. For details on this insurance, see page 139.

Eligibility

Employee Eligibility

Active Employees

As a regular employee on the U. S. payroll of American Eagle Airlines Inc. or Executive, you are eligible for Company subsidized health benefits when you have completed one month of Company seniority**.**

If you are not at work on the date coverage would otherwise begin, coverage is effective on the date you are actively at work, unless you are not actively at work due to a health condition; then coverage is effective on the date coverage would otherwise begin. If you do not enroll for coverage when you are first eligible for benefits, you will receive no coverage. Your next opportunity to enroll will be during the annual open enrollment period for the following year.

For coverage requiring proof of good health, coverage becomes effective only after coverage is approved and your first contributions are paid either by you or through payroll deductions.

Upon completing one month of Company service, you will be able to enroll online via *Jetnet*. For more information about enrollment, see page 19.

Employees Married to Other Employees

If both you and your spouse are Company employees, you are each covered as single employees and neither of you may be covered as a dependent under the other's medical and dental coverage, except in the following circumstances:

Change in spouse's employment: If one spouse ends his or her employment with the Company, the spouse who changes his or her employment is eligible for coverage as a dependent, (if he or she waives coverage under the subsidiary's health benefits). However if an employee is discharged for gross misconduct not related to any existing health condition for which treatment was provided for under the Plans, benefits or medical benefit options or dental benefit, he or she cannot be covered as a dependent of the active employee.

Spouse not eligible for full benefits: During the one-month waiting period required to be eligible for benefits, the new employee may be covered as the spouse of the active employee who already has benefits. If your spouse or Domestic Partner is working as a part-time employee, he or she may waive medical and dental coverage and be covered as a dependent under your coverage.

Retirees married to active employees*:* Retirees married to active employees are eligible for coverage as dependents of active employees. The benefits available and medical maximum benefit limits are defined by the active employee's coverage. Any claims paid under Company-sponsored benefits, while covered as an active employee, dependent, or retiree will apply to your medical maximum benefit.

Spouse on leave of absence: For leaves such as a personal leave of absence, when Company-provided benefits terminate, a spouse on a leave of absence may continue to purchase coverage as an employee on leave or elect to be covered as the dependent of the actively working spouse, but not both.

The actively working spouse's health coverage determines the health benefit coverage for all dependents. Because a leave of absence is a Life Event (see page 28), the actively working spouse may make changes to his or her other coverages.

The actively working spouse may elect to:

- Add the spouse on leave as a dependent
- Cover only eligible dependent children
- Cover both the spouse and children.

If an employee elects to be covered as a dependent during a leave of absence, the following conditions apply:

- Optional coverages the person elected as an active employee end, unless payment for these coverages is continued while on leave
- Proof of good health may be required to re-enroll or increase optional coverages upon the employee's return to work.

Company-provided coverage automatically continues for a period of time for employees on family, sick, injury-on-duty, or maternity leave. These employees cannot be covered as dependents.

Other Information

Eligible dependent children*:* If both spouses are covered under the Group Life and Health Benefits Plan, eligible dependent children are covered as dependents of the parent whose birthday occurs first in the calendar year, unless the parents elect otherwise. Contact HR Employee Services at 800-447-2000 to change this requirement. Children cannot be covered under both parents' health benefits. See *Dependent Eligibility* on page 13 for additional information.

Contributions: If both you and your spouse are covered under the Group Life and Health Benefits Plan and select exactly the same medical or dental option at the same cost, your contributions will be adjusted to ensure you pay approximately the same for your total family coverage as you would if your spouse worked elsewhere. The savings will be divided equally and applied to both your paychecks.

Family deductibles: Family deductibles (see page 37) apply if both employees choose the same medical option. If the parents choose different options, the family deductible applies to the employee covering the children and the individual deductible applies separately to the other parent.

HMO participation*:* If you and your spouse enroll in the same HMO, the entire family unit is covered under the male employee's name because of HMO administrative procedures. If the male spouse takes a Leave of Absence (LOA), coverage for the family unit transfers to the female spouse for the duration of the leave. Domestic Partners are not eligible for HMO coverage.

Life insurance: Both employees are eligible to elect life insurance covering their spouse regardless of any other life insurance coverage the spouse has elected as an employee. Both parents may elect Child Term Life Insurance (see page 120) for eligible dependent children.

Accident coverage: Each of you may enroll for yourself. You cannot be covered as an employee and a dependent; therefore, only the parent who elects medical coverage for the dependent children may elect family accident coverage, and the spouse must waive coverage. If your spouse works for an AMR subsidiary that does not offer accident coverage, you may elect Voluntary Personal Accident Insurance Benefits (see page 123) for him or her.

Flexible Spending Accounts: Deposits to the Health Care and Dependent Day Care Flexible Spending Accounts (see page 147) may be made by one or both spouses. Either of you may submit claims to the account. However, if only one spouse is making deposits to the account, claims must be submitted under that person's Social Security number. If you both make deposits, you may only contribute the maximum amount the law permits for a couple filing a joint tax return. You may not file claims for expenses incurred by a Domestic Partner or his or her dependents under your Flexible Spending Accounts according to federal law.

Eligibility During Leaves of Absence and Disability

Subject to the specific rules governing leaves of absence, you may be eligible to continue benefits for yourself and eligible dependents for a period of time during a leave. The type of leave you take determines whether you must pay for benefits while on leave and the cost of those benefits.

When you begin a leave of absence, HR Employee Services sends you a personalized *Leave of Absence Worksheet* listing your options and the cost to continue coverage during your leave. If you have not received this worksheet within 10 days of being placed on unpaid leave, contact HR Employee Services at 800-447-2000 immediately to be sure you can continue coverage during the leave.

During the first year (12 months) of an unpaid sick or unpaid injury-on-duty leave of absence, you may keep the same benefits you had while actively working. You are responsible for paying your share of the cost for coverage. After this period, your coverage ends. At that time, you may elect Continuation of Coverage (COBRA) (see page 81).

For detailed description of each Leave of Absence, refer to Eagle Policies located under Policies and Procedures on *Jetnet* or consult with your supervisor.

Eligibility After Age 65

As an active employee, your medical coverage continues for you and your covered dependents after you reach age 65 (or your spouse reaches age 65), unless you (or your spouse) notify the Company in writing that you want Medicare to be your only coverage.

If you elect Medicare as your only coverage, your Company-sponsored medical coverage will terminate, including coverage for your dependents. If your spouse elects Medicare as his or her only coverage, your spouse's Company-sponsored coverage will terminate.

Dependent Eligibility

Dependent Eligibility Criteria

An eligible dependent is an individual (other than the employee covered by the Plan) who lives in the United States, Puerto Rico, U.S. Virgin Islands, or who accompanies an employee on a Company assignment outside the U.S. and is related to the employee in one of the following ways:

- Spouse, not employed by the Company (Domestic Partners and their children are not eligible to participate in HMOs or Flexible Spending Accounts)
- Unmarried child under age 19, as defined on page 14
- Unmarried incapacitated child age 19 or over, as defined on page 15

- Unmarried child age 19 through 22, if the child is registered as a full-time student at an educational institution in a program of study leading to a degree or certification (proof of continuing eligibility will be required from time to time) and 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 (see page 74).

If, for medical reasons, the child is required to reduce or terminate his or her studies, coverage will be continued for up to nine months. The child must be under a physician's care, and statements must be provided from the attending physician and educational institution to UnitedHealthcare. After nine months, coverage will end unless the child returns to school full-time or meets the definition of an incapacitated child. If you are enrolled in an HMO, you must contact your individual HMO to determine eligibility requirements and when coverage will be terminated.

Determining a Child's Eligibility

For the purpose of determining eligibility, "child" includes your:

- Natural child
- Legally adopted child
- Natural or legally adopted child of a covered Domestic Partner as defined by the Plan (see page 16)
- Stepchild, if the child lives with you and you the employee, either jointly or individually, claim the stepchild as a dependent on your federal income tax return.
- Stepchild of your Domestic Partner, if the child lives with you and your Domestic Partner claims the child on his or her federal income tax return and the tax return indicates the same address as yours. The child must not have income over the amount of a federal income tax personal exemptions for that year ($3,200 in 2005).
- Special Dependent, if you meet all of the following requirements:
    - You must have legal custody or legal guardianship of the child awarded to you by the court. (The documents must consist of a court order signed by a judge. A document bearing the notarized signature of the custodian or guardian is not sufficient to determine proof of eligibility.)
    - You must claim the child as a dependent on your federal income tax return.
    - You must submit a Special Dependent Statement to UnitedHealthcare (UHC) and UHC must approve the form. (Complete and return the form to UHC at the address on the form, along with copies of the official court documents awarding you custodianship or guardianship of the child.)
    - UHC 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 UHC. If you submit the request after the 60-day time frame, coverage is not effective until the date that UHC approves the coverage.
    - The child must have income less than the amount of the federal income tax personal exemption for that year ($3,200 in 2005).

- You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a National Medical Support Notice issued by a state agency (see page 74).

Coverage for an Incapacitated Child

An "incapacitated child" age 19 or over is eligible if all of the following criteria are met:

- The child was covered as your dependent under this Plan before reaching age 19 (or age 23 if registered as a full-time student before reaching age 23).
- The child is mentally or physically incapable of self-support.
- Within 31 days of the date coverage would otherwise end, you must file a Statement of Dependent Eligibility and UnitedHealthcare must approve the application.
- The child continues to meet the criteria for dependent coverage under this Plan.
- You provide additional medical proof of incapacity as may be required by UnitedHealthcare from time to time. Coverage will be terminated and cannot be reinstated if you cannot provide proof or if UnitedHealthcare determines the child is no longer incapacitated. If you elect to drop coverage for your child, you may not later reinstate it.
- And either:
    - The child maintains legal residence with you and is wholly dependent on you for maintenance and support and has income less than the amount of the federal income tax personal exemption for the tax year ($3,200 in 2005).
    - You are required to provide coverage under a Qualified Medical Child Support Order (QMCSO) that is issued by the court or a state agency (see page 74).

Proof of Eligibility

As a reminder, AMR Corporation and its subsidiaries reserve the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct and may result in termination of employment, benefit or plan coverage termination, and recovery of any overpaid benefits.

Whether you

- enroll dependents when you are first eligible to enroll in benefits, or
- enroll new dependents at annual enrollments, or
- enroll new dependents as the result of a Life Event,

you must submit to HR Employee Services proof of the dependents' eligibility within 30 days of the date you enroll them. Proof that dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc. The proof of eligibility requirements are listed on Jetnet, under Benefits and Pay, in the Resources site, or you may contact HR Employee Services for proof of eligibility requirements (see *Contact Information* on page 1).

Dependents of Deceased Employees

If you have elected medical coverage for your spouse and children and you die as an active employee, your dependents' medical coverage will continue for 90 days at no contribution cost. Your covered dependents are also eligible to continue medical coverage and certain other benefit options for up to 36 months under COBRA (see page 81) at the full COBRA rate. This 90 days of coverage is part of the 36 months of COBRA coverage.

Your covered dependents can elect to continue dental benefit and certain other benefits such as vision coverage (if applicable) under COBRA at the full COBRA rate, if they had dental or vision coverage at the time of your death. To continue dental coverage, your dependents must pay contributions effective from the day of your death.

If you have elected coverage for your spouse[1] under the Supplemental Medical Plan (see page 88), your spouse continues to be eligible to purchase the Supplemental Medical Plan until your spouse remarries or dies.

Common Law Spouse/Domestic Partners

Throughout this Guide, the term "spouse" is used to refer to your legally married spouse, as well as your eligible common law spouse or Domestic Partner unless Domestic Partners are addressed separately. Under current laws, a Domestic Partner is not eligible for certain health and welfare benefits under an ERISA-covered plan. We have identified where a Domestic Partner is not eligible for a certain benefit under the relevant section of this Guide.

"**Common law spouses**" may be eligible for benefits if you live in a state that recognizes common law marriage and you have met the state's common law marriage requirements. To enroll your common law spouse for benefits, you must complete and return a Common Law Marriage Recognition Request Form available online through *Jetnet*.

Along with the form, you must provide proof of common law marriage, as specified on the form.

Applicants for common law recognition may not be married to other persons; additionally, applicants may not be of the same gender.

Although criteria vary by state, the following guidelines usually apply:

- The couple cohabitates for a specified period of time established by the state.
- The persons recognize each other as husband and wife.
- The persons hold each other out publicly as husband and wife.

A common law spouse is eligible for enrollment in Plan benefits only if your 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.

[1] If you die while you and your Domestic Partner are covered under the Supplemental Medical Plan, your Domestic Partner may elect to continue Supplemental Medical coverage for 90 days from the date of your death at the active plan contribution rate to continue coverage. At the end of the 90-day period, coverage ends.

"Domestic Partners" are defined by AMR as two people in a spouse-like relationship who meet all of the following criteria:

- Are the same gender
- Reside together in the same permanent residence and have lived in a spouse-like relationship for at least six consecutive months
- Are both at least 18 years of age and are not related by blood in a degree that would bar marriage
- Are not legally married to, or the common law spouse or Domestic Partner of any other person and cannot enter into a marriage recognized as legal in all 50 states and under the laws of the United States.
- Submit a complete and valid "Declaration of Domestic Partnership" from the *Domestic Partner Kit* available online at *Jetnet*.

Domestic Partners and their eligible dependent children **ARE** eligible to be covered under the following benefits or Plans:

- Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options
- Dental Benefit (for active employees, their spouse or Domestic Partner, and eligible dependents)
- Supplemental Medical Plan (coverage available only to employees and spouses/Domestic Partners, however, Domestic Partner coverage is limited to 90 days following the participant's death.)
- Vision Insurance Benefit
- Accident Insurance Benefit
- Spouse Life Insurance Benefit (Domestic Partner)

Domestic Partners **ARE NOT** eligible to participate in:

- Health Maintenance Organizations (HMOs)
- Flexible Spending Accounts (your Domestic Partner's health care expenses may not be reimbursed from your HCFSA)
- COBRA Continuation Coverage under the Supplemental Medical Plan is not offered to surviving Domestic Partners in the event of the employee's death. Surviving Domestic Partners can elect to continue Supplemental Medical Plan coverage (if applicable) for the 90 days immediately following the employee's death at the active plan contribution rate. At the end of the 90-day period, Supplemental Medical Plan coverage ends.

After reviewing the Domestic Partner Kit, if you need additional information regarding benefits and privileges available to Domestic Partners, please contact HR Employee Services at 800-447-2000.

Ineligibility

None of the following individuals is eligible to participate in this benefits program:

- A leased employee, as defined in section 414(n) of the Internal Revenue Code;
- Any person (regardless of how such person is characterized, for wage withholding purposes or any other purpose, by the Internal Revenue Service, or any other agency, court, authority, individual or entity) who is classified, in the sole and absolute discretion of the Company as a temporary worker; this term includes any of the following former classifications:
    - temporary employee
    - provisional employee
    - associate employee
- An independent contractor; or
- Any person:
    - who is not on the Company's salaried or hourly employee payroll (the determination of which shall be made by the Company in its sole and absolute discretion);
    - who has agreed in writing that he or she is not an employee or is not otherwise eligible to participate; or
    - whose compensation is reported to the Internal Revenue Service on a form other than a Form W-2, regardless of whether such person was treated as an employee for federal income tax purposes.

Parents and Grandchildren

Neither your parents nor grandchildren are eligible as dependents, regardless of whether they live with you or receive maintenance or support from you (unless you are the grandchild's legal guardian). However, you may be eligible for reimbursement of their eligible expenses under the Health Care and Dependent Day Care Flexible Spending Accounts (see page 147) if you claim your parent or grandchild as a dependent on your federal income tax return.

Enrollment

New Employee Enrollment

As an American Eagle or Executive Airlines employee, in order to receive coverage when first eligible, you must complete an online enrollment. If you do not complete the enrollment process, you will not be enrolled in any benefits, and your next opportunity to enroll will be during the annual open enrollment period for the following year. You will receive enrollment information shortly after you begin working. Upon completing one month of Company service, you will be eligible to receive Company subsidized medical, dental, basic life, basic accidental and vision benefits. You may elect coverage for yourself and your eligible dependents (see page 13) and have a ONE-TIME opportunity to enroll in the following coverages without having to provide proof of good health:

- Long Term Disability Plan (LTD)
- Optional Short-Term Disability Insurance (OSTD) Benefit
- Contributory Term Life Insurance Benefit
  (You may choose Contributory Term Life Insurance (see page 117) one level above the Company provided amount without proof of good health. During future annual enrollments, you may only increase your life insurance one level each annual enrollment with proof of good health.)

Proof of good health is required if you wish to enroll in the above coverages later (if/when you are eligible) or to increase life insurance coverage levels You must submit (postmarked) a completed, dated, and signed Statement of Health form to MetLife within 30 days after your enrollment deadline. If your statement of health is not postmarked within 30 days after the close of annual enrollment, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.

- Supplemental Medical Plan
  (As a new employee, you have a ONE-TIME opportunity to purchase Supplemental Medical Plan coverage. The only other time you will be able to enroll in the Supplemental Medical Plan is when/if you get married or *declare a Domestic Partner*.

Employees have the opportunity to select benefits tailored to individual needs and preferences. The Benefits Enrollment Center on *Jetnet* reflects the current benefits coverages available to you and the rates for those coverages.

Default Coverage

Newly eligible employees that do not complete the enrollment process will not be enrolled in any benefits. Your next opportunity to enroll will be during the annual open enrollment period for the following year.

As a new employee, you can enroll for benefits when you are first eligible during your “enrollment window”, and each year, during annual enrollment, you can enroll for benefits that will be effective the following year. The annual Benefits Enrollment period is October 1 through October 31. Your Benefits Enrollment Center will be updated by October 1 with your benefits options and the new rates for the upcoming year.

This page indicates the default benefits that may be assigned and explains when default benefits apply.

During annual enrollment, if you do not make selections for the upcoming benefit year, you will default to the same benefits and plans (at the applicable new rates) as you are enrolled in for the current year with the following exceptions:

- **Flexible Spending Accounts (FSAs):** If you do not elect the FSA options, you default to "waive", and you will not have FSA accounts for the following year.
- **Current Plan Not Offered or Employee Not Eligible:** If you no longer qualify for the current year's benefit or plan, or if your current benefit or plan is no longer offered in your area, you must select a replacement benefit or option or "waive" coverage. If you do not either elect coverage or waive coverage, you will default to the coverages listed in the table below:

Benefit	Default	Comments
Medical Benefit Option	PPO Deductible	If your current medical benefit option is not available in your location, you and your eligible dependents will be enrolled in the PPO-Deductible option. If you are not eligible for the PPO-Deductible option, you and your eligible dependents will be enrolled in the Out-of-Area Coverage option.
Supplemental Medical Plan	No coverage	
Dental Benefit Option	Dental Benefit	
Vision Insurance Benefit	No coverage	
Optional Short-Term Disability Insurance Benefit	No coverage	
Long-Term Disability Plan	LT6	
Employee Life Insurance Benefit	Current coverage	1x salary
Spouse Life Insurance Benefit	No coverage	
Child Life Insurance Benefit	No coverage	
AD&D Insurance Benefit	A20	1x salary
VPAI Benefits	No coverage	
Flexible Spending Account Benefits (Health Care FSA, Dependent Day Care FSA)	No coverage	Your FSA accounts will default to $0.00 unless you enter an amount.

Waiving Coverage

You may choose to waive coverage if you do not want to participate in the Company's Group Medical Benefits. Please keep in mind that your dependents will not receive coverage unless you are covered. You can reinstate your medical coverage during the year if you experience a qualifying Life Event such as marriage, divorce or the birth or adoption of a child.

How to Enroll

Follow these steps to enroll before your enrollment deadline:

Step 1: Visit the Enrollment Center on *Jetnet*

- Look over the information contained in the Benefits Enrollment Center on *Jetnet*. The Benefits Enrollment Center displays your benefit options for the remainder of the year and monthly costs for each.
- Verify that the personal information shown is correct.

Step 2: Review your dependents

- You may add your spouse and any eligible dependent children to records during enrollment.
- After you have added your dependents, if any, it is necessary to decide whether or not you wish to cover each dependent under your Group Medical Benefit Option before continuing with your enrollment for other benefits.
- Within 30 days of your enrolling your dependents for benefits, you must submit to HR Employee Services proof that these dependents qualify as your eligible dependents. Proof that the dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc. The proof of eligibility requirements are listed on Jetnet, under Benefits and Pay, in the Resources site, or you may contact HR Employee Services for proof of eligibility requirements (see *Contact Information* on page 1).

Step 3: Enroll

- You can enroll online on *Jetnet* any time before the enrollment deadline.
- Be sure to enroll by the deadline indicated on your online worksheet. Newly eligible employees that do not complete the enrollment process, will not be enrolled in any benefits.
- You will not have another opportunity to enroll until the next annual open enrollment — or unless you experience a qualifying Life Event (see page 28).

Coverage Levels

You may choose from the following levels of coverage for medical, dental and vision:

- Employee
- Employee + One
- Employee + Two or more.

When Coverage Begins

If you enroll by the enrollment deadline, your selected coverage is retroactive to your eligibility date and your paycheck is adjusted as necessary. However, if a death or accident occurs before your enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment Insurance coverage that will be paid is the amount under *Default Coverage* on page 19.

If you select an HMO and need medical care during this interim period, you must receive treatment from a network provider to receive network coverage. If not, you will have no coverage if enrolled in an HMO.

Paying for Coverage

Each year the Company reviews the benefit options offered to employees and the cost of each plan. Based on your employment status and the number of family members enrolled in your coverage, the Company pays a certain amount towards the cost of your benefits. Once you have completed one month of Company service, the Company pays the majority of the cost of your medical and dental coverage,. You pay the remaining amount of the actual cost for providing these benefits.

Company-Provided Benefits

All employees are provided with basic benefits protection. These benefits include:

- **Medical Benefits.** You can choose from Out-of-Area Coverage, PPO-Deductible, PPO-Copay, Minimum Coverage or an HMO option (if available in your area). Your contributions fund a portion of the cost with the Company covering the majority of the cost.
- **Dental Benefit.** You contribute a portion of the contribution cost.
- **Basic Life Insurance** coverage based on your annual salary for benefits (See *Term Life Insurance* on page 117.)
- **Accidental Death and Dismemberment Insurance Benefit** of 1x your annual salary.
- **Vision Discount Program.** All employees who elect medical coverage will be offered this discount program. (See *Vision Benefits* on page 114).

Employee-Paid Benefits

In addition to these Company-provided benefits, you can select from a number of optional benefits for which you pay the full cost. These include:

- Supplemental Medical Plan coverage for you and your spouse or Domestic Partner
- Vision Insurance Benefits
- Contributory Term Life Insurance Benefits
- Voluntary Personal Accident Insurance Benefits for you alone or for you and your family
- Optional Short Term Disability Insurance Benefits
- Long Term Disability Plan
- A Health Care Flexible Spending Account Benefit
- A Dependent Day Care Flexible Spending Account Benefit.

You pay the same amount for benefits each month, even if your number of pay periods varies from month to month (for example, if you are paid bi-weekly or weekly). Depending on your pay cycle, here is how payroll deductions work. (The amount may vary by a few cents due to rounding.) If you are paid:

- **Semi-monthly:** You always receive two paychecks per month, so the same amount is deducted from each paycheck.
- **Bi-weekly:** You generally receive two paychecks per month, so the same amount is deducted from the first two paychecks each month. However, in months with three pay periods, your last monthly paycheck will not have benefit deductions.
- **Weekly:** You generally receive four paychecks per month, so the same amount is deducted from the first four paychecks each month. However, in months with five pay periods, your last paycheck of the month will not have benefit deductions.

The amount deducted from your paycheck is your contribution to the cost of coverage. (The amount may vary by a few cents due to rounding.)

Taxation of Benefits

You pay for most benefits on a before-tax basis, which means the cost of your benefits is deducted from your pay before taxes are calculated. Tax withholding is calculated only on the remaining amount. Therefore, your contributions for before-tax benefits actually reduce your taxable income, and the amount of taxes withheld from your pay is also lower. However, a few benefits must be paid on an after-tax basis.

Here are a few important points about before-tax and after-tax benefits:

- Each before-tax dollar you contribute to your Dependent Day Care Flexible Spending Account reduces the eligible amount you may claim on your federal income tax return for the dependent day care tax credit. Consult your tax advisor to determine whether you would benefit more from the Dependent Day Care Flexible Spending Account or the federal dependent day care tax credit.
- When you calculate your federal income tax deduction for medical expenses, you may not include any money contributed before-tax to the Health Care Flexible Spending Account. If you anticipate having medical expenses of more than 7.5% of your adjusted gross income, you should consult your tax advisor before signing up for the Health Care Flexible Spending Account.
- According to the IRS, Domestic Partners are not allowed to participate in Flexible Spending Accounts.
- Long Term Care Insurance is paid with your after-tax contributions.
- You do not pay federal (or most state or local) taxes or Social Security (FICA) taxes on your pay used to purchase before-tax benefits. Because this reduces your Social Security wages, before-tax benefits could reduce your future Social Security benefits by a small amount. If your taxable pay remains above the Social Security wage base ($90,000 for 2005), your before-tax benefits do not affect future Social Security benefits.

The following table summarizes options available to eligible employees under the benefit program for American Eagle Airlines, Inc. and Executive Airlines, Inc. employees. The second column shows whether you pay for the benefit before-tax. The third column indicates whether you may waive coverage (choose no coverage) for this benefit option.

Type of Benefits	Before-Tax?	May Waive?
Medical Benefit Options • Out-of-Area Coverage Option • PPO-Deductible Option • PPO-Copay Option • Minimum Coverage Option Health Maintenance Organizations (HMOs)	Yes	Yes[1]
Dental Benefit Option	Yes	Yes
Vision Insurance Benefit	Yes	Yes
Supplemental Medical Plan	No	Yes[2]
Contributory Term Life Insurance Benefit	Yes	Yes[3]
Voluntary Personal Accident Insurance Benefit	No	Yes
Spouse Term Life Insurance Benefit	No	Yes[3]
Child Term Life Insurance Benefit	No	Yes
Optional Short Term Disability Insurance Benefit	No	Yes[3]
Long Term Disability Plan	No	Yes[3]
Health Care Flexible Spending Account Benefit	Yes	Yes[4]
Dependent Day Care Flexible Spending Account Benefit	Yes	Yes
Long Term Care	No	Yes

Annual Enrollment

Each fall in October, eligible employees have the opportunity to select benefits for the following year. During the annual enrollment period, you can enroll online for coverage, make changes to your prior elections, or continue your previous elections at the applicable new rates. (New rates will be available in your Benefits Enrollment Center on *Jetnet*.) With the exception of specific Life Events, annual enrollment is the only time you can change your coverage selections.

Any selections you make during annual enrollment are generally effective the following January 1. If proof of good health is required, the effective date for coverage, if approved, may be delayed to allow for review of your Statement of Health form, (e.g., to add or increase Life Insurance coverage).

[1] Your dependents cannot have coverage if you are not covered.
[2] You may only elect Supplemental Medical Plan coverage when you are first eligible or if you later marry or claim a Domestic Partner.
[3] Requires proof of good health any time you increase your level of coverage or if you waive coverage and later decide to elect it.
[4] During the year, if you experience a qualifying Life Event, you may start or increase contributions to a Health Care Flexible Spending Account only if you are enrolling a dependent who was not previously covered.

Some benefits and plans require proof of good health if you elect these benefits or plans at any time after you first became eligible to enroll. During annual enrollment, if you want to:

- increase the amount of your employee or spouse term life insurance benefit;
- enroll in the Optional Short Term Disability Insurance Benefit, or
- enroll in the Long Term Disability Plan,

you must submit (postmarked) a completed, dated, and signed Statement of Health form to MetLife within 30 days after the close of annual enrollment. For example, if during annual enrollment for the 2006 benefit year (this occurs in October, 2005), you elect to increase the amount of your employee term life insurance benefit for 2006, you must submit your Statement of Health form to MetLife no later than November 30, 2005. If your statement of health is not postmarked within 30 days after the close of annual enrollment, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.

Please be aware of these important points:

The annual enrollment period is from October 1 to October 31.

- If you do not enroll for benefits during the October annual enrollment period, you will automatically default to your current selections (if available) for the following year, at the applicable rates for the following year.
- If one of your current selections is no longer available, you will default to the applicable benefit or plan as listed in the table on page 20.
- After October 31st, you will only be able to make changes to your elections if you experience a qualifying Life Event. (see page 28).
- If you are adding new dependents to your benefits during the annual enrollment period, keep in mind that you must submit to HR Employee Services proof that these dependents qualify as your eligible dependents within 30 days of the date you enroll them. Proof that the dependents you enroll qualify as your dependents includes (but is not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc. The proof of eligibility requirements are listed on Jetnet, under Benefits and Pay, in the Resources site, or you may contact HR Employee Services for proof of eligibility requirements (see *Contact Information* on page 1).

Flexible Spending Account elections do not automatically carry over to the following year. If you do not enroll and enter an amount, you will not have FSA dollars in the following benefit plan year.

Benefit ID Cards

If you have elected to participate in a Medical Benefits Option, UnitedHealthcare will mail your benefit ID cards to you. If you have elected to participate in an HMO, your HMO will mail your benefit ID cards to you. Contact your HMO directly if you have questions. ID cards are not provided for Dental Benefit. Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Benefits participants also receive a Medco ID card for retail prescription drug purchases.

If you elected to participate in Flexible Spending Account(s), UnitedHealthcare will mail your UnitedHealthcare Consumer Account Card (your “FSA card”) to you. For information how the card works, see the Flexible Spending Accounts sections beginning on page 147.

Special Enrollment Rights

If you or your dependents declined coverage under the Medical Benefits Option because you or they have medical coverage elsewhere and one of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your dependents in this benefit program:

- You and/or your dependents lose the other medical coverage because eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).
- The employer contributions to the other coverage have stopped.
- The other coverage was COBRA and the maximum COBRA coverage period ends.

As an employee, you may enroll your new spouse within 60 days of your marriage and a new child within 60 days of his or her birth, adoption or placement for adoption. In addition, if you are not enrolled in the employee benefits as an employee, you also must enroll in the employee benefits when you enroll any of these dependents. And, if your spouse is not enrolled in the employee benefits, you may enroll him or her in the employee benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage, coverage will begin on the first day of the first calendar month after the completed enrollment form is received. In the case of birth, adoption or placement for adoption, coverage is retroactive to the date of birth, adoption or placement for adoption.

If you are adding new dependents to your benefits as a result of a Life Event, keep in mind that you must submit to HR Employee Services proof that these dependents qualify as your eligible dependents. Proof that the dependents you enroll qualify as your dependents include (but are not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc. The proof of eligibility requirements are listed on Jetnet, under Benefits and Pay, in the Resources site, or you may contact HR Employee Services for proof of eligibility requirements (see *Contact Information* on page 1).

Making Changes During the Year

Overview

After annual enrollment is completed each year, you may only change your elections if you experience a qualifying Life Event and your change is consistent with that event. Allowable changes vary by the type of Life Event you experience, as shown in the table beginning on page 28 and on the Life Events landing page on *Jetnet*.

When you experience a qualifying Life Event, keep these important thoughts in mind:

- Most Life Events can be processed online through *Jetnet*. Visit the Employee Self-Service Life Events page for a complete list of all Life Events and the correct procedures for processing your changes.
- If you process your Life Event within 60 days of the event, your changes are retroactive to the date the Life Event occurred (or the date proof of good health is approved, as applicable).

- If you process your Life Event after the 60-day time frame, changes are effective on the day that HR Employee Services processes your Life Event, rather than on the date the event actually occurred. If you miss the 60-day deadline and the event occurred in the current year, you may only add or delete dependents from the medical or dental coverage you previously elected; you may not make other changes. If you miss the 60-day deadline and the event occurred in the previous year, you may add dependents to your file but you may not cover them under your benefits, make any changes to existing dependents or make any benefit plan changes. (Adding the dependent to your file lists the dependent as eligible to be enrolled at the next annual enrollment, but does not enroll him or her in benefits currently.)
- AMR Corporation and its affiliates reserve the right to request documented proof of dependent eligibility for benefits at any time. If you do not provide documented proof when requested, or if any of the information you provide is not true and correct, your actions will be considered a violation of the Rules of Conduct and may result in termination of employment and termination of benefits coverage.

  If you are adding new dependents to your benefits as a result of a Life Event, keep in mind that you must submit to HR Employee Services proof that these dependents qualify as your eligible dependents within 30 days of the date you enroll them. Proof that the dependents you enroll qualify as your dependents include (but are not limited to) official government-issued birth certificates, adoption papers, marriage licenses, etc. The proof of eligibility requirements are listed on *Jetnet*, under Benefits and Pay, in the Resources site, or you may contact HR Employee Services for proof of eligibility requirements (see *Contact Information* on page 1).
- Any change in your cost for coverage applies on the date the change is effective. Catch-up contributions or deductions will be deducted from one or more paychecks after your election is processed at the discretion of the Plan Administrator.
- You cannot enroll your dependents for coverage if you are not covered.
- You may start or increase a Health Care Flexible Spending Account only if you have enrolled a dependent who was not previously covered.
- Starting or increasing either Life, Accident, or Disability Insurance Benefits may require proof of good health and coverage will only be effective after the applicant is approved. If death occurs before a Life Event is processed, the amount of coverage payable is your current amount of Life and/or Accident Insurance. When you add Life or Accident Insurance Benefits, you must designate a beneficiary. Periodically thereafter, you may want to update your beneficiary designations, and you can make beneficiary changes on the Employee Self-Service “My Beneficiaries“ page on *Jetnet*. Once you complete and submit the online beneficiary designation form, it supercedes all previous designations.
- If a death or accident occurs before your first-time enrollment is processed, the amount of Life Insurance and Accidental Death and Dismemberment Insurance Benefits that will be paid is your “default coverage.“ If you have coverage and you are requesting an increase, the amount payable is your current amount of coverage.
- You or your spouse may only increase your Life Insurance coverage by one level per year, with proof of good health.

- If you elect to enroll in any coverage requiring proof of good health, you must submit (postmarked) a completed, dated, and signed Statement of Health form to MetLife within 30 days after your enrollment/election date. If your statement of health is not postmarked within 30 days after your enrollment/election date, your application for these coverages will not be considered, and you must wait until the next annual enrollment (or your next qualifying Life Event) to apply for any of these coverages.
- If you plan to cover your Domestic Partner under your Life Insurance, you must submit a MetLife Affidavit of Domestic Partnership. This form is part of the Domestic Partner Kit available on the Employee Self-Service forms page on *Jetnet*.
- See also *Special Life Event Considerations* on page 33 for other information regarding Life Events that may trigger allowable changes in coverage.

Life Events

If ...	Then, You Can ...
You become eligible for Company-provided benefits	Enroll online through *Jetnet*.
You get married or *de*clare a Domestic Partner	• **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents; stop coverage for a dependent or yourself. Although you can add or drop coverage for dependents or yourself, you cannot change benefit options at this time. You may add or drop dental coverage. • **Supplemental Medical Plan:** Add coverage for yourself and your spouse, even if you are not currently enrolled for this coverage • **Optional Short Term Disability Insurance Benefit**: Start coverage, however this coverage applies to the employee only • **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Add coverage for your spouse and/or child, or increase or decrease existing employee coverage • **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts.

If ...	Then, You Can ...
You divorce or legally separate, **Your Domestic Partner relationship ends, or** **You obtain a protective order**	• **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for your spouse. You cannot change benefit options at this time. • **Supplemental Medical Plan:** Stop coverage for spouse or you and your spouse • **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Stop coverage for your spouse and/or child, or increase or decrease existing employee coverage • **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for yourself; stop coverage for spouse or child; increase or decrease existing employee coverage • **Flexible Spending Accounts Benefits**: Start/stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions. However, Domestic Partners and their dependents are not eligible to participate in Flexible Spending Accounts
You or your spouse becomes pregnant	• **Contact**: Health International at 800-638-9599 before the 16th week of pregnancy, if you are covered by the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or PPO-Copay Option • **Contact:** The HMO, if you are covered by an HMO • This does not permit you to make any changes in your benefit elections until the baby is born
You or your spouse gives birth or adopts a child or has a child placed with you for adoption or you add eligible dependent(s) to your household	• **Medical and Dental Options and Vision Insurance Benefit:** Start/add coverage for the dependent(s) and yourself, and/or your spouse. You cannot change benefit options at this time • **Supplemental Medical Plan:** Stop coverage for spouse or you and your spouse • **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Add coverage for your child, increase or decrease existing coverage for you with proof of good health • **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

If ...	Then, You Can ...
Your covered dependent no longer meets the plan's eligibility requirement	• **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for dependent. You cannot change benefit options at this time • **Supplemental Medical Plan:** Stop coverage for spouse or you and your spouse • **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Stop coverage for your dependent; increase or decrease existing coverage for you with proof of good health • **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions
Your spouse or dependent dies	• **Medical and Dental Options and Vision Insurance Benefit:** Stop coverage for spouse or dependent. You cannot change benefit options at this time • **Supplemental Medical Plan:** Stop coverage for spouse or you and your spouse • **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Stop coverage for your dependent; increase or decrease existing coverage for you with proof of good health • **Voluntary Personal Accident Insurance Benefit:** Stop coverage for your spouse or dependent, or start or stop coverage for yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions

If ...	Then, You Can ...
Change in spouse's employment or other health coverage, or **Your spouse's employer no longer contributes toward health coverage**	• **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time • **Supplemental Medical Plan:** Stop coverage for your spouse, yourself, or you and your spouse • **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan**: Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Start or stop coverage • **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions
You move to a new home address: • Update your address online through **Jetnet.aa.com** • Submit a revised **W-4 form** for payroll tax purposes. The form is available online through *Jetnet.aa.com* • Contact other organizations such as the American Airline Credit Union and C. R. Smith Museum directly to update your contact information • Provide your new address and current emergency contact numbers to your supervisor, as well	• **Medical Option:** May select from medical options available in new location • **Supplemental Medical Plan**: Stop coverage for your spouse and yourself • **Optional Short Term Disability Insurance Benefit**: Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent; increase or decrease existing coverage • **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions
You become disabled	• **Notify:** Your supervisor and download a Disability Claim Form from *Jetnet* • **Complete and submit:** Your claim for disability benefits
You take a leave of absence	• **You will receive:** A personalized Leave of Absence Worksheet from HR Employee Services when the Payroll Transaction Request (PTR) placing you on unpaid leave is processed. The worksheet lists your options during the leave, cost for benefits coverage, and the election deadline. • **Your cost depends on:** The type of leave you are taking

If ...	Then, You Can ...
You return from an unpaid leave of absence	• **Medical and Dental Options and Vision Insurance Benefit:** Resume coverage. You cannot change benefit options at this time • **Supplemental Medical Plan:** Stop coverage for your spouse, or you and spouse • **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Start or stop coverage; increase or decrease existing employee coverage • **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions
You change from part-time to full-time or full-time to part-time	• **Medical and Dental Options and Vision Insurance Benefit:** Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time • **Supplemental Medical Plan:** Stop coverage for your spouse, yourself, or you and your spouse • **Optional Short Term Disability Insurance Benefit:** Start coverage; however, this coverage applies to the employee only • **Long Term Disability Plan:** Start or stop coverage; however, this coverage applies to the employee only • **Contributory Term Life Insurance Benefit:** Start or stop coverage for your spouse and/or dependent, or increase or decrease existing coverage • **Voluntary Personal Accident Insurance Benefit:** Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage • **Flexible Spending Accounts Benefits:** Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions
You die	• **Continuation of Coverage**: Your dependents or Domestic Partner should contact your supervisor, who will coordinate with a Survivor Support representative in HR Employee Services to assist with all benefits and privileges, including the election of Continuation of Coverage, if applicable. See N*EMPLOYEE DEATH in SABRE.
Your Domestic Partner dies	• **Continuation of Coverage:** You will receive information about Continuation of Coverage through COBRA for the surviving children of your Domestic Partner, if you contact HR Employee Services as required below • **Contact:** HR Employee Services at 800-447-2000 within 60 days of your Domestic Partner's death to update your records and make the appropriate changes, if applicable, to your benefits coverage

If ...	Then, You Can ...
You end your employment with the Company or you are eligible to retire	• **Review:** *When Coverage Ends* within this Guide • **Review:** The information you receive regarding Continuation of Coverage through COBRA • **Contact:** HR Employee Services at 800-447-2000 for information on retirement
You transfer to another work group or subsidiary of AMR Corporation	• **Contact:** Your supervisor, HR Employee Services, or the new subsidiary to determine benefits available to you and to make new benefit elections

Special Life Event Considerations

The following section explains special circumstances that may happen in your life and how these changes affect your benefits. You must take all of the steps described below for your special Life Event within 60 days of the date it occurs.

Special dependent: To cover a special dependent (foster child or child for whom you become the legal guardian), you must complete a *Statement of Dependent Eligibility* (available on *Jetnet*) and return it to UnitedHealthcare), regardless of the medical option you select, along with a copy of the court decree or guardianship papers. For detailed criteria regarding coverage for a special dependent, see also *Dependent Eligibility Criteria* on page 13.

Stepchild: You may add coverage for a stepchild if the child lives with you and you the employee, either jointly or individually, claim the stepchild as a dependent on your federal income tax return.

Birth or adoption of a child: To add a natural child to coverage, you may use hospital records or an unofficial birth certificate as documentation of the birth. You should not wait to receive the baby's Social Security number or official birth certificate. These documents may take more than 60 days to arrive and prevent you from starting coverage effective on the baby's birth date.

To add an adopted child to your benefits coverage, you must supply a copy of the placement papers or actual adoption papers. Coverage for an adopted child is effective with the date the child is placed with you for adoption and is not retroactive to the child's date of birth.

Relocation: If you are enrolled in the PPO-Deductible or PPO-Copay Option and you move to a location where PPO providers are not available, you must choose another medical option or you may waive coverage. If you are enrolled in an HMO and you move out of that plan's service area, you may choose another medical option. If you are enrolled in the Out-of-Area Coverage Option or Minimum Coverage Option and move to an area where the PPO is available, you will no longer be eligible for the Out-of-Area Option. However, if you change to another medical option, your deductibles and out-of-pocket maximums do not transfer to the new option.

Call HR Employee Services at 800-447-2000 and a representative will assist you with your selection. If you do not process your relocation Life Event within 60 days of your move, you will automatically be enrolled in another medical option and will receive a confirmation statement indicating your new coverage.

Benefit Coverages Affected by Life Events

Contributory Term Life Insurance Benefit: You may only increase this coverage by one level per year with approved proof of good health.

Vision Insurance Benefit: You may add coverage for yourself and your eligible dependents if you experience a qualifying Life Event. The Vision Insurance Benefit is structured in a manner similar to the Medical Options the Company offers and is insured and administered by Spectera, a national vision care company. This coverage offers a network of providers and copayments for certain vision services.

Optional Short Term Disability Insurance Benefit: If you elect coverage, your choice remains in effect for two calendar years. After this time, you have the option to continue or waive future coverage. However, you may add coverage if you have experienced a Life Event with approved proof of good health.

Flexible Spending Accounts Benefits: If you change the amount of your deposits during the year, claims from your Health Care Flexible Spending Account for eligible health care expenses incurred before the change are payable up to the original amount you elected to deposit. Claims for expenses incurred after the change are payable up to your newly elected deposit amount. You forfeit part of your balance when the deposits before your change are greater than your claims before the change and you reduce the amount you elect to deposit. Your Dependent Day Care Flexible Spending Account reimburses based on the deposits in your account at the time of the claim.

Remember, when you process a Life Event change, the change (if applicable) to your Flexible Spending Accounts is only valid for the remainder of the calendar year. If you process a Life Event change within the last 60 days of the year, there will not be time to process changes to your Flexible Spending Accounts for that year.

Benefit Coverages Not Affected by Life Events

The following benefits are not affected by Life Event changes, except as noted:

Medical Options: You may change medical options only if you relocate (see the chart beginning on page 28). However, if you are enrolled in either the PPO-Copay, PPO-Deductible, or Out-of-Area Options when you relocate, you may not change from one of these options to another due to relocation, unless the option you were enrolled in previously is no longer available in your new location.

When Coverage Ends

Coverage for you and your dependents ends when you terminate employment, cancel coverage, stop paying for coverage, or if you become ineligible for coverage (for example, due to a change in your job classification). In addition, your dependent's coverage ends if the dependent no longer meets the eligibility requirements, as explained in *Dependent Eligibility Criteria* (see page 13).

If you die as an active employee, your covered dependents continue to receive the same medical coverage[1] they had before you died. This coverage continues for 90 days at no cost. At the end of 90 days, your eligible dependents are eligible to continue medical coverage for up to 36 months under COBRA at the full COBRA rate. The 90 days of coverage immediately following your death is included in the 36 months. Dental coverage is available for purchase through COBRA. All other coverages end at the time of your death.

For information regarding benefits that can be continued through COBRA, see page 81.

During the initial period of an absence for a disability, while you are receiving accrued sick pay and during the first year (12 months) of an unpaid sick or injury-on-duty leave of absence, the Company continues to pay its part toward the cost of your medical coverage for active employees, and you must pay your part of the cost, as well. You will receive a personalized Leave of Absence Worksheet from HR Employee Services when the Payroll Transaction Request (PTR) placing you on unpaid leave is processed. The worksheet lists your benefits options during the leave, costs for benefit coverage, and the election deadline. If you elect to continue your medical and dental benefit, this coverage ends at the end of the 12th month of your leave.

[1] If you die while you and your Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Domestic Partner continues for 90 days from the date of your death, provided he or she pays the active plan contribution rate to continue coverage. At the end of the 90-day period, coverage ends.

Medical Benefits

Overview

The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of illness or injury. You may choose from several medical options offered to American Eagle employees, or you may waive coverage completely.

Some options may not be offered in all locations. During enrollment periods (as a new employee when you are first eligible for benefits, during the annual enrollment period), or if you experience a qualifying Life Event, your Benefits Enrollment Center on *Jetnet* will reflect the options that are available to you.

- Out-of-Area Coverage, PPO-Deductible, PPO-Copay and the Minimum Coverage Options are self-funded by the Company. UnitedHealthcare (UHC) administers these options; however, reimbursements for covered health care expenses are paid from the general assets of the Company, not by an insurance company.
- HMOs are insured options whose covered services are paid by the HMO. The Company pays a flat monthly premium and the HMO pays for all covered services. If you live in a location where an HMO is offered, it will be indicated as an option when you enroll online.
- You may waive coverage; however, your dependents cannot have coverage if you are not covered. You will not be able to file claims under a medical option of any AMR subsidiary if you waive coverage. You will not be able to enroll in coverage during the year unless you experience a qualified Life Event (see page 28).

Employees residing in Puerto Rico will have the choice between HMOs and the Out-of-Area Coverage and Minimum Coverage Options. All other employees will be eligible to participate in either the Out-of-Area Coverage Plan, or have a choice between the PPO-Deductible, PPO-Copay, or Minimum Coverage Options. This determination is based on whether your home zip code falls within a PPO service area. Each year an analysis is done to be sure that each PPO service area provides reasonable access to physicians, specialist, hospitals, and pharmacies for our members. If you live within a PPO service area you have a choice of either the PPO-Deductible Option or the PPO-Copay Option. If you do not live within a PPO service area you will be eligible for the Out-of-Area Coverage and Minimum Coverage Options.

Under the Out-of-Area Coverage and Minimum Coverage Options you will receive the PPO in-network level of coverage. This benefit is offered to the Out-of-Area Coverage Option members because there is not a reasonable number of PPO providers within driving distance, as determined by your home zip code. If you live within a zip code that is covered by the PPO you will not be eligible for the Out-of-Area Coverage Option.

Refer to page 11 for details regarding eligibility for benefits, dependent coverage, and employees married to other employees.

Regardless of the medical coverage you select, you may take advantage of the Employee Assistance Program (EAP) offered by the Company (see page 108 for more information).

Key Features of the Medical Options

The following are key features of the Out-of-Area Coverage, PPO-Deductible, PPO-Copay, and Minimum Coverage Options. Refer to the *Covered Expenses* section of this guide (see page 57) for a list of specific covered expenses.

Medically necessary: Medical care is covered by the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options when the care is medically necessary, is an Eligible Expense, and it is not excluded from coverage. The Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options also cover well-child care (up to age 2) and periodic mammograms. Under the PPO-Copay Option, the same medically necessary requirements apply. However, some services, such as routine physical exams and preventive care, are covered when you use a network provider. Please note that just because a physician orders a service does not mean the service is medically necessary.

Usual and prevailing fee limits: The amount of benefits paid for eligible expenses is based on the usual and prevailing fee limits for a particular service or supply in that geographic location. Because participating providers in the Preferred Provider Organization (PPO) network have agreed to discounted fees, the usual and prevailing fee limits do not apply.

Individual annual deductible: Your annual deductible under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options is the amount of Eligible Expenses you must pay each year before your medical option coverage will start reimbursing you. After you satisfy the deductible, your selected medical option pays the appropriate percentage of the usual and prevailing fee limits for eligible covered medical services.

Family annual deductible: Under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options, once the family annual deductible has been satisfied, all members of your family are eligible for reimbursement of eligible medical expenses, regardless of whether they have satisfied *individual* annual deductibles. The family annual deductible is available if three or more family members are covered.

Refer to Medical Benefit Options Comparison on page 40 for more information regarding individual and family deductibles.

Claims: Participating PPO providers typically file claims for you; however, in some cases, you may be required to pay for services in advance and file a claim to receive reimbursement. You will need to file a claim if you receive services from an out-of-network provider or facility.

Annual out-of-pocket maximum: After you satisfy the annual out-of-pocket maximum for Eligible Expenses under the option you have selected for coverage, the medical option pays 100% of Eligible Expenses within usual and prevailing fee limits for the rest of the year.

- Under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options, all coinsurance amounts (except outpatient mental health care amounts and mail order prescription copayments) apply to the annual out-of-pocket maximum.
- For network services under the PPO-Deductible and PPO-Copay Options, coinsurance amounts for hospital-based services apply to the annual network out-of-pocket maximum.
- Copayments and deductibles do not apply toward the annual network out-of-pocket maximum.

Lifetime medical maximum benefit: $5,000,000 is the most any participant can receive in medical benefits during the entire period the person is covered. All expenses incurred under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options, the Mail Service Prescription Program and any other company-sponsored medical plans are included in the maximum. Effective January 1 of each year, part of your Lifetime Medical Maximum benefit is automatically restored. The amount restored is $3,500, or the amount necessary to restore your full $5,000,000, whichever is less.

CheckFirst: Under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options, you should contact UnitedHealthcare to determine whether a proposed medical service is covered under the option (i.e., CheckFirst). If you are not using a network provider, you will also want to determine if the charges fall within the usual and prevailing fee limits. When you use a physician that participates in the PPO network, usual and prevailing fee limits do not apply because the PPO network provider has a contract fee arrangement with UnitedHealthcare, and has agreed to accept this discounted contract fee as its billed fee. However, you may still need to use CheckFirst to determine whether the medical service is covered.[1]

QuickReview: Call for a QuickReview in the following situations:

- To pre-authorize (QuickReview) a surgery or hospitalization (for emergency care see page 51).
- If you are covered by the PPO-Deductible or PPO-Copay Option and are using out-of-network services, you must call UnitedHealthcare to pre-authorize (QuickReview) any surgery or hospitalization.
- If you need emergency care, you should contact UnitedHealthcare within 48 hours after you receive initial care to ensure you receive the network benefit level.

Injury by others: If someone else injures you and this Plan pays a benefit, the Company will recover payment from the third party (*Subrogation* see page 164).

Prescription drug benefits: The Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options cover medically necessary prescription drugs purchased at any retail pharmacy (e.g., Walgreen's, Eckerds, etc.) and offer discounted prescriptions at participating Medco network pharmacies, including prescriptions for psychotherapeutic drugs.

The PPO-Deductible and PPO-Copay Options cover medically necessary prescriptions with copayments or coinsurance when purchased at a participating retail pharmacy (e.g., Walgreen's, Eckerds, etc. up to a 30 day supply). When you visit a network pharmacy, it is important that you provide your insurance card to ensure that your out-of-pocket expenses are automatically applied to your prescription drug deductible. If you visit an out-of-network pharmacy, you must submit your receipts to UnitedHealthcare to be reimbursed at the out-of-network benefit rate.

Prescription drugs covered by the Medical Options are described in the *Covered Expenses* section on page 62. Refer to the *Prescription Drug Benefits* section on page 66 for a description of the prescription drug benefit and to the *Exclusions* section on page 70 for a list of drugs not covered by the medical options.

Certain over-the-counter (OTC) medicines and drugs may now be covered under a Health Care Flexible Spending Account (see page 149).

[1] The Annual Out-Of-Pocket Maximum does not include your annual deductible, expenses that are not covered or exceed the usual and prevailing fee limits, any copayments, or any expenses which are reimbursed at 50% (example: outpatient mental health care).

Maximum Medical Benefit

The most any covered participant and eligible covered dependent can receive in medical benefits during the entire period the person is covered is $5,000,000. (Prior to January 1, 2004, the maximum medical benefit was $1,000,000 per employee and covered eligible dependent. Any participant who exhausted his/her maximum medical benefit prior to January 1, 2004, is not eligible to receive the increased maximum medical benefit.) All benefits paid under the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, and the Prescription Drug Benefits are included in the maximum medical benefit.

Each January 1, part of your maximum medical benefit is automatically restored. The amount restored is $3,500, or the amount necessary to restore $5,000,000, whichever is less.

When you have exhausted your maximum medical benefit your medical coverage terminates, you do not receive the annual restoration of benefits, and you are not eligible for any future increases in the maximum medical benefit.

Even if you have exhausted your maximum medical benefit, your covered eligible dependents may continue their medical coverage under the Plan up to their maximum medical benefit as long as they continue to meet the eligibility requirements.

If your selected medical coverage (for both the employee and covered eligible dependents) is one of the self-funded medical coverages (Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or PPO-Copay Options), and you and/or your eligible dependents exhaust the maximum medical benefit under the self-funded medical coverage, neither you nor your eligible dependents who exhaust the maximum medical benefit can elect any medical coverage (including an HMO) under the Plan.

If you and your covered eligible dependents exhaust the maximum medical benefit, you may continue other coverages/benefits in the Plan, e.g., life insurance, dental coverage, Accidental Death and Dismemberment (AD&D), flexible spending accounts, and disability coverages. The Medical Benefit is the only coverage that terminates for the affected individual.

Individuals who lose medical benefits as the result of their exhausting the maximum medical benefit are not entitled to continuation of coverage under COBRA, and will not be solicited for COBRA.

Pre-Existing Conditions

The Eagle Medical Benefit Options exclude pre-existing conditions from coverage under the option for employees who do not enroll in coverage when first eligible for company-paid coverage. If you enroll at this first opportunity, all eligible medical expenses for you and your covered dependents will be reimbursed, subject to the usual medical benefit option provisions. An 18-month pre-existing condition exclusion will apply only to employees who elect no coverage under the medical benefit option when they are first given the opportunity to enroll — and later decide to elect coverage.

The exclusion for “late” enrollees will mean that during the first 18 months of coverage under the medical benefit option, conditions (other than pregnancy) which were diagnosed or treated within the six months prior to enrollment in the medical benefit option will not be covered. After you or your dependents have been enrolled in an Eagle medical benefit option for 18 months, all pre-existing conditions will be eligible for coverage.

You may be able to reduce or eliminate this pre-existing condition exclusion period for yourself and your dependents if you can show proof (a "Certificate of Group Health Plan Coverage" from your previous plan) that you were enrolled in other health coverage immediately prior to enrolling in the Eagle medical benefit option.

Medical Benefit Options

Medical Benefit Options Comparison

The following tables provide a summary of features under the Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options. Benefits are available for Eligible Expenses that are medically necessary and within the usual and prevailing fee limits.

The tables show the amount or percentage you pay for Eligible Expenses, and you pay any amounts not covered by the options. If you are covered under Out-of-Area Coverage, PPO-Deductible, PPO-Copay and Minimum Coverage Options or you use out-of-network services or network hospital-based services under the PPO-Deductible or PPO-Copay, you must satisfy any individual annual deductibles before the option pays benefits for Eligible Expenses.

As you review the following Comparison of Options tables, please keep the following points in mind:

- The out-of-pocket maximum under the medical options applies to coinsurance amounts you pay (i.e., for hospital services, including inpatient and outpatient care and surgery). The out-of-pocket maximum does not include deductibles or copayment amounts, amounts not covered, amounts exceeding the usual and prevailing fee limits, or services covered at 50%.
- Visit www.provider.uhc.com/american to determine if your physician is a network provider.

For information regarding eligible medical expenses and expenses that are excluded from coverage, refer to *Covered Expenses* (page 57) and *Excluded Expenses* (page 70).

Preventive Care

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	**In-Network PPO-Copay**	**Minimum Coverage**	**Out-of-Network PPO-Deductible & PPO-Copay**
Annual routine physical exams	You pay the full cost (not covered under this Option)	$20 copayment	You pay the full cost (not covered under this Option)	You pay the full cost (not covered under this Option)
Well-child care	20% coinsurance for children up to age 2, for initial hospitalization following birth, all immunizations, and up to 7 well-child care visits	$20 copayment	20% coinsurance for children up to age 2, for initial hospitalization following birth, all immunizations, and up to 7 well-child care visits	20% coinsurance for children up to age 2, for initial hospitalization following birth, all immunizations, and up to 7 well-child care visits

Copayments do not apply toward the annual out-of-pocket maximum.

Medical Services

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	**In-Network PPO-Copay**	**Minimum Coverage**	**Out-of-Network PPO-Deductible & PPO-Copay**
Physician's office visit (including x-ray and lab work)	20% coinsurance	$20 copayment	20% coinsurance	40% coinsurance
Specialist's office (including x-ray and lab work)	20% coinsurance	$30 copayment	20% coinsurance	40% coinsurance
Urgent care clinic	20%coinsurance	$25 copayment	20%coinsurance	40% coinsurance
Gynecological care	20% coinsurance; preventive care not covered (except for mammograms, as listed below)	$20 copayment for preventive visits $30 copayment if not a preventive diagnosis	20% coinsurance; preventive care not covered (except for mammograms, as listed below)	40% coinsurance; preventive care not covered (except for mammograms, as listed below)
• Pap tests	20% coinsurance if medically necessary; routine pap tests are not covered	No cost if part of office visit	20% coinsurance if medically necessary; routine pap tests are not covered	40% coinsurance if medically necessary; routine pap tests are not covered
• Mammograms	20% coinsurance if medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in *Covered Expenses* on page 60	No cost if part of office visit or at an independent facility; 10% coinsurance if hospital outpatient	20% coinsurance if medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in *Covered Expenses* on page 60	40% coinsurance if medically necessary; routine mammograms are covered according to specific guidelines – refer to Mammograms in *Covered Expenses* on page 60
Pregnancy	20% coinsurance	$30 copayment per visit $300 maximum copayment per pregnancy (includes prenatal/postnatal/ delivery)	20% coinsurance	40% coinsurance
Second surgical opinions (No cost if ordered by the plan or claim administrator)	20% coinsurance if elected by participant	$20 copayment if elected by participant	20% coinsurance if elected by participant	40% coinsurance if elected by participant
Chiropractic care	20% coinsurance if medically necessary	$30 copayment	20% coinsurance if medically necessary	40% coinsurance if medically necessary
	Maximum 20 chiropractic visits per person per year combined network and out-of-network			

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Speech, physical, occupational, restorative, and rehabilitative therapy	20% coinsurance	$30 copayment per visit (maximum copayment of $300 per person per year)	20% coinsurance	40% coinsurance
Allergy care	20% coinsurance	$30 copayment per visit (maximum copayment of $300 per person per year)	20% coinsurance	40% coinsurance

Copayments do not apply toward the annual out-of-pocket maximum.

Outpatient Services

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Diagnostic x-ray and lab	20% coinsurance	10% coinsurance at hospital; no cost if received at an independent network lab or in a physician's office	20% coinsurance	40% coinsurance
Outpatient surgery in physician's office (pre-authorization is recommended to ensure medical necessity; see QuickReview on page 56)	20% coinsurance	$20 copayment	20% coinsurance	40% coinsurance
Outpatient surgery in a hospital or free standing surgical facility (pre-authorization is recommended to ensure medical necessity; see QuickReview on page 56)	20% coinsurance	10% coinsurance	20% coinsurance	40% coinsurance
Pre-admission testing	20% coinsurance	10% coinsurance	20% coinsurance	40% coinsurance

Copayments do not apply toward the annual out-of-pocket maximum.

Hospital Services

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	**In-Network PPO-Copay**	**Minimum Coverage**	**Out-of-Network PPO-Deductible & PPO-Copay**
Inpatient room and board, including intensive care unit or special care unit	20% coinsurance	$150 copayment per admission plus 10% coinsurance for all other hospital-based services	20% coinsurance	40% coinsurance
Ancillary services, including radiology, pathology, operating room, and supplies	20% coinsurance	10% coinsurance for all hospital-based services	20% coinsurance	40% coinsurance
Newborn nursery care is considered under the baby's coverage, not the mother's. Within 60 days of the birth, be sure to process a Life Event change online through *Jetnet* to enroll your baby in your health coverage. Payment of maternity claims does not automatically enroll your baby	20% coinsurance	10% coinsurance for all hospital-based services ($150 copayment for hospital admission does not apply to the baby)	20% coinsurance	40% coinsurance
Surgery and related expenses (such as anesthesia and medically necessary assistant surgeon)	20% coinsurance	10% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Blood transfusions	20% coinsurance	10% coinsurance (no cost if performed in physician's office)	20% coinsurance	40% coinsurance
Organ transplants	20% coinsurance	10% coinsurance for inpatient hospital	20% coinsurance	40% coinsurance
Emergency ambulance	20% coinsurance	No cost	20% coinsurance	40% coinsurance
Emergency room	20% coinsurance	$75 copayment (waived if admitted to the hospital)	20% coinsurance	40% coinsurance

Copayments do not apply toward the annual out-of-pocket maximum.

Out of Hospital Care

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	**In-Network PPO-Copay**	**Minimum Coverage**	**Out-of-Network PPO-Deductible & PPO-Copay**
Convalescent and skilled nursing facilities following hospitalization	20%, coinsurance	10%, coinsurance	20% coinsurance	40% coinsurance
	Maximum of 60 days per year in-network and out-of-network combined			
Home health care	20% coinsurance	$20 copayment	20% coinsurance	40% coinsurance
Hospice care	20% coinsurance	10%, coinsurance if performed at a hospital; $20 copayment per day if home care	20% coinsurance	40% coinsurance

Copayments do not apply toward the annual out-of-pocket maximum.

Other Services

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	**In-Network PPO-Copay**	**Minimum Coverage**	**Out-of-Network PPO-Deductible & PPO-Copay**
Tubal ligation or vasectomy (Reversals are not covered)	20% coinsurance	$20 copayment in physician's office; 10% coinsurance in hospital or free-standing surgical center	20% coinsurance	40% coinsurance
Infertility treatment, including in-vitro fertilization	You pay the full cost (not covered)	You pay the full cost (not covered)	You pay the full cost (not covered)	40% coinsurance
Radiation therapy and chemotherapy	20% coinsurance	No cost in physician's office; 10% coinsurance if billed by hospital	20% coinsurance	40% coinsurance
Kidney dialysis (If the dialysis continues more than 12 months, participant must apply for Medicare)	20% coinsurance	No cost in physician's office; 10% coinsurance in hospital or dialysis center	20% coinsurance	40% coinsurance

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Supplies, equipment, and durable medical equipment (DME)	20% coinsurance	No cost if rented or purchased from a network provider	20% coinsurance	40% coinsurance

Copayments do not apply toward the annual out-of-pocket maximum.

Mental Health and Chemical Dependency Care

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Inpatient mental health care	20% coinsurance (maximum of 30 days per year and 60 days per lifetime)	10% coinsurance for all hospital-based services	20% coinsurance (maximum of 30 days per year and 60 days per lifetime)	40% coinsurance (maximum of 30 days per year and 60 days per lifetime)
Alternative mental health care center	50% coinsurance (maximum of 30 days per year)	10% coinsurance for all hospital-based services	50% coinsurance (maximum of 30 days per year)	50% coinsurance (maximum of 30 days per year)
Outpatient mental health care	50% coinsurance (maximum of 50 days per year)	$20 copayment	50% coinsurance (maximum of 50 days per year)	50% coinsurance (maximum of 50 days per year)
Marriage counseling	You pay the full cost (not covered)	You pay the full cost (not covered)	You pay the full cost (not covered)	You pay the full cost (not covered)
Detoxification (see page 66)	20% coinsurance	10% coinsurance for all hospital-based services	20% coinsurance	40% coinsurance
Chemical dependency	No inpatient or outpatient chemical dependency rehabilitation is covered without prior approval from the Employee Assistance Program (EAP) or the AMR Medical Department. Only one rehabilitation, combined inpatient and outpatient, is covered during the entire time a person is covered by the Company-sponsored group health plan.			
Inpatient chemical dependency rehabilitation	20% coinsurance if approved by EAP ($5,000 maximum benefit)	10% coinsurance for all hospital-based services if approved by EAP	20% coinsurance if approved by EAP ($5,000 maximum benefit)	40% coinsurance if approved by EAP ($5,000 maximum benefit)
Outpatient chemical dependency rehabilitation	50% coinsurance if approved by EAP	$30 copayment per visit if approved by EAP (maximum payment of $300 per person per year)	50% coinsurance if approved by EAP	50% coinsurance if approved by EAP

Copayments and 50% coinsurance amounts do not apply toward the annual out-of-pocket maximum.

Prescription Medication

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	**In-Network PPO-Copay**	**Minimum Coverage**	**Out-of-Network PPO-Deductible & PPO-Copay**
Retail pharmacies (typically up to a 30-day supply); See page 70 for excluded expenses.	**Generic Drugs** • $10 for generic drugs **Brand Name Drugs** • When no generic drug is available, you pay 30% for brand name drugs purchased at participating network pharmacies, up to a maximum coinsurance amount of $75 per prescription • If a generic drug is available, and you choose a brand name drug, you pay the 50% for brand name drug			Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)
Mail service option (90-day supply) See page 70 for excluded expenses.	• **Generic Drugs:** You pay a $20 copayment per prescription or refill for generic drugs. If the cost of the drug is less than $20, you pay the actual prescription cost. • **Brand Name Drugs:** You pay 25% of the cost for brand name drugs, up to a $150 maximum per prescription or refill. These copayments apply to prescriptions (up to a 90-day supply) for treatment of chronic medical conditions, including psychotherapeutic prescriptions.			Not Applicable
Oral contraceptives	Not covered, unless prescribed as medically necessary treatment of a diagnosed illness or injury. (Oral contraceptives used for family planning or birth control are not covered but are offered at a discounted price (see page 70) through the mail service option).			You pay the full cost (not covered)
Fertility (infertility) Medications	Medications used to treat infertility or to promote fertility are never covered			
Over-the-counter medication (OTC)	Over-the-counter medications are not covered under the medical options; however, certain OTC medicines may be reimbursed through a Health Care Flexible Spending Account (see page 149).			

Copayments do not apply toward the annual out-of-pocket maximum.

Other Information

All services must be medically necessary.

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	**In-Network PPO-Copay**	**Minimum Coverage**	**Out-of-Network PPO-Deductible & PPO-Copay**
Pre-determination of benefits (see CheckFirst on page 55)	Call Health International for pre-authorization at 1-800-638-9599			

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Hospital pre-authorization (see QuickReview on page 56)	Call United HealthCare at 1-800-638-9599 for a form; complete and mail			

Deductibles/Maximum Medical Benefit

Features	Amount You Pay Under …			
	In-Network PPO-Deductible & Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Individual annual deductible	$150	None	$1,000	$500
Family annual deductible	$450	None	$2,000	Not Applicable
Individual annual out-of-pocket maximum[1]	$1,500 per person for services that require you to pay 10% coinsurance	$1,500 per person for services that require you to pay 10% coinsurance	$3,000	$4,000
Maximum Medical Benefit	$5,000,000 per employee and covered family member			

[1] Maximum does not include your annual deductible, expenses that are not covered or exceed the usual and prevailing fee limits, any copayments, or any expenses which are reimbursed at 50% (example: outpatient mental health care)

Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options

How the Medical Options Work

Only employees who do not have adequate access to PPO providers will have the Out-of-Area Coverage as an option. The PPO-Deductible Option provides different levels of benefits based on whether or not you use a network or out-of-network provider.

Under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, you are required to satisfy an annual deductible before the plan begins paying a percentage of the eligible, medically necessary expenses. The Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options allow you to use any qualified licensed physician. However, when you use a network provider under the Out-of-Area Coverage and Minimum Coverage Options, you save and the company saves. See page 49 for information regarding physicians, hospitals, and other medical service providers that have agreed to charge discounted fees for medical services.

After meeting the annual deductible under the Out-of-Area Coverage and Minimum Coverage Options and in-network under the PPO-Deductible Option, the plan pays 80% of most eligible expenses up to usual and prevailing fee limits for most medically necessary services. Your coinsurance is 20%. When using a non-network provider under the PPO-Deductible Option, the plan pays 60% of most eligible expenses up to usual and prevailing fee limits for most medically necessary services and your coinsurance is 40%. After you meet the annual out-of-pocket maximum, eligible medical services are covered at 100% for the remainder of the year. Outpatient mental health care is covered at 50% and does not count toward the annual out-of-pocket maximum.

For a detailed explanation of the eligible expenses and exclusions under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, see *Covered Expenses* on page 57 and *Excluded Expenses* on page 70.

Special Provisions

The Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options include the following special features:

Accidental Injury Benefit: If you and/or a covered dependent are injured in a non-work related accident, the plan pays 100% of the first $250 of hospital and physician charges per person each calendar year. Treatment must be received within 24 hours of the accident. After the first $250, you must satisfy the deductible.

If two or more members of your family are injured in the same accident, only one individual deductible applies to all injured family members for expenses in connection with that accident during the year in which the accident occurs. Individual annual deductibles (up to the family maximum) still apply to each person for expenses not related to the accident.

Deductibles: You pay an annual $150 per person deductible under the Out-of-Area Coverage option with a family deductible of $450. Under the PPO-Deductible option, you pay an annual $150 per person, $450 family deductible for network services and an annual $500 per person deductible for services received by out-of-network providers. Under the Minimum Coverage option, you pay an annual deductible of $1,000 per person or $2,000 per family.

Filing Claims: In most cases, when you use network providers they file claims for you.

Medical Discount Program: The medical options offer a voluntary preferred provider organization (PPO), which is a network of over 400,000 physicians, hospitals, and other medical service providers that have agreed to charge discounted fees for medical services. The Medical Discount Program helps save you and the Company money when you or a covered dependent needs medical care and chooses a participating provider.

This discount is automatic when you present your medical option ID card to a PPO provider, even if you are enrolled in the Out-of-Area Coverage Option. PPO network providers who contract with UnitedHealthcare agree to provide services and supplies at discounted rates. When you use a network provider, you are not responsible for the difference between the amount charged by the network provider and the amount allowed by their contractual agreement with UHC. Please keep in mind that some providers charge more than others for the same services. For this reason, using a participating provider may not always be the least expensive alternative. However, you will always receive a discount off that provider's normal fees.

In addition to the fee discounts from PPO providers, you receive another advantage. In most cases, you pay nothing to the physician at the time of service and the physician's office files your claim for you. You receive a bill for only the remaining amount that you are responsible for paying, such as your deductible or coinsurance amounts.

Contact UnitedHealthcare to learn more details about this Medical Discount Program feature or go to www.myuhc.com for a list of PPO providers in your area. Because these network providers may change, you should confirm that your physician is part of the network whenever you make an appointment.

Please keep in mind the following situations when using PPO providers:

- If you go to a PPO hospital but receive services from a physician who is not a PPO provider, you receive the PPO discount for hospital charges, but the physician's fee is not eligible for the discount.
- If you use a PPO physician or hospital, charges for your lab services may not be eligible for the PPO discount if your physician or hospital uses a lab that is not part of the PPO network.
- Whenever possible, be sure to check with your provider in advance to ensure you receive the maximum discount.

Preventive care: Under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, well-child care (for children up to age 2) and periodic mammograms are covered.

PPO-Copay Option

How the PPO-Copay Option Works

The PPO-Copay Option offers a network of physicians and hospitals that have agreed to provide medical services to participants at preferred rates. Check the location of network providers if you are considering enrolling in the PPO-Copay Option to be sure there are network providers near where you live or within a comfortable distance.

Under the PPO-Copay Option, you may decide whether to use network or out-of-network providers each and every time you need care. You also have the option of seeing any specialist physician without a referral. However, when you use network providers, you receive a higher level of benefits, called in-network benefits. If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact United Healthcare for approval to visit an out-of-network specialist. Provided you have obtained approval from United Healthcare, your out-of-network care will be covered at the network benefit level. If an approval is not obtained prior to the visit to the specialist, the visit will be covered out-of-network.

If you go to a provider who is not part of the network, you are still covered for eligible, medically necessary services, but at a lower level of benefits, called the out-of-network benefit level. At the out-of-network benefit level, you pay a deductible and higher out-of-pocket amounts. For most out-of-network services, the plan pays 60% and you pay the remaining 40% after you satisfy the $500 deductible.

Advantages of the PPO-Copay Option include:

- Access to network providers wherever UnitedHealthcare has a network location. For a list of network providers, visit www.provider.uhc.com/american to determine if your physician is in the network
- You can seek network specialist care without a referral from your Primary Care Physician (PCP); however, you are still encouraged to have a PCP coordinate all your medical needs
- Greater benefits and lower out-of-pocket costs when you use network providers.
- Covered preventive care from network providers.

If you live in a location where the PPO-Copay Option is offered, this option will be listed as an option in your Benefits Enrollment Center on *Jetnet*. Eligibility for the PPO-Copay Option is determined using UnitedHealthcare's standard access requirements based on your five-digit home ZIP code.

For a detailed explanation of the Eligible Expenses and exclusions under the PPO-Copay Option refer to the *Medical Options Benefit Comparison* section starting on page 40, *Covered Expenses* (see page 57) and *Excluded Expenses* (see page 70) sections of this Guide.

In this section, the PPO-Copay Option may also be referred to as the "Plan".

Network Services

You may use physicians and other service providers who are part of the network, or you may use providers who are not part of the network (out-of-network). However, when you use network providers, you receive a higher level of benefits, (network benefit level). At the network benefit level, you pay only a fixed copayment or coinsurance.

Network providers who contract with UnitedHealthcare agree to provide services and supplies at discounted rates. When you use a network provider, you are not responsible for the difference between the amount charged by the network provider and the amount allowed by their contractual agreement with UnitedHealthcare.

Out-of-Network Services

If you go to a provider who is not part of the network, you are still covered for eligible medically necessary services; however, coverage is at a lower level of benefits (out-of-network benefit level).

At the out-of-network benefit level, you pay an annual $500 per person per year deductible and higher out-of-pocket coinsurance amounts – for most services, the plan pays 60% and you pay the remaining 40% of covered out-of-network charges, after you satisfy the annual per person deductible. Each time you or your covered dependent needs medical care, you choose whether to use a network or out-of-network provider.

For additional information regarding deductibles, see *Special Provisions of PPO-Copay Option* on page 51.

Primary Care Physicians

PCPs practice in pediatrics, family practice, general practice, or internal medicine. You are encouraged to establish a relationship with a PCP.

Specialist Care

To receive the network benefit level for care from a specialist, you do not need a referral from your PCP, but you must use a network specialist, and services must be eligible under the terms of the Plan. To receive the network level of benefits for mental health services, you must contact United Behavioral Health (UBH).

If you need the care of a specialist and the network in your area does not offer providers in that specialty, you should contact your PCP or UnitedHealthcare to determine if a referral to an out-of-network specialist is needed. In these *rare* instances, your out-of-network care is covered at the network benefit level, but only with prior approval through United Healthcare.

After you have enrolled, you will receive a PPO-Copay Option ID card from UnitedHealthcare indicating that you and your covered dependents are covered by the Plan. The ID card includes important phone numbers and should be presented each time you go to a network physician, other provider, or hospital**.**

Special Provisions

The following are some of the important features of the PPO-Copay Option.

Care while traveling: If you have a medical emergency while traveling, get medical attention immediately. If you need urgent (not emergency) care, you should call UnitedHealthcare for a list of network providers and urgent care facilities. However, if it is after hours, seek treatment but call UnitedHealthcare within 48 hours. If you go to a network provider, you should only have to pay your copayment or coinsurance and your claim should be filed for you.

If you go to an out-of-network provider, you or a family member will need to call UnitedHealthcare within 48 hours of your care. You will need to submit a claim, but are eligible for the network level of benefits if you follow these procedures.

Continuing care: In the event you are newly enrolled in the PPO-Copay Option, and you or a covered family member has a serious illness, or you or your spouse are in the 20th (or later) week of pregnancy, you may ask UnitedHealthcare to evaluate your need for continuing care. You may be eligible to continue with your current care provider at the network benefit level, even if that provider is not part of the network. Contact UnitedHealthcare for more information.

Copayments vs. coinsurance: What you pay for eligible medical services depends on where you receive those services. At the network benefit level, you pay a fixed copayment for services such as physician office and specialist visits, including any tests or treatment received during that visit.

For services received in a network hospital-based setting, you pay a $150 copayment, and then you pay the 10% coinsurance (a percentage of the cost). For eligible out-of-network services, you must first satisfy a $500 annual per person deductible, and then you pay the higher out-of-network coinsurance amount.

Deductibles: For eligible out-of-network services (including but not limited to hospital-based services), you pay an annual $500 per person deductible.

Emergency care: If you have a medical emergency, go directly to an emergency facility. You or a family member must call Health International within 48 hours of your emergency care to be eligible for the network benefit level. You should arrange any follow-up treatment through your physician. If you receive services at an out-of-network facility, you will need to submit a claim.

Filing Claims: In most cases, when you use network providers, they file your claims for you.

Hospital out-of-pocket maximum: You pay 10% coinsurance for network hospital-based services up to an annual out-of-pocket maximum of $1,500 per covered person per year after you satisfy the $150 copayment per admission. The copayment does not apply to the network out-of-pocket maximum. Hospital-based services include: hospital facility charges, free-standing surgical facilities, physician charges, room and board, diagnostic testing, x-ray and lab fees, anesthesia, dialysis, chemotherapy, MRIs, and mammograms.

Copayments for network office visits, prescription drug copayments and coinsurance, out-of network deductibles, and non-hospital network coinsurance amounts do not apply to the annual out-of-pocket maximum.

Leaving the service area: With the exception of the annual enrollment period, the only other time you may change your election for coverage under the PPO-Copay Option is if you relocate out of your network service area.

If you move out of your PPO-Copay Option's network service area, you may either stay enrolled in the PPO-Copay Option(if available in your new location), select another medical plan available in your new location or, you may waive coverage. You must contact HR Employee Services to process a relocation Life Event within 60 days of the event. This allows you to update your records and make a new benefits coverage selection, if applicable. If you do not notify HR Employee Services of your election, you will be automatically enrolled in a plan offered in your new location.

Network administrator: UnitedHealthcare establishes standards for participating providers, including physicians, hospitals, and other service providers. They carefully screen providers and verify their medical licenses, board certifications, hospital admitting privileges, and medical practice records. They also periodically monitor whether participating providers continue to meet network standards. The network administrator performs all these selection and accreditation activities.

However, when you use network providers, you receive a higher level of benefits, called in-network benefits.

Preventive care: You and each covered family member are eligible to receive benefits for annual routine physical exams, well-woman exams, and well-child exams provided by your network PCP or a network obstetrician/gynecologist.

Special health programs: In addition to the coverage available to all PPO-Copay Option participants, many of the network locations offer special programs. Although these programs may vary by network location, examples of special programs include prenatal, diabetes, and asthma programs. Not all of these are available in each network. Call UnitedHealthcare for information.

Urgent care: If you are in your network service area and need urgent care, but you do not have an actual emergency, contact United Healthcare first and they will direct you to an appropriate place for care. You are eligible for the network benefit level if you follow these procedures.

Health Maintenance Organizations (HMOs)

Overview

HMOs are insured programs whose covered services are paid by the HMO. The Triple S and Humana Health Maintenance Organizations (HMO) are currently offered only to employees living in Puerto Rico.

HMOs include a network of physicians, hospitals, and other medical service providers. Your medical care is only covered when you use network providers. When you enroll in an HMO, a primary care physician (PCP) usually coordinates your medical care. Most HMOs require you to obtain a referral from your PCP before receiving care from a specialist.

Features of HMOs include:

- A network of providers
- A primary care physician who coordinates your covered medical care
- Low copayments for covered services
- Covered preventive care
- No claims to file

If you elect an HMO, your HMO coverage replaces medical coverage offered through the Out-of-Area Coverage, Minimum Coverage PPO-Deductible and PPO-Copay Options. Your benefits, including prescription drugs from physicians and dentists, as well as mental health care, are covered according to the rules of the HMO you select. For example, some HMOs do not cover dental prescriptions.

Under most HMOs, chemical dependency rehabilitation for HMO participants will be coordinated by the Employee Assistance Program (EAP), and will be covered as described in *Covered Medical Expenses* on page 57. However, some HMOs provide their own chemical dependency rehabilitation programs to comply with state insurance laws. Detoxification is covered under the HMO.

HMOs provide their members with comprehensive health care services for a fixed monthly payment.

HMOs offered through the benefit program are completely independent of the Company. Because each HMO is an independent organization, the benefits, restrictions, and conditions of coverage vary from one HMO to another and the Company cannot influence or dictate the coverage provided.

Domestic Partners are not eligible to participate in HMOs.

Benefits

If you enroll in an HMO, you will receive information from the HMO describing the services and exclusions of that HMO. Review that material carefully. Benefits provided by the HMO often differ from benefits provided under the other medical plans offered by the Company.

Most of your other elections are not affected by your decision to participate in an HMO. However, if you enroll in the Supplemental Medical Plan, benefits under that plan will only be available to you if you later switch to the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible, or PPO-Copay Options. If you elect the Supplemental Medical Plan while enrolled in an HMO, your covered spouse will be eligible for coverage in the event of your death.

HMO Contact Information

HMO Name	HMO Customer Service Phone No.	Web Site Address	Group Numbers
Humana Puerto Rico	(787) 282-7900 ext. 5500	www.pr.humana.com	3262
TRIPLE-S, Inc – Puerto Rico	(787) 749-4777	www.ssspr.com	1-08500

Additional Rules for HMOs

Problems and Complaints

Each HMO has a grievance procedure or policy to appeal claim denials or other issues involving the HMO. Call your HMO for information on filing complaints or grievances.

If You and Your Spouse Work for the Company

If you and your spouse enroll in the same HMO, the entire family unit is covered in the male employee's name because of HMO administrative procedures. If the male spouse takes a Leave of Absence (LOA), coverage for the entire family unit is transferred to the female spouse for the duration of the leave. Domestic Partners are not eligible for HMO coverage.

Children Living Outside the Service Area

If your child does not live with you, either because the child is a student or because you are providing the child's coverage under a Qualified Medical Child Support Order (QMCSO) (see page 74), you must contact the HMO to find out whether the child can be covered. If the HMO cannot cover the child, you may be required to select one of the other medical options.

Termination of Coverage

Your HMO coverage terminates on the date your employment terminates or you move out of the HMO service area. If your employment terminates, you may be eligible to continue HMO coverage under COBRA. You may also apply for individual HMO coverage.

Following is special information about termination of coverage that applies to HMOs:

- **Leaving the service area:** With the exception of the annual enrollment period, the only other time you may change your election for HMO coverage is if you move out of the HMO's service area.
- If you move out of your HMO's service area, you may register this move as a Life Event on *Jetnet*, and enroll in Eagle medical option offered for your new area. To make another election following your move, call HR Employee Services at 800-447-2000 within 60 days of your move. If you do not notify HR Employee Services of your election, you will be enrolled in a medical option offered in your new area and will receive a confirmation statement indicating your new coverage.

- **Active employees over age 65:** If you or your covered spouse reaches age 65 and becomes eligible for Medicare while covered under an HMO, most HMOs allow you to continue coverage. Coordination of benefits applies. The HMO is primary and Medicare is secondary (as explained in Coordination of Benefits) as long as you are an active employee.

CheckFirst (Pre-Determination of Benefits)

If you are covered by the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or the PPO-Copay Option, CheckFirst allows you to find out if:

- The recommended service or treatment is covered by the your selected Medical Option
- Your physician's proposed charges fall within the Plan's usual and prevailing fee limits.

If you are covered by the PPO-Deductible or the PPO-Copay Option and you are using a PPO provider, the provider's fees will always be within the usual and prevailing fee limits. However, you may want to contact UnitedHealthcare at the appropriate CheckFirst number for your medical option to determine if the proposed services are covered under your selected Medical Option.

To use CheckFirst, you may either submit a *CheckFirst Pre-determination of Medical Benefits form* (available on *Jetnet*) to UnitedHealthcare before your proposed treatment, or you may call UnitedHealthcare to obtain a pre-determination of benefits by phone or to request the pre-determination form. If you are having outpatient surgery, UnitedHealthcare will coordinate with Health International (as part of the QuickReview for Hospital Pre-authorization process) to determine the medical necessity of your proposed surgery before making a pre-determination of benefits. Both UnitedHealthcare and Health International will mail you a written response.

Before calling CheckFirst, or completing the *CheckFirst Pre-determination of Medical Benefits form*, you will need the following information from your physician:

- Diagnosis
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician's name and office ZIP code
- Name and ZIP code of the hospital or clinic where surgery is scheduled.

Even if you use CheckFirst, UnitedHealthcare reserves the right to make adjustments upon receipt of your claim if the actual treatment or cost is different than the information submitted for predetermination of benefits.

For hospital stays, CheckFirst can predetermine the amount payable by the Plan. A CheckFirst pre-determination does not pre-authorize the length of a hospital stay or determine medical necessity. You must call Health International for pre-authorization (see QuickReview on page 56 for hospital pre-authorization).

Although you may find CheckFirst beneficial whenever you need medical treatment, there are two circumstances when you may especially benefit by using CheckFirst. Use this predetermination procedure if your *physician* recommends either of the following:

- **Assistant surgeon**: A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if there is a medical necessity, you must use the CheckFirst procedure.
- **Multiple surgical procedures:** If you are having multiple surgical procedures performed at the same time, any procedure that is not the primary reason for surgery is covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgery. You must use CheckFirst to find out how the Plan reimburses the cost for any additional procedures.

If you are enrolled in the Supplemental Medical Plan, see page 103 for additional information about CheckFirst.

QuickReview (Pre-Authorization)

Regardless of which medical plan you are enrolled in, you or your provider acting on your behalf are required to request pre-authorization (QuickReview) before any hospital admission, or within 48 hours (or the next business day if admitted on a weekend) following emergency care. If you do not use QuickReview, your expenses are still subject to review and will not be covered under the Plan if they are considered not medically necessary.

If you are covered by an HMO: Contact the HMO for any hospitalization.

When to Request a QuickReview

Any portion of a stay that has not been approved through the QuickReview process is considered not medically necessary and will not be covered. For example, if QuickReview determines that five hospital days are medically necessary for your condition and you stay in the hospital seven days, charges for the extra two days will not be covered. Your physician should contact QuickReview to request pre-authorization for approval of any additional hospital days.

Call for a QuickReview in the following situations:

- Before you are admitted to the hospital for an illness, injury, surgical procedure, or pregnancy
- Within 48 hours after an emergency hospital admission (or the next business day if you are admitted on a weekend)
- Before outpatient surgery to ensure that the surgery is considered medically necessary
- During the first 16 weeks of pregnancy to participate in your medical option’s healthy pregnancy program.
- Before you undergo testing or treatment for sleep disorders
- Before you contemplate or undergo any organ transplant.

If your physician recommends surgery or hospitalization ask your physician for the following information:

- Diagnosis and diagnosis code
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician’s name and telephone number

- Name and telephone number of the hospital or clinic where surgery is scheduled.

If your illness or injury prevents you from personally contacting QuickReview, any of the following may call on your behalf:

- A family member or friend
- Your physician
- The hospital

QuickReview will tell you:

- Whether the proposed treatment is considered medically necessary and appropriate for your condition
- The number of approved days of hospitalization
- In some cases, QuickReview may refer you for a consultation before surgery or hospitalization will be authorized. To avoid any delays in surgery or hospitalization, notify QuickReview as far in advance as possible

If you receive pre-authorization of a hospital stay over the phone, ask for written confirmation of the pre-authorization. QuickReview does not determine whether you are eligible for benefits under the Plan or how much you will be reimbursed. For information on eligibility or coverage, contact UnitedHealthcare at the appropriate CheckFirst number.

After you are admitted to the hospital, the QuickReview program provides case management services to monitor your stay. If you are not discharged from the hospital within the authorized number of days, Health International consults with your physician and hospital to verify the need for any extension of your stay. If you are discharged from the hospital and then readmitted or transferred to another hospital for treatment of the same illness you must contact QuickReview again to authorize any additional hospitalization.

If you are scheduled for outpatient surgery, you should call Health International. If you do not call, you may be subject to a retrospective review of the surgery to determine whether it was medically necessary. This means you or your physician may be asked to provide medical documentation to support the medical necessity of your surgery before any claim will be paid.

The QuickReview program does not guarantee that benefits will be paid. QuickReview reserves the right to make adjustments upon receipt of the final claim papers if the actual service differs from the pre-authorization information that was submitted.

If you are enrolled in the Supplemental Medical Plan, see page 101 for additional information about QuickReview.

Covered Expenses

This section contains descriptions of the eligible medical expenses (listed alphabetically) that are covered under the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options when medically necessary. Benefits for some of these eligible expenses vary depending on the medical option you have selected and whether or not you use network providers. The Medical Benefit Comparison tables starting on page 40 demonstrate how most services are covered.

For a list of items that are excluded from coverage, refer to the *Excluded Expenses* section of this Guide (see page 70).

Acupuncture: Medically necessary treatment for illness or injury when performed by a Certified Acupuncturist.

Allergy care: Charges for medically necessary physician's office visits, allergy testing, shots, and serum are covered. (See *Exclusions* for allergy care not covered under the Plan).

Ambulance: Medically necessary professional ambulance services and air ambulance once per illness or injury to and from:

- The nearest hospital qualified to provide necessary treatment in the event of an emergency
- The nearest hospital or convalescent or skilled nursing facility for inpatient care

Air ambulance services are covered when medically necessary services cannot be safely and adequately performed in a local facility and the patient's medical condition requires immediate medical attention for which ground ambulance services might compromise the patient's life. Ambulance services are only covered in an emergency and only when care is required en route to or from the hospital.

Ancillary charges: Ancillary charges including charges for hospital services, supplies, and operating room use.

Anesthesia expenses: Anesthetics and administration of anesthetics. Expenses are not covered for an anesthesiologist to remain available when not directly attending to the care of a patient.

Assistant surgeon: The Medical Options only cover assistant surgeon's fees when the procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst pre-determination procedure.

Blood: Coverage includes blood, blood plasma, and expanders. Benefits are paid only to the extent there is an actual expense to the participant.

Chiropractic care: Under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, coverage includes medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license. Under the PPO-Copay Option, you are limited to 20 visits per year for combined network and out-of-network chiropractic care.

Convalescent or skilled nursing facilities: Under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options, these facilities are covered at 50% of the most common semi-private room rate in that geographic area for inpatient hospital expenses for up to 60 days per illness (for the same or related causes) after you are discharged from the hospital for a covered inpatient hospital confinement of at least three consecutive days. Under the PPO-Copay Option, these facilities are covered the same as hospitalization, except there is a combined maximum stay of 60 days per illness or injury for network and out-of-network facilities.

To be eligible, the confinement in a convalescent or skilled nursing facility must begin within 15 days after release from the hospital and be recommended by your physician for the condition which caused the hospitalization.

Eligible Expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility, are under the continuous care of a physician, and require 24-hour nursing care. Your physician must certify that this confinement is an alternative to a hospital confinement, and, Health International must approve your stay. Custodial Care is not covered.

Cosmetic surgery: Medically necessary expenses for cosmetic surgery, are only if they are incurred under either of the following conditions:

- As a result of a non-work related injury
- For replacement of diseased tissue surgically removed.

Other cosmetic surgery is not covered because it is not medically necessary.

Dental care: Dental expenses for medically necessary dental examination, diagnosis, care, and treatment of one or more teeth, the tissue around them, the alveolar process, or the gums, only when care is rendered for:

  - Accidental injury(ies) to sound natural teeth, in which both the cause and the result accidental, due to an outside and unforeseen traumatic force
  - Fractures and/or dislocations of the jaw
  - Cutting procedures in the mouth (this does not include extractions, dental implants, repair or care of the teeth and gums, etc., unless required as the result of accidental injury (as set forth in the first bullet under Dental Care above).

Detoxification: Detoxification, covered as a medical condition when alcohol and drug addiction problems are sufficiently severe to require immediate inpatient medical and nursing care services. Contact QuickReview for authorization.

Dietician services: Under the PPO-Copay Option, coverage includes services recommended by your network provider and provided by a licensed network dietician. Dietician services are not covered under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options.

Durable medical equipment (DME): Reimbursement for the rental of DME is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the purchase of such items instead of rental. Replacement of DME is covered only when medically necessary for a change in a patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of DME resulting from normal wear and tear is not covered.

Coverage includes the initial purchase of eyeglasses or contact lenses required because of cataract surgery.

Emergency room: Charges for services and supplies provided by a hospital emergency room to treat medical emergencies. You must call QuickReview within 48 hours of an emergency resulting in admission to the hospital.

Facility charges: Charges for the use of an outpatient surgical facility, when the facility is either an outpatient surgical center affiliated with a hospital or a free-standing surgical facility.

Hearing care: Covered expenses include medically necessary hearing exams and up to one hearing aid for each ear per year. Coverage for hearing aids is limited to basic hearing aids. Cochlear implants are covered if medically necessary.

Hemodialysis: Removal of certain elements from the blood through selective diffusion for treatment of kidney failure.

Home health care: Home health care, when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. Custodial care is not covered.

You should call QuickReview to be sure home health care is considered medically necessary.

Hospice care: Eligible Expenses medically necessary for the care and treatment of a terminally ill covered person. Expenses in connection with hospice care include both facility and outpatient care. Hospice care is covered when approved by QuickReview.

Inpatient room and board expenses: Under the Out-of-Area Coverage and Minimum Coverage Options, hospital room and board charges are covered at 80% up to the most common semi-private room rate in that geographic area plus $4.00. If the hospital does not have semi-private rooms, the Plan considers the eligible expense to be 90% of the hospital's lowest private room rate plus $4.00. The PPO-Deductible and PPO-Copay Options pay based on the negotiated rates with that particular network hospital.

Intensive care, coronary care, or special care units (including isolation units): Coverage includes room and board and medically necessary services and supplies.

Mammograms: Medically necessary diagnostic mammograms, regardless of age.

Coverage under the Out-of-Area Coverage, Minimum Coverage and out-of-network under the PPO-Deductible and PPO-Copay Options for routine mammograms for female employees and female dependents is based on the following guidelines:

- Once between ages 35 and 39 to serve as a baseline against which future mammograms will be compared
- Once every one to two years from ages 40 to 49 as recommended by your physician
- Once every year beginning at age 50.

Under the PPO-Deductible and PPO-Copay Options network coverage, mammograms are covered if ordered by a network provider.

Mastectomy: Certain reconstructive and related services are covered following a medically-necessary mastectomy, including:

- Reconstruction of the breast on which surgery was performed
- Reconstruction of the other breast to produce symmetrical appearance
- Prostheses
- Services in connection with complications resulting from a mastectomy, including lymphedemas.

Medical supplies: Covered medical supplies include, but are not limited to:

- Oxygen, blood, and plasma
- Sterile items including sterile surgical trays, gloves, and dressings
- Needles and syringes
- Colostomy bags
- The initial purchase of eyeglasses or contact lenses required because of cataract surgery

Non-sterile or disposable supplies such as Band-Aids and cotton swabs are not covered.

Multiple surgical procedures: Out-of-Area Coverage, Minimum Coverage and out-of-network under the PPO-Deductible and PPO-Copay Options, reimbursement for multiple surgical procedures is at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage, and to be sure the charges are within the usual and prevailing fee limits, use the CheckFirst pre-determination program. The PPO-Deductible and PPO-Copay Options pay benefits based on the negotiated rate with the participating network surgeon.

Newborn nursery care: Hospital expenses for a healthy newborn baby are considered under the baby's coverage, not the mother's.

To enroll your newborn baby in your health benefits, you must process a Life Event change within 60 days of the birth. The filing or payment of a maternity claim does not automatically enroll the baby.

> You can process most Life Event changes online through *Jetnet*. Visit the Life Events landing page and follow the prompts to process your Life Event.

Nursing care: Coverage includes Medically necessary private duty care by a licensed nurse, if it is of a type or nature not normally furnished by hospital floor nurses.

Oral surgery: Hospital charges in connection with oral surgery involving teeth, gums, or the alveolar process, only if it is medically necessary to perform oral surgery in a hospital setting rather than in a dentist's office. If medically necessary, the medical option will pay room and board, anesthesia, and miscellaneous hospital charges. Oral surgeons' and dentists' fees are not covered under the medical options. However, they may be covered under the Dental Benefit.

Outpatient surgery: Charges for services and supplies for a medically necessary surgical procedure performed on an outpatient basis at a hospital, freestanding surgical facility, or physician's office. You should pre-authorize the surgery through QuickReview to ensure the procedure is medically necessary.

Physical or occupational therapy: Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist when ordered by a physician

Physician's services: Office visits and other medical care, treatment, surgical procedures, and post-operative care for medically necessary diagnosis or treatment of an illness or injury. The Medical Options cover office visits for certain preventive care, as explained under *Preventive Care*.

Pregnancy: Charges in connection with pregnancy, only for female employees and female spouses of male employees. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed, or certified by the state in which he or she practices.

Within the first 16 weeks of pregnancy, you should call QuickReview to pre-authorize your hospitalization and take advantage of the healthy pregnancy program your plan offers.

Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority. Prescription prenatal vitamin supplements are covered. Federal law prohibits the plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a cesarean delivery, or from requiring your provider to obtain pre-authorization for a longer stay. However, federal law does not require you to stay any certain length of time. If, after consulting with your physician, you decide on a shorter stay, benefits will be based on your actual length of stay.

Charges in connection with pregnancy for covered dependent children are covered only if due to certain complications of pregnancy, for example: ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Prescription drugs: Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition.

See page 66 for details of the prescription drug benefit. Prescriptions related to infertility treatment, weight control, and oral contraceptives (used for family planning or birth control) are not covered. See *Excluded Expenses* on page 70 for additional information regarding drugs that are excluded from coverage.

Medically necessary medications are also covered for the following special situations:

- Medications administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit.
- Medications which are to be taken or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital, or similar institution which operates an on-premises pharmacy are covered as part of the facility's ancillary charges.

Certain types of medicines and drugs that are not covered by the medical benefits may be reimbursed under the Health Care Flexible Spending Accounts (HCFSAs) (see page 149).

Preventive care: The PPO-Copay Option covers preventive care, including well-child care, immunizations, mammograms, pap smears, male health screenings, and annual routine physical exams for participants of all ages when you use network providers. Non-routine tests for certification, sports, or insurance are not covered unless medically necessary. Preventive care covered under the Out-of-Area Coverage, Minimum Coverage and out-of-network under the PPO-Deductible and PPO-Copay Options includes mammograms (see Mammograms in this section for guidelines) and well-child care for children up to age 2 (including initial hospitalization following birth, all immunizations, and up to seven well-child care visits).

Prostheses: Prostheses (such as a leg, foot, arm, hand, or breast) necessary because of illness, injury, or surgery. Replacement of a prosthesis is only covered when medically necessary because of a change in the patient's condition (improvement or deterioration) or due to the natural growth of a child. Replacement of a prosthesis resulting from normal wear and tear is not covered.

Radiology (x-ray) and laboratory expenses: Examination and treatment by x-ray, radium, or other radioactive substances, diagnostic laboratory tests, and annual mammography screenings for women (see Mammograms for guidelines). Please note that under the PPO-Deductible and PPO-Copay Options, your network coverage depends on whether the care is received in a hospital-based setting or a physician's office or laboratory facility. (See copayment vs. coinsurance for details on page 52.)

Reconstructive surgery: Surgery following an illness or injury, including contralateral reconstruction to correct asymmetry of bilateral body parts, such as breasts or ears.

Under the Women's Health and Cancer Rights Act, covered reconstructive services include:

- Reconstruction of the breast on which a mastectomy was performed
- Surgery or reconstruction of the other breast to produce a symmetrical appearance
- Services in connection with other complications resulting from a mastectomy, such as lymphedemas

- Prostheses

Speech therapy: Restorative and rehabilitative care and treatment for loss or impairment of speech when the treatment is medically necessary because of an illness (other than a mental, psychoneurotic, or personality disorder), injury, or surgery. If the loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must be performed before the therapy.

Surgery: When medically necessary and performed in a hospital, free-standing surgical facility, or physician's office. (See QuickReview on page 56 and CheckFirst on page 55 for details about hospital pre-authorization and pre-determination of benefits.)

Temporomandibular joint dysfunction (TMJD): Eligible Expenses under the medical benefits include only the following, if medically necessary:

- Injection of the joints
- Bone resection
- Application of splints, arch bars, or bite blocks if their only purpose is joint stabilization and not orthodontic correction of a malocclusion
- Manipulation or heat therapy.

Crowns, bridges, or orthodontic procedures for treatment of TMJD are not covered.

Transplants: Expenses for transplants or replacement of tissue or organs if they are medically necessary and not experimental, investigational, or unproven services. Benefits are payable for natural or artificial replacement materials or devices.

Donor and recipient coverage is as follows:

- If the donor and recipient are both covered under the Plan, expenses for both individuals are covered by the Plan
- If the donor is not covered under the Plan and the recipient is covered, the donor's expenses are covered to the extent they are not covered under any other medical plan, and only if they are submitted as part of the recipient's claim.
- If the donor is covered under the Plan but the recipient is not covered under the Plan, no expenses are covered for the donor or the recipient

The total benefit paid under this Plan for the donor's and recipient's expenses will not be more than any Plan maximums applicable to the recipient.

You may arrange to have the transplant at a network transplant facility rather than a local network hospital. Although using a network transplant facility is not required, these centers specialize in transplant surgery and may have the most experience, the leading techniques, and a highly qualified staff.

It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria—not all transplant situations will be eligible for benefits. Therefore, you **must** contact QuickReview as soon as possible for pre-authorization **before** contemplating or undergoing a proposed transplant. The following transplants are covered if they are medically necessary for the diagnosed condition and are not experimental, investigational, unproven, or otherwise excluded from coverage under the Medical Options, as determined in the sole discretion of the Plan Administrator and its delegate, the claims processor:

- Artery or vein
- Bone
- Bone Marrow or stem cell

- Cornea
- Heart
- Heart and Lung
- Heart valve replacements
- Implantable prosthetic lenses in connection with cataract surgery
- Intestine
- Kidney
- Kidney and Pancreas
- Liver
- Liver and Kidney
- Liver and Intestine
- Pancreas
- Pancreatic islet cell (allogenic or autologous)
- Prosthetic bypass or replacement vessels
- Skin

Transportation expenses: Regularly scheduled commercial transportation by train or plane, when necessary for your emergency travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip ticket is covered for any illness or injury and will be covered only if medical attention is required en route. For information on ambulance services, see Ambulance in this section.

Tubal ligation and vasectomy: These procedures are covered; however, reversal of these procedures is not covered.

Urgent care: Charges for services and supplies provided at an urgent care clinic are covered. You should contact your network provider or UnitedHealthcare for authorization before seeking care at an urgent care clinic, or if you are traveling and need urgent medical care. If the UnitedHealthcare offices are closed, seek treatment and then call UnitedHealthcare within 48 hours to ensure that you receive the network level of benefits.

Well-child care: Under the Out-of-Area Coverage, Minimum Coverage and out-of-network coverage under the PPO-Deductible and PPO-Copay Options, children up to age two are covered for initial hospitalization following birth, all immunizations, and up to seven well-child care visits. There is no age limitation when you use network providers under the PPO-Deductible and PPO-Copay Options.

Wigs and hairpieces: Active employees and eligible dependents are covered up to a $350 lifetime maximum for an initial synthetic wig or hairpiece, if purchased within six months of hair loss. The wig must be prescribed by a physician for a covered medical condition causing hair loss. These conditions include, but are not limited to: chemotherapy, radiation therapy, alopecia areata, endocrine disorders, metabolic disorders, cranial surgery, or severe burns. This benefit is subject to the usual and prevailing fee limits, deductibles, copayments, coinsurance, and out-of-pocket limits of the selected medical option.

Replacement wigs or hairpieces are not covered, regardless of any change in the patient's physical condition. Hair transplants, styling, shampoo, and accessories are also excluded.

Mental Health and Chemical Dependency Benefits

In addition to covered medical expenses, the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options cover the following medically necessary mental health and chemical dependency care:

Mental Health Care

Covered expenses include medically necessary inpatient care (in a psychiatric hospital, acute care hospital, or an alternative mental health care center) and outpatient care for a mental health disorder.

Inpatient mental health care: When you are hospitalized in a psychiatric hospital for a mental health disorder, expenses during the period of hospitalization are covered the same as inpatient hospital expenses (see inpatient room and board expenses under *Covered Expenses*), up to Plan maximums.

If you are covered by the PPO-Copay Option and use out-of-network providers for mental health care, your benefits are limited to 30 days of inpatient confinement per calendar year.

Alternative mental health care center: Treatment in an alternative mental health care center is covered at 50% under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options and out-of-network under the PPO-Copay Option. Under the PPO-Copay Option, such treatment is covered at 90% when using network providers. A day of treatment is defined as not more than eight (8) hours in a 24-hour period. This may also be referred to as alternative hospitalization.

Outpatient mental health care: Expenses for outpatient mental health care are covered at 50% under the Out-of-Area Coverage, Minimum Coverage and PPO-Deductible Options and out-of-network under the PPO-Copay Option. The 50% coinsurance for outpatient mental health care is not included in the annual out-of-pocket maximum. Out-of-network benefits under the PPO-Copay Option for outpatient mental health care are limited to 60 visits per year.

For outpatient mental health care through a network provider under the PPO-Copay Option, the copayment is $30 per visit. Psychotherapeutic drugs purchased at a network pharmacy are covered the same as any other prescription drug.

Chemical Dependency Care

Chemical dependency rehabilitation: Covered chemical dependency rehabilitation expenses for treatment of drug or alcohol dependency can be inpatient, outpatient, or a combination. You and your covered dependents are each covered for one chemical dependency rehabilitation program during the entire time you are covered by the Plan (regardless of whether the program is inpatient or outpatient). The Plan does not cover expenses for a family member to accompany the patient being treated, although many chemical dependency treatment centers include family care at no additional cost.

To be eligible for reimbursement under the Plan, the chemical dependency rehabilitation program must be approved in advance by the AMR Employee Assistance Program (EAP) at 800-555-8810 or the AMR Medical Department and be considered medically necessary. Your treatment will not be covered without this advance approval.

Detoxification: Chemical dependency rehabilitation does not include detoxification. Detoxification is considered a medical procedure and is reimbursed under the Plan's regular medical provisions. However, the following provisions apply:

- You must call Health International for approval (QuickReview) of detoxification.
- To receive the network benefit level under the PPO-Deductible or PPO-Copay Option, detoxification treatment must be approved by Health International within 48 hours of admission for detoxification.
- If you are covered by the PPO-Deductible or PPO-Copay Option and you do not receive Health International approval for detoxification, coverage is provided at the out-of-network benefit level, even if you use a network facility.

Prescription Drug Benefits

The prescription drug program for the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options is administered by Medco Health. Drugs prescribed by a physician or dentist may be purchased either at retail pharmacies or through the Mail Service prescription drug option.

For information on drugs that are covered, see *Covered Expenses* on page 62. For drugs that are excluded, refer to the *Exclusions* section on page 70.

Prescription drug coverage under an HMO is administered by the individual HMO.

Retail Drug Coverage

As a medical plan participant, you may have your prescriptions filled at any pharmacy. However, if you present your Medco ID card at a network pharmacy, you will have access to negotiated discount prices. The prescription drug program administered by Medco, has over 51,000 network pharmacies throughout the United States, Puerto Rico, and the U.S. Virgin Islands. The network includes nine out of ten retail pharmacies nationwide.

When you use network pharmacies, you pay $10 for generic drugs or 30% of the cost for brand name drugs (up to a maximum of $75 if no generic is available), or 50% of the cost of a brand drug when there is a generic available, for up to a 30-day supply of any medically-necessary covered prescription, including psychotherapeutics.

To request a list of participating pharmacy chains, call Medco at 800-988-4125 or visit their Website at www.medco.com.

Filling Prescriptions

Follow these steps to fill prescriptions at a network pharmacy and file for reimbursement:

- Present your Medco ID card to the pharmacy when you order your prescription from a network pharmacy.
- Pay the discounted price for the prescription and obtain a receipt when you pick up your prescription.
- File a claim for reimbursement of your covered expenses through Medco as explained in Filing Claims.

If you fill your prescription at an out-of-network pharmacy, you will follow the same procedures, but will not receive a discount. You pay the full retail price for your prescription and file the claim in the same manner.

Medco reports the claim to UnitedHealthcare (the claims processor). UnitedHealthcare then mails you an Explanation of Benefits (EOB) and applicable payment, advising you of the total charges you submitted, any amounts not covered and the reason, and the amounts eligible and paid under the medical plan.

If you elected to participate in the Health Care Flexible Spending Account (see page 147), your retail drug out-of-pocket expense is eligible for reimbursement.

If you have questions concerning this program, call the Medco Member Services number on your Medco ID card. If you have questions about the benefit amount paid, call UnitedHealthcare.

Claim Filing Deadline

You must submit all health claims, including prescription drug claims, within two years of the date expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment. Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency under the HHS may file claims for a claim under the Medicare Secondary Payer Statute within the 36 months of the date on which the expense was incurred.

Prior Authorization

To be eligible for benefits, certain covered prescriptions require prior authorization by Medco to determine medical necessity before you can obtain them at a participating pharmacy or through the mail service option. Medications requiring prior authorization include (but are not limited to) the following:

- Growth hormones
- Drugs prescribed for the treatment of impotence
- Contraceptives for medical conditions

When you fill your prescription, Medco will send a message instructing your pharmacist to call Medco. A Medco pharmacist will then contact your physician to review the request for approval. Medco sends both you and your physician a letter about the authorization review. If authorization is approved, the system automatically allows refills for the original approved time up to one year. In the event a pharmacy does not fill a prescription, the pharmacy's denial shall not be treated as a claim for benefits, instead you must file a claim with the Claims Administrator for the medication to initiate the benefit claim and appeal procedures under the medical benefits option.

Prior authorizations must be renewed each year and must be initiated by the employee. When the renewal date approaches, you should contact Medco for renewal instructions.

To request prior authorization, ask your physician to write a letter on his or her letterhead to Medco. Your physician should provide the following information:

- The name of the drug, strength, and supply being prescribed
- The medical condition for which the drug is being prescribed
- The proposed treatment plan
- Any other information your physician believes is pertinent

Medco will advise you whether your prior authorization is approved or denied. If it is denied, they will explain the reason for denial.

Mail Service Prescription Drug Option

As a participant in the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, you and your covered dependents are eligible for the Mail Service Prescription Drug Option offered through Medco. You may use the mail service option to order prescription drugs you take on an ongoing basis to treat chronic medical conditions such as allergies, arthritis, diabetes, emphysema, heart disease, high blood pressure, thyroid disease, and ulcers. You may also purchase injectable drugs that are approved by the Food and Drug Administration (FDA) for self-administration.

Under the Mail Service Prescription Drug Option, you may order up to a 90-day supply of your prescription drug (but no more than the number of days prescribed by your physician). You pay a copayment (with no annual deductible) for each prescription or refill. Copayments, which are subject to change, are currently:

- **Generic Drugs:** $20 per prescription or refill for generic drugs (or the actual cost of the drug, if the prescription cost is less than $20).
- **Brand Name Drugs:** 25% of the cost of the drug, up to a $150 maximum per prescription or refill.

Although non-medically necessary oral contraceptives (for family planning or birth control) are not covered by the Medical Benefit Options, you and your covered dependents may purchase oral contraceptives through the mail service program at 100% of the discounted price. A registered pharmacist fills your prescription. Generally, your order is shipped within three working days of receipt. All orders are sent by United Parcel Service (UPS) or first class mail. UPS delivers to rural route boxes but not to post office (P.O.) boxes. If you have only a P.O. Box address, your order is sent by first class mail.

You may use the mail service program to fill prescriptions for treatment of mental health conditions. You pay 50% of the discounted rates for these drugs. You should compare the cost of a 90-day supply of psychotherapeutic drugs though the mail service program to the cost of copayments for three 30-day supplies from a retail pharmacy to determine which will cost you less.

Generic Drugs

Many drugs are available in generic form. Your prescription will be substituted with a generic when available and your physician considers it appropriate. A-rated generic drugs are used because they generally cost less and have the same therapeutic effect and active ingredients as their brand equivalents. By using A-rated generic drugs, you save money for yourself and the Company. If a brand name drug is not specified, your prescription may be filled with the generic. (This applies, even if your doctor writes the prescription for a brand name drug.)

Ordering Mail Service Prescriptions

Initial order: To place your first order for a prescription through the mail service option, follow these steps:

- Provide the information requested on the back of your mail service order envelope, and complete and enclose the patient profile form found in your initial packet from Medco. (The profile will not be necessary on refills or future orders unless your health changes significantly.)
- Insert the original written prescription signed by your physician.

- If the prescription is for a non-medically necessary oral contraceptive, or you elect to take a brand name drug when a generic is available, call Medco or visit the Medco website to find out how much you must pay for the prescription.
- Indicate the desired method of payment on the mail service order envelope. You may charge your payment to a major credit card (MasterCard, VISA, or Discover) or pay by personal check or money order. If paying by check or money order, enclose your payment with the order. Do not send cash.
- Mail your order to the address on the order envelope

You may request a mail order envelope on *Jetnet* under the **Benefits and Pay** tab (click on **Forms**), or you may contact Medco at 800-988-4125 to request an envelope.

Internet Refill Option

The Internet gives you access to Medco 24 hours a day, seven days a week. Using Medco online, you can order prescription drug refills, check on the status of your order, request additional forms and envelopes, or locate a network pharmacy near you (www.medco.com).

To refill a prescription online, you will simply need to supply your Medco member ID number (Social Security number), the prescription (RX) numbers you want to refill and the method of payment. Verify your address on file and review your order. When you order refills online, you will receive a detailed summary of your order, including costs. Please allow up to 14 days for delivery of your prescription.

Other Refill Options

If you elect not to use the Internet refill option, place your order at least two weeks before your current supply runs out in one of the following two ways:

- Call at 800-988-4125 to request a refill. They will need your Medco ID number, current mailing address, and Medco Health Rx Services prescription number
- If you prefer to order by mail, complete a mail service order envelope and attach your Medco refill prescription label to the form or write the prescription refill number on the envelope. Include your payment with your order.

Maximum Medical Benefits

Medco Rx Services sends you a statement with each prescription they fill. The statement advises you of your copayment, and the amount the Company paid. The amount the Company paid is applied to your maximum medical benefit (explained further in *Key Plan Features* on page 39).

Reimbursement of Copayments

Your mail service copayments for prescription drugs are not eligible for reimbursement under the Medical Options. However, if you elected to participate in the Health Care Flexible Spending Account, you may submit your copayment for reimbursement. (See page 152 for details.)

Over-the-Counter Drugs and Medicines

Certain over-the-counter (OTC) medicines and drugs may be reimbursed from a Health Care Flexible Spending Account (HCFSA). Refer to the *HCFSA Eligible Expenses* section (see page 148).

Excluded Expenses

The following items are excluded from coverage, under all Medical Benefit Options offered to employees of American Eagle Airlines, Inc. or Executive Airlines, Inc. (excluding HMO coverage), unless otherwise stated. For exclusions under an HMO, check with the HMO directly.

Allergy testing: Specific testing (called provocative neutralization testing or therapy), which involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

Alternative and/or Complementary medicine: Evaluation, testing, treatment, therapy, care and medicines that constitute alternative or complementary medicine, including but not limited to herbal, holistic, and homeopathic medicine.

Claim forms: The Plan will not pay the cost for anyone to complete your claim form.

Care not medically necessary: All services and supplies considered not medically necessary.

Cosmetic treatment:

- Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, liposuction, and sclerotherapy for varicose veins or spider veins)
- Cosmetic surgery, unless medically necessary and required as a result of accidental injury or surgical removal of diseased tissue

Counseling: All forms of marriage and family counseling

Custodial care and custodial care items: Custodial care and items such as incontinence briefs, liners, diapers, and other items when used for custodial purposes, unless provided during an *inpatient* confinement in a hospital or convalescent or skilled nursing facility.

Developmental therapy for children: Charges for all types of developmental therapy.

Dietician services: Dietician services are covered *only* under the PPO-Copay Option and *only* if you are using network providers. Contact Health International or your network provider to determine what services are covered. All other dietician services are excluded.

Drugs:

- Drugs, medicines, and supplies that do not require a physician's prescription and may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies, which are limited to insulin, needles, chem-strips, lancets, and test tape.)

Certain over-the-counter (OTC) medicines and drugs may now be reimbursed through a Health Care Flexible Spending Account (HCFSA). See page 149 for more details.

- Drugs which are not required to bear the legend “Caution-Federal Law Prohibits Dispensing Without Prescription”
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician's order
- Contraceptive drugs, patches, or implants when used for family planning or birth control. Even though oral contraceptives are not covered, you may order these drugs through the mail service prescription program and receive a discount. (See *Mail Service Prescription Drug Option* on page 68.)

- Drugs requiring a prescription under state law, but not federal law
- Medications or products used to promote general well-being such as vitamins or food supplements (except for prenatal vitamins, which are covered prior to/during pregnancy)
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Medications used primarily for the purpose of weight control
- Drugs used to treat infertility, or to promote fertility
- Drugs labeled “Caution-Limited by Federal Law to Investigational Use,” drugs not approved by the Food and Drug Administration (FDA), or experimental drugs, even though the individual is charged for such drugs
- Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis.

Ecological and environmental medicine: See Alternative and/or Complementary Medicine

Educational testing or training: Testing or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded)

Experimental, Investigational, or Unproven treatment: Medical treatment, procedures, drugs, devices, or supplies that are generally regarded as experimental, investigational, or unproven, including, but not limited to:

- Treatment for Epstein-Barr Syndrome
- Hormone pellet insertion
- Plasmapheresis

See the Experimental, Investigational or Unproven treatment definitions in the Glossary .

Eye care: Eye exams, refractions, eye glasses or the fitting of eye glasses, contact lenses, radial keratotomy or surgeries to correct refractive errors, visual training, and vision therapy.

Foot care: Diagnosis and treatment of weak, strained, or flat feet including corrective shoes or devices, or the cutting or removal of corns, calluses, or toenails. (This exclusion does not apply to the removal of nail roots.)

Free care or treatment: Care, treatment, services, or supplies for which payment is not legally required.

Government-paid care: Care, treatment, services, or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

Infertility treatment: Expenses or charges for infertility treatment *or* testing and charges for treatment or testing for hormonal imbalances that cause male or female infertility, regardless of the primary reason for hormonal therapy.

Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer, and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction, and infertility drugs such as , for example, Clomid or Pergonal, are also excluded.

Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility, such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.

Lenses: No lenses are covered except the first pair of medically necessary contact lenses or eye glasses following cataract surgery.

Massage therapy: All forms of massage and soft-tissue therapy, regardless of who performs the service.

Medical records: Charges for requests or production of medical records.

Missed appointments: If you incur a charge for missing an appointment, the Plan will not pay any portion of the charge.

Nursing care:

- Care, treatment, services, or supplies received from a nurse that do not require the skill and training of a nurse
- Private duty nursing care that is not medically necessary, or if medical records establish that such care is within the scope of care normally furnished by hospital floor nurses
- Certified nurses' aides.

Organ donation: Expenses incurred as an organ donor, when the recipient is not covered under the Plan.

Pregnancy for dependents: Prenatal care and delivery charges are excluded for covered dependent children unless the charges are due to certain complications. Examples of covered complications include ectopic pregnancy, hemorrhage, toxemia, placental detachment, and sepsis.

Preventive care: Coverage for preventive care varies, depending on the medical option you have elected for coverage. To determine if preventive care is covered by your selected medical option, refer to the *Medical Options Benefit Comparison* section starting on page 40.

Relatives: Coverage is not provided for treatment by a medical practitioner (including, but not limited to: a nurse, physician, physiotherapist, or speech therapist) who is a close relative (spouse, child, brother, sister, parent, or grandparent of you or your spouse, including adopted and step relatives).

Sleep disorders: Treatment of sleep disorders, unless it is considered medically necessary.

Sex changes: Sex change, gender reassignment/revision, treatments or transsexual and related operations.

Speech therapy: Except as described in *Covered Expenses*, expenses are not covered for losses or impairments caused by mental, psychoneurotic, or personality disorders or for conditions such as learning disabilities, developmental disorders, or progressive loss due to old age. Speech therapy of an educational nature is not covered.

TMJD: Except as described in *Covered Expenses*, diagnosis or treatment of any kind for temporomandibular joint disease or disorder(TMJD), or syndrome by a similar name, including orthodontia to treat TMJD. Crowns, bridges, or orthodontic procedures to treat TMJD.

Transportation: Transportation by regularly scheduled airline, air ambulance, or train for more than one round trip per illness or injury.

Usual and prevailing: Any portion of fees for physicians, hospitals, and other providers that exceeds the *usual and prevailing fee limits*.

War-related: Services or supplies when received as a result of a declared or undeclared act of war or armed aggression.

Weight reduction: Hospitalization, surgery, treatment, and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact QuickReview (or HMO if applicable) to determine if treatment is covered.

Wellness items: Items that promote well-being and are not medical in nature, and which are not specific for the illness or injury involved (including but not limited to, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas, and health club memberships). Also excluded are:

- Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning
- Services related to vocation, including but not limited to: physical or FAA exams, performance testing, and work hardening programs

Contact UnitedHealthcare (CheckFirst) to determine if your option covers a specific preventive service for a particular medical condition.

Work-related: Medical services and supplies for treatment of any work-related injury or illness sustained by you or your covered dependent, whether or not it is covered by Workers' Compensation, occupational disease law, or other similar law.

Filing Claims

UnitedHealthcare (UHC) is the claims processor for the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options. UHC provides claim services; however, they do not insure the health benefits. Benefits for these medical options are self-funded, which means that all claims are paid from the Company’s general assets.

Regardless of which medical option you are enrolled in, if you received services from a Medical Discount Program PPO provider, your provider will generally file the claim for you. If you use a non-network provider or for any reason you must file the claim yourself, follow the procedures below:

- Complete a Medical Claim (UHC)-AA form (instructions are provided on the form)
- Submit the completed form to UnitedHealthcare, along with all itemized receipts (originals) from your physician or other health care provider. A cancelled check is not acceptable.

Each bill or receipt submitted to UnitedHealthcare must include the following:

- Name of patient
- Date the treatment or service was provided
- Diagnosis of the injury or illness for which treatment or service was given
- Itemized charges for the treatment or service
- Provider’s name, address, and tax ID number

Be sure to make copies of the original itemized bill or receipt provided by your physician, hospital, or other medical service provider for your own records. Photocopies are not accepted by UnitedHealthcare.

All medical claims payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid, unless your physician, hospital, or other medical provider has agreed to accept assignment of benefits (see page 163). In this case, the EOB will be mailed to you and the payment mailed to your provider.

It is very important that you fully complete the sections of the form regarding other possible coverage. Examples of other possible coverage include a spouse's group health plan, Workers' Compensation, Medicare, Champus, TriCare and no-fault motor vehicle insurance.

If you have questions about your coverage or your claim, contact UnitedHealthcare at 800-638-9599. For information about how to file a prescription drug claim, see page .

Claims Filing Deadline

You must submit all health claims within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment. Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency of the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

The full claims procedure is described in detail at page 163.

Additional Rules

The following sections apply to the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, HMOs, Dental Benefit, Vision Insurance Benefit, HCFSA Benefit, and the Supplemental Medical Plan (except as noted).

Qualified Medical Child Support Order

Federal law authorizes state courts and administrative agencies to issue Qualified Medical Child Support Orders (QMCSOs). A QMCSO may require you to add your child as a dependent for health and dental benefit in some situations, typically a divorce. If you are subject to a QMCSO, your choice of benefits may be affected. For example, if the child doesn't live in the same location as you, you may not be eligible for Health Maintenance Organization (HMO) coverage.

The following procedures have been adopted and amended with respect to medical child support orders received by group health benefits and plans maintained for employees of participating AMR Corporation subsidiaries. These procedures shall be effective for medical child support orders issued on or after the Omnibus Budget Reconciliation Act of 1993 (OBRA) relating to employer-provided group health plan benefits.

These Procedures are for health coverage under the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries ("the Plan"), consisting of the following options:

- Out-of-Area Coverage Option
- Minimum Coverage Option
- PPO-Deductible Option
- PPO-Copay Option
- Health Maintenance Organization (HMO)
- Dental Benefit

- Vision Benefits.

Use of Terms

The term “Plan” as used in these procedures refers to the options and benefits described above, except to the extent that a plan is separately identified.

The term “Participant,” as used in these procedures, refers to a Participant who is covered under the Plan and has been deemed (by the court) to have the responsibility of providing medical support for the child under one or more of the coverages under the Plan as those benefits/terms are defined in the Plan described above.

The term “Alternate Recipient” as used in these procedures, refers to any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

The term “Order,” as used in these procedures, refers to a “medical child support order,” which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

The term “QMCSO” or “NMSN,” as used in these procedures, refers to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), which is a medical child support order creating or recognizing the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a plan and that meets the requirements set out in these procedures, or a notice from a state agency ordering the coverage of an a Alternate Recipient under health benefits with respect to a Participant under a plan and that meets the requirements to be an NMSM decreed to be a QMCSO.

The term “Plan Administrator,” as used in these procedures, refers to American Airlines, Inc., acting in its capacity as Plan Sponsor and Administrator to the Plan described above.

Procedures Upon Receipt of Medical Child Support Order or State Agency Notice

Notice that a Participant is a party to a matter wherein an Order may be entered must be provided in writing to the Plan Administrator by delivering such notice to the attention of the Plan Administrator at P. O. Box 619616, MD 5146-HDQ, DFW Airport, TX 75261-9616. In addition, QMCSOs or NMSNs should be delivered to the same address.

Upon receipt (or within 15 days of receipt) by the Plan Administrator of a request for information on health coverage or a state agency notice to enroll a child, the Plan Administrator will send out a letter notifying the requesting party that it has received the order or notice and describing the Plan’s procedures for determining whether the order is qualified or a notice is received, whether the coverage is available under the Plan to the child and the steps to be taken by the custodial parent or agency to effectuate coverage.

Upon receipt of an Order, or upon request, the Plan Administrator will advise each person or party specified in the medical child support order that, in order to be a QMCSO or NMSN, the Order must satisfy the requirements of ERISA and OBRA ’93 before the Plan Administrator is obligated to comply with its terms. These requirements state that the Order:

- Must be a “medical child support order,” which is any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law that: (i) provides for child support with respect to a child of a participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under such plan, or (ii) enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.
- Must relate to the provision of a medical child support and create or recognize the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive health benefits with respect to a Participant under a Plan and that meets the requirements set out in these procedures.
- Must affirm that all Alternate Recipients shall fulfill the eligibility requirements for coverage under the Plan.
- Does not require the Plan to provide any type or form of benefit or option that is not otherwise available under the Plan.

Must clearly specify:

- The name and last known mailing address of the Participant and the name and address of each alternate recipient covered by the Order
- A reasonable description of the coverage that is to be provided by the Plan to each Alternate Recipient or the manner that the coverage shall be determined;
- The period to which the Order applies (if no date of commencement of coverage is provided, or if the date of commencement of coverage has passed when the Order is approved, the coverage will be provided prospectively only, starting as soon as administratively practicable following the approval of the Order).
- The name of each Plan to which the Order applies (or a description of the coverage to be provided);
- A statement that the Order does not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan (except as a condition of receiving federal assistance for Medicaid
- The fact that all Plan contributions with regard to the Alternate Recipient shall be deducted from the Participant’s pay.

American Eagle Airlines, Inc. does not provide interim coverage to any employee's dependent during the pendency of a QMCSO or NMSN review. A dependent's entitlement to benefits under the Plan prior to the approval of a QMCSO or an NMSN is determined by the dependent's eligibility and enrollment in the Plan in accordance with the terms of the Plan. Without a QMCSO or NMSN American cannot be held liable if an employee's dependent is either (i) not enrolled in coverage in the Plan, or (ii) is eliminated from coverage in the Plan. In addition, neither American Eagle Airlines, Inc. nor the Plan has any obligation to automatically or immediately enroll (or to enroll at the next available enrollment period or at any other time) an employee's dependent except upon application by the employee in accordance with the terms of the Plan, or in accordance with a QMCSO or NMSN. If the requesting party needs assistance in preparing or submitting a QMCSO or NMSN, he or she may contact the Plan Administrator or go to the Web site www.dol.gov/ebsa/publications/qmcso.html for more information on QMCSOs and NMSNs and for sample NMSN forms or to www.acf.hhs.gov/programs/cse/forms/ to obtain a sample National Medical Support Notice.

Review of a Medical Child Support Order or Notice

Not later than 20 business days after receipt by the Plan Administrator of a medical child support order, the Plan Administrator shall review the Order to determine if it meets the criteria to make it a QMCSO or NMSN. Under OBRA '93, a state-ordered medical child support order is not necessarily a Qualified Medical Child Support Order. Thus, before the Plan honors the Order, the Order must meet the requirements for a QMCSO or NMSN specified above.

Procedures Upon Final Determination

The Participant, Alternate Recipient and any party specified in the medical child support order shall be notified of the acceptance of the medical child support order or national medical support notice as being qualified. Once the Order is determined to be a QMCSO or NMSN, the Plan Administrator will follow the terms of the Order and shall authorize enrollment of the Alternate Recipient as well as have any payments for such coverage deducted from the payroll of the Participant. In addition, a copy of the appropriate health benefit guide and claim forms shall be mailed to the Alternate Recipient (when an address is provided) or, in care of the Alternate Recipient, at the issuing agency's address. If the Participant is not enrolled, the Plan Administrator shall enroll the Participant as well as the child in the coverage. Notification will occur within 40 business days of receipt of the Order or notice.

If the Plan Administrator determines that the Order is not qualified, then the Plan Administrator shall notify the Participant, the Alternate Recipient, the state agency issuing the notice, or any designated representative in writing of such fact within 40 business days of receipt of the Order or notice. The notification will state the reasons the Order or notice is not a QMCSO or NMSN and that the Plan Administrator shall treat the Participant's benefits as not being subject to the Order. Any subsequent determination that an Order is a QMCSO will be administered prospectively only.

Appeal Process

If the Participant or Alternate Recipient wishes to dispute the terms of the QMCSO or NMSN, he or she must file an Application for Appeal within 60 days of receiving notification of denial of the medical child support order's or medical support notice's qualification. Appeals will be reviewed by the Pension Benefits Administration Committee (PBAC) in accordance with ERISA and the terms and provisions of the Plan and notify the Participant or Alternate Recipient within 60 days of receipt of the appeal of their decision. A copy of the Plan's appeal procedures, as set forth in the Employee Benefits Guide (the formal Plan Document and Summary Plan Description) shall be provided upon request.

Coordination of Benefits

These coordination of benefits provisions apply to health benefits described in this Guide, except for the Supplemental Medical Plan. For coordination of benefits information applicable to the Supplemental Medical Plan, see *Coordination of Benefits Under the Supplemental Medical Plan* on page 106.

This section explains how to coordinate coverage between the Company-sponsored Medical and Dental Benefit and any other benefits/plans that provide coverage for you or your eligible dependents.

If you or any other covered dependents have primary coverage (see *Which Plan is Primary* on page 78) under any other group medical or group dental benefit/plan, your Company-sponsored Medical and Dental Benefit will coordinate to avoid duplication of payment for the same expenses. The benefit program will take into account all payments you have received under any other benefits/plans, and will only supplement those payments up to the amount you would have received if your Company-sponsored Medical and Dental Benefit were your only coverage.

If your dependent is covered by another benefit/plan and the PPO-Copay Option is his/her secondary coverage, the PPO-Copay Option pays only up to the maximum benefit amount payable under the PPO-Copay Option, and only after the primary benefit/plan has paid. The maximum benefit payable depends on whether the network or out-of-network providers are used.

If you or your dependent is hospitalized when coverage begins, your prior coverage is responsible for payment of medical services until you are released from the hospital. If you have no prior coverage, the benefit program will pay benefits only for the portion of the hospital stay occurring after you became eligible for coverage under the benefit program for American Eagle employees.

If you or your dependent is hospitalized when your benefit program coverage changes from one Medical Benefit Option to another, your prior coverage is responsible for payment of eligible expenses until you or your dependent is released from the hospital.

Other Plans

The term “other group medical benefit/plan” or “other group dental benefit/plan” in this section includes any of the following:

- Employer-sponsored benefits/plans under which the employer pays all or part of the cost or takes payroll deductions, regardless of whether the plans are insured or self-funded
- Government or tax-supported programs, including Medicare or Medicaid
- Property or homeowner's insurance or no-fault motor vehicle coverage, except if the plan participant has purchased this coverage.

Which Plan Is Primary

When a person is covered by more than one plan, one plan is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid. Proof of other coverage will be required from time to time.

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an employee.

- A plan that has a coordination of benefits provision is the secondary plan if it covers the individual as a dependent or as a laid-off or retired employee.
- If a participant has coverage as an active full-time or part-time employee under two employee plans, and both plans have a coordination of benefits provision, the plan that has covered the employee the longest is primary.
- Any benefits payable under Medical Benefit Options or Dental Benefit and Medicare are paid according to federal regulations. In case of a conflict between Medical or Dental Benefit provisions and federal law, federal law prevails.
- If the coordination of benefits is on behalf of a covered child
    - For a natural child or adopted child, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. If the parents are divorced, these rules still apply, unless a Qualified Medical Child Support Order (QMCSO) specifies otherwise (see page 74).
    - For a stepchild or special dependent, the plan of the parent whose birthday occurs earlier in the calendar year pays before the plan of the parent whose birthday occurs later in the year, regardless of the parents' ages. If the parents have the same birthday, the plan that has been in effect the longest is the primary plan and pays benefits before the other plan. A stepchild not living in the employee's home is not an eligible dependent under the benefit program, regardless of any child support order.
- If the other plan has a gender rule, that plan determines which plan is primary.

When Coverage Ends

Coverage for you and your spouse will automatically terminate on the earliest of:

- The date this Plan or benefit option terminates
- The last day for which your contribution has been paid
- The date you are no longer eligible for this coverage.
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the Plan.

Your spouse’s coverage will automatically terminate on the earliest of:

- The date this plan or benefit option terminates
- The last day for which your spouse’s contribution has been paid
- The date he or she is no longer your spouse
- The date you are no longer eligible for this plan or benefit option
- The date the Plan Administrator determines in its sole discretion that you have made a false statement on any enrollment form or claim form or filed a fraudulent request with the plan or benefit option.
- The date your surviving spouse remarries
- For a Domestic Partner, 90 days after your death

Expenses incurred after the date your coverage (or your spouse's coverage) terminates are not eligible for reimbursement under the plan or benefit option.

Coordination with Medicare

Benefits for Individuals Who Are Entitled to Medicare

If you (or one of your dependents) are entitled to Medicare benefits, the following rules apply:

The AMR Corporation plan is the primary payer — in other words, your claims go to the AMR Corporation plan first — if both of the following apply:

- You are currently working for a participating AMR Corporation subsidiary
- You (or your dependent) first become entitled to Medicare benefits because you (or your dependent) have end-stage renal disease. In this case, the AMR Corporation plan is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the primary payer.

The AMR Corporation plan pays secondary and Medicare is the primary payer if you (or your dependent) are covered by Medicare, do not have end-stage renal disease and you are not currently working for the AMR Corporation.

If you (or your dependent) are over age 65 and the AMR Corporation plan would otherwise be the primary payer because you are still working, you or your dependent may elect Medicare as the primary payer of benefits. If you do, benefits under the AMR Corporation plan will terminate.

Benefits for Disabled Individuals

If you stop working for a participating AMR Corporation subsidiary because of a disability, or if you retire before age 65 and subsequently become disabled as defined by Social Security, you must apply for Medicare Parts A and B. Medicare Part A provides inpatient hospitalization benefits and Medicare Part B provides outpatient medical benefits, such as doctor's office visits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for individuals who qualify for Medicare because of disability, Medicare is the primary payer; in other words, your claims go to Medicare first. If Medicare pays less than the current benefit allowable by the AMR Corporation plan, the AMR Corporation plan will pay the difference, up to the maximum current benefits allowable. In addition, if Medicare denies payment for a service that the AMR Corporation plan considers eligible, the AMR Corporation plan will pay up to its normal benefit amount after you meet the calendar-year deductible, if any. Services not covered by Medicare include prescription drugs.

When Medicare is the primary payer, no benefits will be payable under the AMR Corporation plan for eligible Medicare benefits that are not paid because you did not enroll, qualify, or submit claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United States. Contact your local Social Security office for more information on Medicare benefits.

Continuation of Coverage

Overview

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your health benefits are cancelled, along with your other benefits. You may elect to continue your health benefits as part of your Continuation of Coverage options (see page 81) available through CONEXIS, the COBRA administrator. CONEXIS will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your medical coverage through COBRA, claims incurred after the date of your termination are not payable.

Several of American Eagle Airlines, Inc. benefits, options or plans (Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, Dental Benefit, HMOs, Vision Insurance Benefit, HCFSA Benefit and the Supplemental Medical Plan) provide for continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in case of certain qualifying events. If you and/or your dependents have coverage at the time of the qualifying event, you may be eligible to elect continuation of coverage under the following:

- Medical Benefits
- Dental Benefit
- Vision Insurance Benefit
- Supplemental Medical Plan
- Health Care Flexible Spending Account Benefit, for the remainder of the calendar year in which you became eligible for continuation of coverage. (Although you would not be able to make contributions on a before-tax basis, by electing continuation of coverage for this account, you would still have the opportunity to file claims for reimbursement based on your account balance for the year.)

The coverage under COBRA is identical to coverage provided under the benefits or plans for similarly situated employees or their dependents[1], including future changes.

COBRA Continuation

Eligibility

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.

Continuation of Coverage for You and Your Dependents – Qualifying Events

Change in job status (layoff or termination of employment): You may elect continuation of coverage for yourself and your eligible dependents, including a Domestic Partner and his/her children, for a maximum period of 18 months, if your coverage would otherwise end because of layoff or termination of your employment for any reason (except in the event of termination for gross misconduct).

[1] Although a Domestic Partner and his/her children do not have rights to COBRA coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur, however this may change. The current voluntary extension of COBRA coverage to Domestic Partners does not apply to the Supplemental Medical Plan and is not available under COBRA to surviving Domestic Partners.

If you are disabled when you lose coverage due to change in job status: If a disability occurs within 60 days of your loss of coverage due to termination of employment or reduction in hours, or you (or any eligible dependent) are disabled at any time during the first 60 days of continuation of coverage, you may be eligible to continue coverage for an additional 11 months (29 months total) for yourself and your dependents, including a Domestic Partner and his/her children. *To qualify for this additional coverage, the Qualified Beneficiary must provide written determination of the disability award from the Social Security Administration to the COBRA administrator (CONEXIS) within 60 days of the date of the Social Security Administration's determination of disability and prior to the end of the 18-month continuation period.*

Continuation of Coverage for Your Dependents Only – Qualifying Events

Your covered dependents may continue coverage for a maximum period of 36 months if coverage would otherwise end because of:

- Your divorce or legal separation
- Your Domestic Partner relationship ends
- You become entitled to (enrolled in) Medicare benefits
- Loss of eligibility because the dependent, including children of a covered Domestic Partner, no longer meets the Plan's definition of a dependent (for example, if a child reaches the Plan's limiting age)
- Your death
- Your Domestic Partner's death[1]

If you experience more than one of these qualifying events, your maximum continuation of coverage is the number of months allowed by the event that provides the longest period of continuation.

How to Elect Continuation of Coverage

Solicitation for Continuation of Coverage

Solicitation following layoff or termination: In the event that your employment ends through layoff or termination, you will automatically receive information from CONEXIS, the COBRA administrator, about electing continuation of coverage through COBRA.

Solicitation following a qualifying Life Event: In the event of a Qualifying Event (as shown above as for your dependents only) (divorce, legal separation, the end of a Domestic Partner relationship[1], your entitlement to or enrollment in Medicare, a dependent reaching the limiting age for coverage, or your Domestic Partner's death[1]), you must notify The Company by processing a Life Event change *within 60 days of the event.* You can process most Qualifying Events that are also Life Events online through *Jetnet*; however, in some instances, you must call HR Employee Services at 800-447-2000 to process the change. For example, in the event of your death, your supervisor or a dependent must call HR Employee Services to make the appropriate notification. If the Qualifying Event is also a Life Event that involves your Domestic Partner, you must call HR Employee Services to process the change.

[1] Your Domestic Partner and his/her covered dependents will be eligible to purchase continuation of coverage if they lose benefits as a result of the termination of your Domestic Partner relationship, your partner's child's loss of eligibility under the Plan, or the death of your Domestic Partner or yourself.

If you fail to notify the Company of a dependent's loss of eligibility *within 60 days* after the qualifying life event, the dependent will not be eligible for continuation of coverage through COBRA, *and* you will be responsible for reimbursing the Company for any benefits paid for the ineligible person. You are also required to repay the Company for premium amounts that were overpaid for fully insured coverages.

Enrolling for Coverage

Following notification of any of Qualifying Event (see page 82), HR Employee Services will advise CONEXIS, who in turn will notify you or your dependents of the right to continuation of coverage. When you process your Life Event, you should provide your dependent's address (if different from your own) where CONEXIS can send solicitation information.

You (or your dependents) must provide written notification of your desire to elect to purchase continuation coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage. (See the contact list for information on CONEXIS' address for sending the written notice.)

You and your dependents may each independently elect continuation coverage. Once you elect continuation 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.

Federal laws require the Company to provide a Certificate of Group Health Plan Coverage outlining your coverage under the Plan and showing the dates you were covered by this Plan. This certificate is sent to you by CONEXIS.

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 CONEXIS before your 60-day election period expires.

Processing Life Events After Continuation of Coverage is in Effect

If you elect continuation of coverage for yourself and later marry or *declare a Domestic Partner*, give birth, or adopt a child while covered by continuation of coverage, you may elect coverage for your newly-acquired dependents after the qualifying event. To add your dependents, contact CONEXIS, the COBRA administrator, at 877-902-9207, *within 60 days* of the marriage, Domestic Partner relationship, birth, or adoption.

A new dependent may be a participant under this coverage for the remainder of your continuation period (18, 29, or 36 months, depending on the qualifying event). This new dependent will not have the right to continue coverage on his or her own if there is a divorce, end of Domestic Partner relationship, or another event that causes loss of coverage**.** You may add a newborn child or a child newly placed for adoption to your COBRA continuation coverage. You should notify CONEXIS and the Plan Administrator of the newborn or child newly placed for adoption within 60 days of the child's birth or placement for adoption. All rules and procedures for filing and determining benefit claims under the Plan for active employees also apply to continuation of coverage.

If you have questions regarding continuation of coverage, contact CONEXIS at 877-902-9207.

Paying for or Discontinuing COBRA Coverage

To maintain COBRA continuation of coverage, you must pay the full cost of continuation of coverage on time, 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 CONEXIS 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. All checks shall be made payable to CONEXIS and sent to CONEXIS, P.O. Box 223886, Dallas, TX 75222.

Refund of Premium Payments

If you elect continuation of coverage and later discover that you do not meet the eligibility requirements for coverage, for example, if you become entitled to (enrolled in) Medicare benefits, you must contact CONEXIS at 877-902-9207 immediately, but no later than three months after you make your first COBRA premium payment in order for you to be eligible for a refund. No payments will be refunded after this three-month period, regardless of the reason.

If claims have been paid during this three-month time period, the Plan will request reimbursement from you. If the amount of your premium payments for continuation of coverage is less than the amount of your claim, no premium payment will be refunded and you will be responsible for the balance due. However, if the plan receives reimbursement for your claim, the Plan will refund your premiums.[1]

This time limit for refunds also applies if the Company discovers that continuation of coverage has been provided to you or your dependent in error.

[1] Although a Domestic Partner and her/her children do not have rights to COBRA coverage under existing federal law, AMR currently offers them the opportunity to continue health coverages that would be lost when certain events occur, with the exception that Supplemental Medical Plan is not available under COBRA to surviving Domestic Partners.

When Continuation of Coverage Begins/Ends

When continuation of coverage begins: If you or your dependents elect continuation of coverage within 60 days of receiving your election forms, the coverage becomes effective on the date your other coverage would otherwise end. Thus, the first premium for continuation of coverage includes payment for this retroactive coverage period.

When continuation of coverage ends: Continuation of coverage may end before the maximum time period expires. Coverage automatically ends on the earliest of the following dates:

- The maximum continuation period (18, 29, or 36 months) expires (See also *Eligibility for Continuation of Coverage* on page 81.)
- Payment for continuation of coverage is not postmarked within 30 days after the date payment is due. Checks returned for non-sufficient funds ("NSF" or "bounced") are considered non-payment of contributions. If full payment is not received (postmarked) within the grace period specified on the invoice, your coverage will be terminated, without the possibility of reinstatement.
- The Plan participant who is continuing coverage becomes covered under any other group medical plan, unless that plan contains a pre-existing condition limitation that affects the plan participant. In that event, the participant is entitled to continuation of coverage up to the maximum time period.
- The Plan participant continuing coverage becomes entitled to Medicare
- The Company no longer provides the coverage for any of its employees or their dependents.

See also *Dependents of Deceased Employees* on page 16.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your medical coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of 24 months (for elections of coverage on or after December 10, 2004) or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days

- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days. The Company may offer additional health coverage or payment options to employees in the uniformed services and their families, in accordance with the provisions set forth in the Employee Policy Guide.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected medical coverage benefits during this time.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition.

Depending on your state of residence, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Other Employees Obligations

In order to protect you and your family's rights, you should keep both CONEXIS and the Company informed of any changes in the addresses of your family members.

Other Special Rules

If your event that qualified you for COBRA coverage was either a Company-mandated reduction in hours or termination of employment and your employment termination or reduction was due to reduced sales due to increased imports and it was certified by the U.S. Department of Labor so that you are a Trade Adjustment Act (TAA)-eligible individual, then you may be eligible for a second chance to elect COBRA continuation coverage. You are only eligible for the second chance to elect COBRA coverage if all of the event described in this paragraph occurred within six (6) months of your loss of coverage. If you are a TAA-eligible individual, you must elect coverage within six (6) months of the date you lost coverage, or you lose the right to elect COBRA coverage as a TAA-eligible individual.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC)(eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Impact of Failing to Elect Continuation Coverage on Future Coverage

In considering whether to elect continuation coverage, you should take into account that a failure to continue your Plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your Plan coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Additional Questions

If you have any additional questions on continuation of coverage under COBRA, you should contact CONEXIS (see *Contact Information* on page 1).

Certificate of Coverage

If you lose your coverage (or when you notify Employee Services of your dependent's loss of coverage) you will automatically be sent a certificate of coverage showing how long you had been covered under the Plan. This document will provide the proof of coverage you may need to reduce any subsequent medical plan's preexisting medical condition limitation period that might otherwise apply to you. If you elect COBRA continuation coverage, when that coverage ends, you will receive another certificate of coverage within the 24 months after your coverage has ended. You may also request a certificate of coverage within the 24 months after your coverage has ended.

Supplemental Medical Plan

Overview

The Supplemental Medical Plan is a medical benefit plan offered to eligible employees and retirees of participating subsidiaries of AMR Corporation ("Company") and their eligible spouses. In this section, the Supplemental Medical Plan may also be referred to as the "Plan".

If you elect coverage under the Supplemental Medical Plan, there are two circumstances under which this Plan would pay a benefit:

- When you or your covered spouse exhausts your maximum medical benefit under your selected Medical Benefit Option under the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (collectively, "Company-sponsored Medical Benefit Option(s)"), or
- If you are the surviving spouse[1] of an active employee who dies while you are both covered under this Plan and you have exhausted your maximum medical benefits under your selected Company-sponsored Medical Benefit Option.

For the purposes of this Guide, whenever we refer to "spouse", Domestic Partner applies, unless otherwise stated.

Coverage under the Supplemental Medical Plan is available only to employees who enroll for coverage when first eligible for benefits (as a new employee), or, if you later marry or *declare a Domestic Partner*.

If you have not enrolled for coverage at those designated times, this section of the Guide is not applicable to you and is included only for employees who have elected this coverage.

Eligibility

You are eligible for the Supplemental Medical Plan if you are an active employee or the spouse of an active employee, and you meet the eligibility requirements described in this section.

Active Employees

To be eligible for coverage under the Supplemental Medical Plan, you must be a regular employee on the U. S. payroll, and you must be eligible for and enrolled in one of the following Company-sponsored Medical Benefit Options for American Eagle Airlines, Inc. employees:

- Out-of-Area Coverage
- Minimum Coverage
- PPO-Deductible
- PPO-Copay, or
- HMO (employees living in Puerto Rico only).

[1] If you die while you and your Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Domestic Partner continues for 90 days from the date of your death, provided he or she pays the active plan contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

You and your spouse may join the Supplemental Medical Plan only when:

- You are first eligible for benefits
- You later marry or *declare a Domestic Partner*, after you are first eligible for benefits.

You pay contributions for this coverage through payroll deductions.

Your coverage begins the first day you are actively at work after you enroll. You are not considered actively at work if you are on a leave of absence.

Employees Married to Employees

If you and your spouse both work for AMR Corporation subsidiaries, you should be aware of the following special considerations.

- If both you and your spouse are eligible for the Supplemental Medical Plan as employees, you must each make a separate election for participation in the Supplemental Medical Plan. If one of you leaves the Company, the spouse that continues employment with the Company may add the other to Supplemental Medical Plan coverage as a dependent spouse within 60 days of your spouse's termination of employment.
- If you are eligible for the Supplemental Medical Plan as an employee, but your spouse is not eligible as an employee, you may cover your spouse as your dependent under the Plan. If your spouse later becomes eligible as an employee, he or she will no longer be eligible for coverage as your dependent, but may elect coverage as an employee.
- If you each elect Supplemental Medical Plan coverage while you are both active employees, you may continue the coverage for you and your spouse when one or both of you retire.

HMO Participants

If you are an active employee covered under an HMO as your Company-sponsored Medical Benefit Option, you are eligible for the Supplemental Medical Plan but will not have the opportunity to collect benefits under this Plan because HMOs do not have maximum medical benefit provisions.

- As an HMO participant, you might consider electing coverage under the Supplemental Medical Plan if
- You want your spouse to have access to surviving spouse coverage in the event of your death (as explained on page 90). Domestic Partners are not eligible for coverage through the HMOs.

Surviving Spouses of Active Employees

If you die as an active employee while you and your spouse are covered under the Supplemental Medical Plan, your surviving spouse[1] may use this Plan as his or her primary medical coverage. If your surviving spouse[1] has other group medical coverage, the Supplemental Medical Plan will be his or her secondary medical coverage.

Your surviving spouse[1] is not required to have coverage through any other group medical plan to be eligible for benefits under the Supplemental Medical Plan. He or she may continue the Plan each year by paying the annual contribution to HealthFirst TPA. If your spouse[1] remarries, he or she is no longer eligible for the Supplemental Medical Plan.

1 If you die while you and your Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Domestic Partner continues for 90 days after the date of your death, provided he or she pays the contribution rate to continue the coverage. At the end of 90 days, Supplemental Medical Plan coverage ends and is not available through COBRA.

If your spouse[1] was covered under any Company-sponsored Medical Benefit Option, he or she remains eligible for that option for 90 days after your death with no contributions. At the end of 90 days, your spouse[2] may elect Continuation of Coverage (see page 81) under COBRA for up to 36 months (including the 90 days). If he or she does not elect COBRA, the Supplemental Medical Plan becomes your spouse's[1] primary coverage sponsored by the Company on the 91st day. (See information below on enrolling as a surviving spouse.)

Enrollment

You may enroll only as an active employee when you are first eligible, or, if you later marry or *declare a Domestic Partner*. If you elect to drop Supplemental Medical Plan coverage for yourself or for you and your spouse, you will not be able to re-enroll, unless you later marry or *declare a Domestic Partner*, while you are still an active employee. If you experience one of these events, and you wish to make a change in your Supplemental Medical Plan coverage, you must make the change within 60 days of the event. You pay Supplemental Medical Plan contributions by after-tax payroll deductions.

If you are an active employee, you can process a Life Event change (see page 28) online through *Jetnet* to add your spouse to your benefits coverage or you may, contact HealthFirst TPA at 800-711-7083 to make changes to your coverage. (Note: if you are adding a Domestic Partner, you must first request a Domestic Partner Kit. The kit contains instructions to add your Domestic Partner to your benefits coverage. Once HR Employee Services has updated your records to reflect your Domestic Partner information, you must then contact HealthFirst TPA to add your partner to your Supplemental Medical Plan coverage.) You pay Supplemental Medical Plan contributions by after-tax payroll deduction.

To understand how the Supplemental Medical Plan coordinates with Medicare, refer to *Coordination of Benefits Under the Supplemental Medical Plan* on page 106.

Surviving Spouses

The Company will notify HealthFirst TPA of a covered active employee's death. If your spouse[2] was enrolled in this Plan at the time of your death, HealthFirst TPA will send enrollment information and a bill for the remainder of the current year[1] within 30 days of receipt of notification of the employee's death. Once enrolled, your spouse will receive an I.D. card, the Supplemental Medical Plan booklet, and a claim form. Your surviving spouse will receive a bill for the annual contribution each year thereafter.

If your surviving spouse does not receive the enrollment information from HealthFirst TPA within 30 days he or she should contact HealthFirst TPA at 800-711-7083 or HR Employee Services at 800-447-2000.

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1 If you die while you and your Domestic Partner are covered under any Company-sponsored Medical Benefit Option, your surviving Domestic Partner receives medical coverage for 90 days from the date of your death, provided he or she pays the active plan contribution rates to continue coverage. At the end of the 90-day period, your Domestic Partner may elect Continuation of Coverage under COBRA for up to 36 months (except as noted above in footnote 1 for Supplemental Medical Plan coverage). The 90 days of coverage are included in the 36 months.

2 If you die while you and your Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Domestic Partner continues for 90 days from the date of your death, provided he or she pays the contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

Plan Features

Eligible expenses: The Supplemental Medical Plan covers regular, medically necessary services, supplies, care, and treatment of non-work-related injuries or illnesses when ordered by a licensed physician acting within the scope of his or her license.

Usual and prevailing fee limits: The amount of benefits paid for eligible medical expenses is based on the usual and prevailing fee limits for that service or supply in that geographic location.

Deductible: Under the Supplemental Medical Plan, you are not required to satisfy a deductible.

Annual out-of-pocket maximum: After you have paid $1,000 for eligible expenses under the Plan (for example, the 20% coinsurance you pay when the Plan covers a service at 80%), the Plan pays 100% of eligible expenses within usual and prevailing fee limits for the rest of the calendar year. Expenses for outpatient mental health care are not included in the annual out-of-pocket maximum and are not eligible for 100% payment by the Plan.

Maximum Medical benefit: $500,000 is the most this Plan will pay for any participant during the entire period a person is covered by the Supplemental Medical Plan.

When an individual's maximum medical benefit is reached, medical coverage terminates as of the date the expenses resulting in exhaustion of the benefit are incurred.

When the individual's maximum medical benefit is exhausted, coverage ends. If the employee exhausts his or her maximum medical benefit but his or her covered eligible spouse has not yet exhausted his or her respective maximum medical benefits, that covered eligible spouse may remain in his or her medical coverage under the Supplemental Medical Plan (as long as he/she continues to meet eligibility requirements).

Maximum Medical benefit rules for Surviving Spouses: If your surviving spouse[1] has coverage under any other group medical plan, he or she must first file claims with that plan. The Supplemental Medical Plan will pay as the secondary plan according to Coordination of Benefits provisions. However, this Plan does not coordinate benefits with any Company-sponsored Medical Benefit Option. If your surviving spouse[1] does not have any other group medical plan coverage, the Supplemental Medical Plan is his or her primary coverage. Coverage for your surviving spouse[1] ends if your spouse remarries or dies.

CheckFirst: To determine if a proposed medical service is covered under the Plan and if your provider's fee falls within the usual and prevailing fee limits, use CheckFirst to obtain a pre-determination. Call HealthFirst TPA to request a pre-determination by phone or to request a pre-determination form. You must receive the pre-determination from HealthFirst TPA before you receive the proposed medical service.

QuickReview: You should request pre-authorization before undergoing surgery or any medical treatment requiring hospitalization. QuickReview ensures that the recommended procedure is medically necessary and that you receive authorization for the length of your hospital stay. If you are age 65 or over, you are not required to use QuickReview because Medicare requires you to use its utilization review program. For more information see page 56.

1 If you die while you and your Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Domestic Partner continues for 90 days from the date of your death, provided he or she pays the active plan contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

Benefits

The Supplemental Medical Plan pays a percentage of eligible expenses for medically necessary care, treatment, and supplies up to the usual and prevailing fee limits, as shown in the following table.

Feature	Amount of Coverage
Maximum medical benefit	$500,000 per Plan participant[1]
Deductible	None
Annual out-of-pocket maximum	$1,000 per person each calendar year[2]
Illness and diagnostic services • Emergency room • Surgery (inpatient or outpatient) • Physician's office visit • X-ray and laboratory charges • Prescription drugs	80%
Hospital care • Daily hospital room allowance (based on average semi-private room rate) • Intensive care room allowance • Ancillary charges	80%
Convalescent and skilled nursing facilities (limited to 30 days confinement per illness or injury for skilled nursing facility)	50%
Home health care	80%
Hospice care (including bereavement counseling within 90 days of the death of the participant for family members [siblings, spouse and children of the patient])	80%
Mental health care inpatient services	80%
Alternative mental health care centers	Actual facility charge or 50% of the area's semi-private room rate, whichever is less
Mental health care outpatient services, including prescription drugs	50%
Chemical dependency care • Inpatient services • Outpatient services • Confinement maximum	 • 80% • 50% • One confinement (whether inpatient or outpatient)
Other covered expenses	80%

1 This maximum applies to the entire time a person is covered by the Plan.
2 This does not include expenses paid by the Plan at 50%.

Covered Expenses

The Supplemental Medical Plan pays benefits to Plan participants for eligible medical expenses only if:

- You or your covered spouse has exhausted the maximum medical benefit payable from a Company-sponsored Medical Benefit Option, or
- Your surviving spouse[1] is covered under this Plan.

If your spouse has coverage under any other group medical plan, he or she must first file claims with that plan. The Supplemental Medical Plan will pay as the secondary plan according to Coordination of Benefits provisions. However, this Plan does not coordinate benefits with any company-sponsored plan. If your surviving spouse does not have any other group medical plan coverage, the Supplemental Medical Plan is his or her primary medical coverage.

To be covered, an expense must be:

- Medically necessary,
- Within usual and prevailing fee limits, and
- An eligible/covered expense under the Plan.

Hospital Care

- **Inpatient hospital expenses:** Hospital room and board charges, based upon of the average semi-private room rate in that geographical area. If the hospital does not have semi-private rooms, this Plan considers the eligible expense to be 90% of the hospital's lowest private room rate.
- **Intensive care unit**: The usual and prevailing fee limits for services and supplies (excluding personal items) provided while the covered person is hospitalized in the hospital's intensive care unit.
- **Emergency room:** Services and supplies provided by a hospital emergency room.
- **Ancillary charges:** Ancillary charges for inpatient hospital services and supplies and operating room use.

Illness and Diagnostic Services

In addition to hospital care, the following services are covered:

- **Physician's office visits:** For a medically necessary diagnosis or treatment of an illness or injury.
- **X-ray (Radiology) and laboratory charges**
- **Prescription drugs**
- **Surgery:** When medically necessary and performed in a hospital, a free-standing surgical facility, or a physician's office.

[1] If you die while you and your Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Domestic Partner continues for 90 days from the date of your death, provided he or she pays the contribution rate to continue coverage. At the end of the 90-day period, Supplemental Medical Plan coverage ends and is not available through COBRA.

Out-of-Hospital Care

- **Convalescent or skilled nursing facilities:** Eligible Expenses include room and board, as well as services and supplies (excluding personal items) that are incurred while you are confined to a convalescent or skilled nursing facility and are under the continuous care of a physician. Your physician must certify that this admission is an alternative to a hospital admission. Benefits are limited to a maximum of 30 days' confinement per illness or injury.

  Room and board charges are covered at one-half the most common semi-private room rate for inpatient hospital expenses in a geographical area. Participants are covered without limits for the number of days you may receive skilled nursing care. Custodial care is not covered.

- **Home health care:** Covered only when your physician certifies that the visits are medically necessary for the care and treatment of a covered illness or injury. The claims processor may require the physician to provide an approved treatment plan before paying benefits and may periodically review the plan. Custodial care is not covered. The Plan does not limit the number of covered home health care visits.

- **Hospice care:** Eligible Expenses in connection with hospice care include hospice facility, outpatient care and bereavement counseling.

  If the physician determines that the patient is terminally ill, the patient may receive hospice care for an unlimited period of time. Bereavement counseling is covered for the participant's family (the patient's spouse, children [natural, step and adopted], and siblings) (including Domestic Partners) for 90 days, beginning on the date of the participant's death. Bereavement counseling benefits continue even if coverage ends under this Plan.

  HealthFirst TPA, the claims processor, may require the physician to provide an approved treatment plan before paying hospice benefits and may periodically review the Plan.

- **Pregnancy:** Charges in connection with pregnancy are covered only for female employees and female spouses of male employees. Prenatal care and delivery are covered when provided by a physician or midwife who is registered, licensed, or certified by the state in which he or she practices.

  Delivery may be in a hospital or birthing center. Birthing center charges are covered when the center is certified by the state department of health or other state regulatory authority. Federal law prohibits the plan from limiting your length of stay to less than 48 hours for a normal delivery or 96 hours for a Cesarean delivery, or from requiring your provider to obtain pre-authorization for a longer stay. However, federal law does not require you to stay any certain length of time. If, after consulting with your physician, you decide on a shorter stay, benefits will be based on your actual length of stay.

Mental Health and Chemical Dependency Care

- **Mental health care:** Covered expenses include inpatient care (in a psychiatric hospital or a residential treatment center) and outpatient care for a mental health disorder.
    - **Inpatient mental health care:** When you are hospitalized in a psychiatric hospital or a residential treatment center for a mental health disorder, expenses during the period of hospitalization are covered (the same as inpatient hospital expenses) up to Plan maximums.
    - **Alternative mental health care center:** The maximum eligible charge per day of treatment in an alternative mental health care center is the lesser of the actual facility charge or 50% of the geographic area's most common semi-private hospital room rate. A day of treatment in an alternative mental health care center is not more than eight hours in a 24-hour period.
    - **Outpatient mental health care:** Expenses for outpatient mental health care (including prescription drugs) are covered.
- **Chemical dependency care**: Covered chemical dependency care expenses can be inpatient, outpatient, or a combination. You are covered at 80% for one inpatient chemical dependency rehabilitation program or at 50% for one outpatient chemical dependency rehabilitation program during the entire time you are covered by the Plan; however, you may only receive benefits for one chemical dependency rehabilitation program under this Plan regardless of whether it is received as an inpatient or an outpatient. The Plan does not cover expenses for a spouse or family member to accompany the patient being treated.

Other Covered Expenses

The following medical services (listed alphabetically) are covered:

- **Ambulance:** Medically necessary professional ambulance services to and from:
    - The nearest hospital able to provide necessary treatment in the event of an emergency
    - The nearest hospital or convalescent or skilled nursing facility for inpatient care.
- **Anesthesia:** Medically necessary anesthesia and its administration. The Plan does not cover expenses for an anesthesiologist to remain available when not directly tending to the care of the patient.
- **Assistant surgeon:** Assistant surgeon's fees only when the surgical procedure makes it medically necessary to have an assistant surgeon. To determine whether an assistant surgeon is considered medically necessary, use the CheckFirst pre-determination procedure.
- **Chiropractic care:** Medically necessary services of a restorative or rehabilitative nature provided by a chiropractor practicing within the scope of his or her license.
- **Cosmetic surgery:** Expenses for cosmetic surgery are only covered if they are medically necessary and incurred for either of the following:
    - As the result of a non-work related injury
    - For replacement of diseased tissue surgically removed.
- **Dietician services:** Services recommended by a physician and provided by a licensed dietician.

- **Durable medical equipment:** Reimbursement for the rental of durable medical equipment (DME) is limited to the maximum allowable equivalent of the purchase price. The Plan may, at its option, approve the purchase of such items instead of rental.

  Replacement of DME resulting from normal wear and tear is not covered. Replacement of DME is only covered when medically necessary.

  Coverage includes prostheses (such as a leg, foot, arm, hand, eye, or breast) necessary because of injury, illness, or surgery. Only charges for the first prosthesis are covered by the Plan. Replacement or subsequent prostheses are not covered.

- **Medical supplies:** Including, but not limited to:
  - Oxygen, blood, and plasma
  - Sterile items, including surgical trays, gloves, and dressings
  - Needles and syringes
  - Colostomy bags
  - The initial purchase of eyeglasses or contact lenses required because of cataract surgery performed while covered.

- **Nursing care:** Medically necessary private duty care by a licensed nurse, if the care is a type or nature not normally furnished by hospital floor nurses.

- **Oral surgery:** Expenses in connection with teeth, gums, or alveolar process are covered only for:
  - Hospital expenses for necessary inpatient care
  - Treatment of tumors
  - Surgery to remove an impacted tooth
  - Repair to sound natural teeth or other body tissue because of an accidental injury, and only if the expense is incurred within 12 months of the injury.

- **Physical or occupational therapy:** Medically necessary restorative and rehabilitative care by a licensed physical or occupational therapist, when ordered by a physician.

- **Physicians:** Office visits, medical care and treatment by a physician, including surgical procedures and post-operative care.

- **Prescription drugs:** Medically necessary prescription drugs that are approved by the Food and Drug Administration (FDA) and prescribed by a physician or dentist for treatment of your condition. Prescriptions related to infertility treatment, weight control, and oral contraceptives are not covered. See *Excluded Expenses* on page 70 for additional information.

  Medications are also covered for the following special situations:
  - Medications administered and entirely consumed in connection with care rendered in a physician's office are covered as part of the office visit.
  - Medications that are to be taken by or administered while you are covered as a patient in a licensed hospital, extended care facility, convalescent hospital, or similar institution that operates an on-premises pharmacy are covered as part of the facility's ancillary charges.

- **Radiology and laboratory:** X-rays, radiology treatments, diagnostic laboratory tests, and annual mammography screenings for women.

- **Reconstruction following mastectomy:** Notwithstanding any other provision herein, in the case of a participant or beneficiary who received a mastectomy and who elected breast reconstruction in connection with such mastectomy, the Supplemental Medical Plan will cover expenses for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and a prostheses and physical complications in all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the individual's attending physician.
- **Secondary surgical procedures:** Secondary surgical procedures will be covered at a reduced rate because surgical preparation fees are included in the fee for the primary surgery. To determine the amount of coverage, use the CheckFirst pre-determination procedure.
- **Speech and hearing care:** The care and treatment for loss or impairment of speech or hearing are covered when the treatment is necessary because of a physical condition such as a stroke, accident, or surgery. Expenses are not covered for conditions such as learning disabilities or progressive hearing loss due to old age because they are not medically necessary for the treatment of an illness.
- **Transplants:** Expenses for transplants or replacements of tissue or organs, if they are medically necessary for the diagnosed illness or injury and are not experimental, investigational, unproven, or otherwise excluded from coverage under the Supplemental Medical Plan, as determined at the sole discretion of the Plan Administrator and/or claims processor. Benefits are payable for natural or artificial replacement materials or devices. Transplants include, but are not limited to, the following (listed alphabetically):
    - Artery or vein
    - Bone
    - Bone marrow or hematopoietic stem cell
    - Cornea
    - Heart
    - Heart and lung
    - Heart valve replacements
    - Implantable prosthetic lenses in connection with cataract surgery
    - Intestine
    - Kidney
    - Kidney and pancreas
    - Liver
    - Liver and kidney
    - Liver and intestine
    - Pancreas
    - Pancreatic islet cell (allogenic or autologous)
    - Prosthetic bypass or replacement vessels
    - Skin

Donor and recipient coverage is as follows:

- If the donor and the recipient are both covered under this Plan, expenses for both individuals are covered.
- If the donor is not covered under this Plan and the recipient is covered, the donor's expenses will be covered to the extent they are not covered under any other medical plan, and only if they are submitted as part of the recipient's claim.
- If the donor is covered under this Plan but the recipient is not covered under this Plan, no expenses are covered for the donor or the recipient.

The total benefit paid under this Plan for the donor's and recipient's combined expenses will not be more than any Plan maximums applicable to the recipient.

- It is important to note that the listed covered transplants are covered only if the proposed transplant meets specific criteria — not all transplant situations will be eligible for benefits. Therefore, you **must** contact QuickReview as soon as possible for pre-authorization **before** contemplating or undergoing a proposed transplant.
- **Transportation:** Regularly scheduled commercial transportation by train or plane is covered within the continental United States and Canada when necessary for your travel to and from the nearest hospital that can provide inpatient treatment not locally available. Only one round-trip for any illness or injury is covered and only if medical attention is required en route.
- **Tubal ligations and vasectomies:** These procedures are covered; however, reversal of these procedures is not covered.

Administrator's Discretion

The Plan Administrator may at its sole discretion, pay benefits for services and supplies not specifically stated under the Supplemental Medical Plan. This applies if the Plan Administrator determines that such services and/or supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of Supplemental Medical Plan participants.

Excluded Expenses

No benefits will be paid for expenses in connection with the following items (listed alphabetically):

Allergy testing: Specific testing (called provocative neutralization testing or therapy) that involves injecting a patient with varying dilutions of the substance to which the patient may be allergic.

Alternative and/or Complementary Medicine: Evaluation, testing, treatment, therapy, care, and medicines that constitute Alternative and/or Complementary Medicine, including but not limited to herbal, holistic, and homeopathic medicine.

Care not medically necessary: All services and supplies considered not medically necessary.

Claim forms: The Supplemental Medical Plan will not pay for the cost of anyone to complete your claim form.

Cosmetic treatment:

- Medical treatments solely for cosmetic purposes (such as treatments for hair loss, acne scars, and sclerotherapy for varicose veins or spider veins)

- Cosmetic surgery unless required and medically necessary as a result of accidental injury or illness (as explained in *Other Covered Expenses* on page 95)

Counseling: All forms of marriage and family counseling

Custodial care and custodial care items: Care provided in a convalescent or skilled nursing facility or hospital and items such as incontinence briefs, liners, diapers, and other items when used for custodial purposes.

Dental treatment: Except as described in *Covered Expenses*, charges for diagnosis and/or treatment of the teeth, their supporting structures, the alveolar process, or the gums are not covered.

Dietician services: Costs of dietician services.

Drugs:

- Drugs, medicines, and supplies that may be obtained over-the-counter, regardless of whether a physician has written a prescription for the item. (This exclusion does not apply to diabetic supplies. Diabetic supplies are limited to insulin, needles, chem strips, lancets, and test tape.)
- Drugs that are not required to bear the legend “Caution-Federal Law Prohibits Dispensing Without Prescription”
- Covered drugs in excess of the quantity specified by the physician or any refill dispensed after one year from the physician’s order
- Contraceptive drugs, patches, or implants when used for family planning or birth control
- Drugs requiring a prescription under state law, but not federal law
- Medications or products that promote general well being such as vitamins or food supplements (except prenatal vitamins, which are covered prior to/during pregnancy.)
- Drugs prescribed for cosmetic purposes (such as Minoxidil)
- Smoking cessation drugs, gum, or patches
- Medications primarily for the purpose of weight control
- Medications used to treat infertility or to promote fertility
- Drugs labeled “Caution-Limited by Federal Law to Investigational Use,” drugs not approved by the FDA, or experimental drugs, even though a charge is made to the individual.
- Any and all medications not approved by the Food and Drug Administration (FDA) as appropriate treatment for the specific diagnosis

Ecological and environmental medicine: See *Alternative and/or Complementary Medicine*.

Educational testing or training: Testing and/or training that does not diagnose or treat a medical condition (for example, testing for learning disabilities is excluded).

Experimental Investigational, or Unproven Treatment: Medical treatment, drugs or supplies which are generally regarded as experimental, investigational, or unproven, (as such terms are defined in the *Glossary* on page 187) including but not limited to treatment of Epstein-Barr syndrome, hormone pellet insertion, or plasmapheresis.

Eye care: Eye exams, refractions, eye glasses or the fitting of eye glasses, contact lenses, radial keratotomy or treatment/surgery to correct refractive errors , visual training, and vision therapy.

Foot care: Services for diagnosis or treatment of weak, strained, or flat feet, including corrective shoes or devices or the cutting or removal of corns, calluses, or toenails. (This exclusion does not apply to the removal of nail roots.)

Free care or treatment: Any care, treatment, services, or supplies for which payment is not legally required.

Government-paid care: Any care, treatment, services, or supplies provided or paid by any governmental plan or law when the coverage is not restricted to the government's civilian employees and their dependents. (This exclusion does not apply to Medicare or Medicaid.)

Infertility treatment: Expenses or charges for infertility treatment or testing and charges for treatment or testing for hormonal imbalances that cause male or female infertility, regardless of the primary reason for hormonal therapy.

Items not covered include, but are not limited to the following: medical services, supplies, procedures for or resulting in impregnation, including in-vitro fertilization, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer, and reversal of tubal ligations or vasectomies. Drug therapy, including treatment for ovarian dysfunction, and infertility drugs such as Clomid or Pergonal, are also excluded.

Only the initial tests are covered to diagnose systemic conditions causing or contributing to infertility such as infection or endocrine disease. Also, the repair of reproductive organs damaged by an accident or certain medical disorders are eligible for coverage.

Lenses: No lenses are covered except the first pair of medically necessary contact lenses or eye glasses following cataract surgery.

Massage therapy: All forms of massage therapy and soft tissue therapy, regardless of who performs the service.

Medical records: Charges for requests or production of medical records

Missed appointments: If you incur a charge for missing an appointment, the Supplemental Medical Plan will not pay any portion of the charge.

Nursing care:

- Care, treatment, services, or supplies received from a nurse that does not require the skill and training of a nurse
- Private duty nursing care that is not medically necessary, or if medical records establish that such care is in the scope of care normally furnished by hospital floor nurses
- Certified nurses' aides.

Organ donation: Expenses incurred as an organ donor when the recipient is not covered under this Plan.

Preventive care: Unless specifically stated elsewhere in this Plan, preventive care is excluded from coverage.

Relatives: Coverage is not provided for treatment by a medical practitioner (including but not limited to: a nurse, physician, physical therapist, or speech therapist) who is a close relative (spouse, child, brother, sister, parent, or grandparent of you or your spouse, including adopted or step relatives)

Sex changes: Sex change, gender reassignment/revision, treatment, or transsexual and related operations.

Sleep disorders: Treatment of sleep disorders unless medically necessary. Quick Review helps you make informed decisions when your physician recommends treatment for a sleep disorder. If you are under age 65, you should call Health International to request pre-authorization for any sleep disorder treatment.

Speech therapy: Except as described in *Covered Expenses*, expenses for losses or impairments caused by mental, psychoneurotic or personality disorders, or for conditions such as learning disabilities, developmental disorders, or progressive loss due to old age; speech therapy of an educational nature are not covered.

TMJD: Expenses for diagnosis and treatment of any kind for temporomandibular joint disease or disorder (TMJD) or syndrome by similar name

Transportation: Transportation by regularly scheduled airline, air ambulance, or train for more than one round trip per illness or injury.

Usual and prevailing: Expenses that exceed the usual and prevailing fee limits.

War-related: Services or supplies received as a result of a declared or undeclared act of war or armed aggression.

Weight reduction: Hospitalization, surgery, treatment, and medications for weight reduction other than for approved treatment of diagnosed morbid obesity. Contact QuickReview to determine if treatment is covered.

Wellness items: Items that promote well-being and are not specific for the illness or injury involved (including but not limited to massage therapy, dehumidifiers, air filtering systems, air conditioners, bicycles, exercise equipment, whirlpool spas, and health club memberships). Also excluded are:

- Services or equipment intended to enhance performance (primarily in sports-related or artistic activities), including strengthening and physical conditioning
- Services related to vocation, including but not limited to: physical or FAA exams, performance testing, and work hardening programs.

Work-related: Medical services and supplies for treatment of any work related illness or injury sustained by you or your spouse, whether or not covered by Workers' Compensation, occupational disease law, or other similar law.

QuickReview and CheckFirst

When to Call QuickReview

Contact QuickReview administered by Health International:

- Before you are admitted to the hospital or undergo a surgical procedure
- Within 48 hours after an emergency hospital admission (or the next business day if you are admitted on a weekend)
- Before you undergo testing or treatment for sleep disorders
- Before you contemplate or undergo any organ transplant.

- During the first 16 weeks of pregnancy, to participate in your medical plans healthy pregnancy program.

QuickReview for Hospital Pre-Authorization

Health International helps you make informed decisions when your physician recommends hospitalization or surgery. If you are under age 65, you should call Health International to request pre-authorization (QuickReview) of any surgery or hospital admission. Although you are not required to contact Health International, you are encouraged to call to find out:

- Whether the proposed treatment is considered medically necessary and appropriate for your condition
- The number of days of hospitalization that are authorized.

Health International does not determine whether you are eligible for benefits under the Plan or how much you will be reimbursed. (For information on eligibility or coverage, call HealthFirst TPA at 800-711-7083 for a CheckFirst pre-determination of benefits.)

Health International determines the medically necessary length of a hospital stay. Any portion of a stay that has not been approved is considered not medically necessary. The Plan does not pay charges for any portion of a stay that is not medically necessary. For example, if Health International determines that five hospital days are medically necessary for your condition and you stay in the hospital seven days, charges for the last two days will not be covered. If your physician recommends surgery or hospitalization, ask your physician for the following information:

- Diagnosis
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician’s name and telephone number
- Name and telephone number of the hospital or clinic where surgery is scheduled.

Call Health International (QuickReview) as soon as possible after surgery or hospitalization is scheduled, with the information provided by your physician. In the event of an emergency hospital admission, call within 48 hours after the admission (or the next business day if you are admitted on a weekend).

If you are unable to contact Health International, any of the following may contact Health International for you:

- A family member
- Your physician
- The hospital.

Health International determines the medically necessary length of your hospital stay. In some cases, they may refer you for a second opinion.

Be sure to write down the reference number Health International gives you when you call. You will need that number if you call them back at a later time.

If you receive pre-authorization of a hospital stay over the phone, ask Health International to send written confirmation of the pre-authorization.

After you are admitted to the hospital, Health International provides case management services to monitor your stay. You or your physician should contact Health International if you need to extend your hospital stay beyond the authorized number of days. Health International will consult with your physician and hospital to verify the need for any extension of your stay. Contact Health International again if you are discharged from a hospital and then readmitted or transferred to another hospital for treatment of the same illness.

Health International does not guarantee that benefits will be paid. HealthFirst TPA, the claims processor, reserves the right to make adjustments upon receipt of the final claim papers if the actual service differs from the pre-authorization information you submitted.

CheckFirst for Pre-Determination of Benefits

CheckFirst, administered by HealthFirst TPA, allows you to find out if your physician's proposed charges fall within the usual and prevailing fee limits and if the recommended service or treatment is covered by the Plan.

HealthFirst TPA will determine if:

- The recommended service or treatment is covered by the Plan
- Your physician's estimated expenses fall within usual and prevailing fee limits.

How to Use CheckFirst

To use CheckFirst, you can call HealthFirst TPA at 800-711-7083 for pre-authorization by phone or you can complete a CheckFirst Pre-determination Form and send it to HealthFirst TPA before your proposed treatment. Active employees may request the Check First Pre-determination Form online at *Jetnet*.

Before calling for pre-authorization or completing the form, you will need the following information from your physician:

- Diagnosis
- Clinical name of the procedure and the CPT code
- Description of the service
- Estimate of the charges
- Physician's name and office ZIP code
- Name and ZIP code of the hospital or clinic where surgery is scheduled.

If you receive pre-determination of benefits over the phone, ask for written confirmation. If you have questions about your eligibility or the Plan's coverage for a particular procedure, call the claims processor. Although the claims processor can pre-determine the amount payable by the Plan, you should still call QuickReview for pre-authorization of any hospital stay. A CheckFirst pre-determination does not pre-authorize coverage for the length of a hospital stay.

Although you may find CheckFirst beneficial whenever you need medical treatment, there are two circumstances when you especially benefit by using CheckFirst. Use this pre-determination procedure if your physician recommends either of the following:

Assistant surgeon: A fee for an assistant surgeon is only covered when there is a demonstrated medical necessity. To determine if it is medically necessary to have an assistant surgeon present at the time of surgery, you must use the CheckFirst procedure.

Secondary surgical procedure: If you are having a secondary surgical procedure at the time of scheduled surgery, the secondary procedure will be covered at a reduced reimbursement rate because surgical preparation fees are included in the fee for the primary surgery. There are further reimbursement reductions if a third procedure is involved. You must use CheckFirst to find out how the Plan reimburses the cost for the secondary surgery.

Filing Claims

Eligibility to File Claims

You may file claims under the Supplemental Medical Plan once you reach the maximum medical benefits under your other group medical coverage — if you have elected coverage under this Supplemental Medical Plan.

Active employees and their spouses: You must file a claim under your Medical Benefits Option and receive an Explanation of Benefits (EOB) showing your claim was denied due to exceeding the maximum medical benefit before you may file your first claim under this Plan.

After you have filed your initial claim under this Plan, HealthFirst TPA records will show that you are eligible to file further claims

Surviving spouses:

As the covered spouse[1] of a deceased employee, this plan is primary if you do not have any other group medical coverage. You will send your claim directly to HealthFirst TPA.

If you have any other medical coverage, you must file a claim with that coverage first. Then, attach a copy of your Explanation of Benefits (EOB) from that coverage when you file your claim under the Supplemental Medical Plan. Coordination of benefits will be calculated.

How to File a Claim

To file a claim, you must complete a Supplemental Medical Benefits Claim Form (available from HealthFirst TPA) according to the instructions on the form. Be sure to provide all required information about your other coverage. Examples of other coverage include your Company-sponsored Medical Benefit Option, your spouse's other group medical coverage, Workers' Compensation, Medicare, Champus, and no-fault motor vehicle insurance.

If this is your first claim, attach your EOB from your Company-sponsored Medical Benefit Option or other group medical coverage showing the denied claim that makes you eligible to file under this Plan. (This is not required if you are covered as a surviving spouse with no other coverage.) Along with your claim, submit an original, itemized statement of expenses from your service provider, showing the following information:

- Name of patient
- Date of treatment
- Description of treatment and charge per treatment code
- Charge per treatment

1 If you die while you and your Domestic Partner are covered under the Supplemental Medical Plan, coverage for your Domestic Partner continues for 90 days, provided your Domestic Partner pays the contribution rate to continue coverage. At the end of 90 days, coverage ends.

- Diagnosis of the injury or illness for which treatment was rendered.

Keep a copy of your completed claim form and any other information you are including with the claim.

Here are some other important points about filing claims:

- If you incur additional medical expenses during the year, you may file the short version of the claim form for those expenses.
- If you assign payment of your benefits directly to the service provider (as described under *Assignment of Benefits* on page 163), the claims processor will send the payment directly to your service provider. Otherwise, the payment will be sent to you.
- If your claim form is incomplete or you do not attach an itemized statement from your service provider, processing of your claim will be delayed until the information has been received.

Send your claims to:

HealthFirst TPA
P. O. Box 130217
Tyler, Texas 75713-0217

Claim Filing Deadline

You must submit all health claims within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment. Notwithstanding the above, the Department of Health and Human Services (“HHS”) and the Center for Medicare and Medicaid Services (“CMS”) or any other agency of HHS may file a claim under the Medicare Secondary Payer Statute within 36 months of the date the expense was incurred.

What Happens to Your Claim

Your claim information goes to a HealthFirst TPA claims processing unit. HealthFirst TPA is not an insurance company. It is responsible for processing claims for the Plan according to the terms of this coverage. You will receive an Explanation of Benefits (EOB) which summarizes the benefit calculation and provides documentation of any payment made or benefit denied. Normally, you will receive an EOB within three weeks after filing a properly documented claim, unless further information is required. Your claims will be processed in accordance with the Claim Processing Requirements on page 165. The claims processor will contact you or the provider to request any additional information. Your prompt response will expedite processing of your claim.

The claims processor, at the Plan’s expense, has the right to have a physician of its choice examine any Plan participant as often as reasonably necessary while a claim is pending.

Who to Call With Questions

For claim forms, questions about the Plan, or the status of your claim, contact HealthFirst TPA at 800-711-7083 between 8:00 a.m. and 5:00 p.m. Central time.

Hospital Bill Audit

If you are hospitalized and your hospital expenses exceed $10,000, the claims processor will compare your bill with hospital records to verify the expenses shown for your stay are correct. It normally takes three months to process this information. During this audit procedure, the claims processor will withhold 10% of the benefits payable until it verifies expenses.

Notify HealthFirst TPA , the claims processor, immediately if you receive a bill from the hospital for the amount withheld. After the audit is complete and expenses have been verified, final payment will be made. If any errors are discovered, the claims processor will make the necessary adjustments. If any hospital charges are found to be above usual and prevailing fee limits, you may be responsible for those charges in excess of eligible expenses.

Coordination of Benefits under the Supplemental Medical Plan

If you or your spouse is covered under any other medical coverage, this Plan will coordinate benefits to avoid duplication of payment. The total amount payable under both plans will not be more than 100% of the expenses eligible for reimbursement under this Plan. The benefits that are payable under this Plan will be coordinated with any other medical coverage that provides benefits for the same expenses.

Other Plans

With respect to the Supplemental Medical Plan, the term “other medical coverage” includes any of the following:

- Government or tax-supported programs, including Medicare or Medicaid
- Employer-sponsored medical coverage under which the employer pays all or part of the costs or takes payroll deductions (Note: This does not include Company-sponsored Medical Benefit Options or Retiree Medical Benefits under the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries), regardless of whether the medical coverage is insured or self-funded and/or union-sponsored medical coverage.
- Property or homeowner’s insurance
- No-fault motor vehicle insurance.
- Union-sponsored medical coverage.

Which Plan Is Primary

When a person is covered by more than one plan, one is the primary plan and all other plans are considered secondary plans. The primary plan pays benefits first and without consideration of any other plan. The secondary plans then determine whether any additional benefits will be paid after the primary plan has paid.

The following determines which plan is primary:

- Any plan that does not have a coordination of benefits provision is automatically the primary plan.
- A plan that has a coordination of benefits provision is the primary plan if it covers the individual as an active employee. The Supplemental Medical Plan is not primary if an employee has coverage under any other group health coverage.
- Any benefits payable under this Plan and Medicare will be paid according to federal regulations. In case of a conflict between Plan provisions and federal law, federal law controls.

- If none of the above conditions apply, the plan that has been covering the employee the longest will be primary.

When Coordination Applies

The Supplemental Medical Plan pays after all other medical coverages have paid. Coordination of benefits is required in all of the following situations:

- If an active employee or spouse has exceeded the maximum medical benefit under a Company-sponsored Medical Benefit Option, but the covered person has coverage under the spouse's other group medical coverage
- If an active employee, spouse, or surviving spouse has Medicare coverage (after the covered person has exhausted his or her maximum medical benefit under one of the Company-sponsored Medical Benefit Options)
- If a surviving spouse has coverage through his or her employer (employer-sponsored coverage)
- If the employee has been covered longer under another supplemental medical coverage.

Additional Rules

The following sections apply to the Supplemental Medical Plan.

- Coordination of Benefits See page 78
- Coordination with Medicare See page 80
- Continuation of Coverage See page 81

Employee Assistance Program (EAP)

How the EAP Works

The Company recognizes that alcohol and drug dependency and other serious personal problems affect an employee's health and job performance. The Employee Assistance Program (EAP) helps employees obtain treatment for these problems before health, safety, and work performance are compromised. The EAP is available to all employees and their dependents at no cost.

The EAP protects confidentiality. Contacting the EAP for assistance does not jeopardize job security and advancement opportunities. However, the Company will not knowingly allow employees to work if there is a question concerning fitness for duty. In addition, EAP participation does not relieve an employee of the obligation to comply with Company rules and regulations.

The EAP is accessible through the following individuals. Both adhere to strict guidelines of confidentiality.

EAP representatives are:

- Members of the EAP staff who facilitate and implement the EAP.
- Accessible to employees and dependents who require information or assistance.

EAP representatives can provide referrals to mental health professionals for employees enrolled in the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options. Any employee or dependent seeking help for an alcohol or drug problem must call the EAP, regardless of which medical option he or she is enrolled in.

Employee coordinators are:

- Employees who volunteer to assist in overall EAP coordination. Employee coordinators are not mental health care professionals, but rather are appointed within each union group and trained by an EAP representative. Management and non-management coordinators volunteer to assist non-union employees.

Chemical Dependency and Rehabilitation

Referral to treatment centers is a valuable service of the EAP. Employees seeking admission to an alcohol or drug treatment facility for themselves or a dependent must contact either an EAP representatives or the AMR Medical Department. EAP representatives can arrange for needed treatment at a licensed treatment facility.

The Medical Benefit Options or Plan only reimburse the cost of chemical dependency treatment and rehabilitation programs that are pre-approved either by an EAP representative or the AMR Medical Department and are eligible for coverage under the Plan. Expenses for rehabilitation are not covered if you fail to follow the proper procedures in seeking treatment. EAP approval does not guarantee coverage for the claim if the expense is not eligible for coverage or if you or your dependent is not covered by the Medical Benefit Options or Plan.

The EAP can also refer you to counseling professionals, credit services, and other services to help you resolve personal problems. For more detailed information concerning the EAP, its procedures, and guidelines, contact an EAP representative.

Dental Benefits

Dental Benefit Features

The Dental Benefit pays benefits for routine dental care and treatment for disease, defect and injury. The Plan is self-funded by the Company and claims are processed by MetLife.

ID cards are not necessary under the Dental Benefit. The dental provider's office is responsible for verifying eligibility.

Feature	Dental Benefit
Annual Deductible	$50 per person
Preventive Service (exams, cleanings, routine x-rays, maximum 2 visits per year)	80%
Basic & Major Services (fillings, extractions, crowns, onlays, dentures)	50%
Orthodontia Services (eligible dependent children only; no deductible applies)	50%
Maximum Benefit (per person per year)	$1,000
Maximum Lifetime Orthodontia Benefit (per dependent child)	$1,500

How the Dental Benefit Option Works

The following is information you need to know about Dental Benefit coverage and circumstances that determine how benefits are paid:

Medically necessary: Only dental services that are medically necessary are covered by the Dental Benefit. Cosmetic services are not covered.

Usual and prevailing fee limits: The amount of benefits paid for eligible expenses is based on the usual and prevailing fee limits for that service in that geographic location.

Pre-determination of benefits: If your dentist estimates that charges for a procedure will be substantial, you should request pre-determination of benefits before you receive treatment. However, it is recommended that you obtain pre-determination for any proposed procedure. To request pre-determination from the claims processor, your dentist may complete the standard Dental Claim Form, indicating that it is for pre-determination of benefits.

Alternative treatment: If you undergo a more expensive treatment or procedure when a less expensive alternative is available, the Dental Benefit pays benefits based on the less expensive procedure that is consistent with generally accepted standards of appropriate dental care.

When expenses are incurred: For purposes of determining Dental Benefit coverage and benefits, the dental expense is deemed to be incurred at the time of the initial treatment or preparation of the tooth.

The Preferred Dentist Program (PDP): The Dental Benefit offers a network of over 70,000 participating dentists nationwide (general dentists and specialists) who provide fee discounts to Dental Benefit participants. You are not required to use PDP network dentists, but will benefit from cost savings when you do. You can request a customized directory of participating dentists in your area by calling MetLife (see *Contact Information* on page 1) or by visiting its Web site at www.metlife.com/dental.

Injury by others: If you are injured by someone else and your dental plan pays a benefit, the Company will recover payment from the third party (see *Subrogation* page 164).

Health Care Flexible Spending Account: Dental expenses are eligible for reimbursement and will automatically roll over to your account if you participate in a Health Care Flexible Spending Account, unless you inform UnitedHealthcare that you want to discontinue the automatic rollover feature. If you cover a Domestic Partner or a dependent of a Domestic Partner, you must inform the FSA administrator that you want to discontinue the automatic rollover feature. See *Eligible Expenses* on page 148 for important details.)

Coordination of benefits: If you or a covered dependent has coverage under any other group dental plan, the Dental Benefit coordinates benefits with the other plan. (See *Coordination of Benefits* on page 78 for additional information.)

Covered Expenses

To be covered by the Dental Benefit Option, a dental expense must be medically necessary and provided by a duly qualified and licensed dentist or physician (unless specifically excluded). Charges for covered items must be within the usual and prevailing fee limits. The following dental services and supplies are covered by the Dental Benefit:

Dentures and bridgework: Full and partial dentures and fixed bridgework, including:

- Installation of the initial appliance to replace natural teeth extracted, including adjustments within six months of installation
- Replacement if the appliance is more than five years old and cannot be repaired (Appliances that are over five years old but can be made serviceable will be repaired, not replaced)
- Installation of the appliance for teeth missing as a result of a congenital anomaly. (Charges are limited to the allowance for a standard prosthetic device.)

The total allowance for both a temporary and permanent denture or bridge is limited to the maximum benefit for a permanent denture or bridge. Charges are determined from the date the first impression is taken.

Extractions, necessary surgery, and related anesthetics: These services are considered covered dental treatments. However, fractures and dislocations of the jaw are included under Medical Benefit Options.

Fillings and crowns: Silver (amalgam) or porcelain fillings and plastic restorations subject to the following:

- Porcelain crowns are covered only for the 10 front upper and 10 front lower teeth
- Porcelain or plastic facings on crowns posterior to the second bicuspid are not covered
- Gold fillings and crowns are covered only when the tooth cannot be restored with other materials

- Crowns may only be replaced if the existing crown is more than five years old, regardless of the reason for the replacement.

Implants: Dental implants, inlays, and onlays only if medically necessary and approved by independent dental consultants selected by the Company.

Oral examinations, x-rays, and laboratory tests: The following are covered if necessary to determine dental treatment:

- Full mouth x-ray once in any three-year period
- Routine x-rays not more than twice per calendar year
- Other x-rays necessary to propose diagnosis or examine progress of treatment.

Periodontal treatment: Necessary periodontal treatment of the gums and supporting structures of the teeth and related anesthetics are covered.

Preventive treatment:

- Exams twice per calendar year
- Routine x-rays twice per calendar year
- Teeth cleaning twice per calendar year
- Fluoride treatments once a year for children under age 18 (not covered on or after the child's 18th birthday)
- Sealants for children under age 15 (not covered on or after the child's 15th birthday)
- Space maintainers.

Root canals: Root canals and other endodontic treatments are covered. The charge for root canal therapy is considered to have been incurred on the date the tooth is opened.

Covered Orthodontia Expenses

The dental plan covers orthodontic treatment for an adult or eligible dependent child and covers 50% of eligible and necessary expenses, to a maximum benefit of $1,500 during the entire time the adult or child is covered by the Plan. Orthodontic coverage includes examinations, x-rays, laboratory tests, and other necessary treatments and appliances. There is no deductible for orthodontic treatments, and payments for orthodontia do not reduce the annual maximum benefit for other services.

The following explains additional information about orthodontia coverage:

Ongoing dental coverage: To remain eligible for coverage of orthodontic treatments that extend into a new coverage period (for example, the next calendar year), you must continue to cover the patient under your dental option during each annual enrollment period.

Payment of claims: Payment for orthodontia is made according to the following procedures (regardless of the payment method you arrange with your provider):

- The provider of service (orthodontist) should submit one billing that reflects the total cost of the patient's orthodontic treatment — even if the duration of treatment moves across calendar years. The Dental Benefit will pay up to the maximum benefit of $1,500, in one lump sum, based upon the orthodontist's lump sum billing for orthodontia treatment (provided the treatment is determined to be an eligible expense under the Dental Benefit).

- Coordination of benefits applies if the patient has other orthodontia coverage. If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the $1,500 maximum benefit

Health Care Flexible Spending Account

If you participate in the Health Care Flexible Spending Account (HCFSA), the total cost of the patient's orthodontic treatment (based upon the lump sum billing from the orthodontist) will be reimbursed from your HCFSA in one lump sum, up to the amount you elected to contribute for the year. Other dental services are also eligible for reimbursement, as explained in *Health Care FSA – Eligible Expenses* (see page 148). Note: Effective January 1, 2005, the FSA administrator changed from FBD Consulting to UnitedHealthcare.

Excluded Expenses

The following expenses are not eligible for reimbursement under the Dental Benefit:

Anesthesia: General anesthetics (unless provided for oral surgery or periodontics).

Cosmetic treatment: Treatment or services partly or completely for cosmetic purposes or characterization or personalization of dentures or appliances for specialized techniques.

Crowns or appliances: Crowns, adjustments, or appliances used to splint teeth, increase vertical dimensions, or restore occlusion. Replacement of crowns less than five years old will not be covered, regardless of the reason for replacement.

Education or training: Education, training, or supplies for dietary or nutritional counseling, personal oral hygiene, or dental plaque control.

Free care: Charges for services or supplies that you are not legally required to pay.

Medical expenses: Any charge for dental care or treatment that is an eligible expense under your Medical Benefit Option.

Night guards: Also referred to as occlusal guards and bruxism appliances.

Prescription drugs: Dental prescriptions. (These are covered under the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options. However, some HMOs do not cover dental prescriptions.)

Relatives: Treatment by a dentist or physician who is a close relative, including your spouse, children, adopted and step relatives, sisters and brothers, parents, and grandparents of you or your spouse.

Replacement dentures or bridges: Replacement charges for full or partial dentures or a fixed bridge that is less than five years old. Appliances that are over five years old but can be made serviceable will be repaired, not replaced. Any charges that exceed the cost of a standard prosthetic appliance.

Services not provided by dentist or physician: Any service not provided by a dentist or physician, unless performed by a licensed dental hygienist under the supervision of a dentist or physician, or for x-ray or laboratory tests ordered by a dentist or physician

Temporary dentures, crowns, or bridges after 12 months: A temporary fixture, such as a temporary denture, crown, or bridge, that remains in place for 12 months or more is considered permanent and the cost of replacement is only covered when the item is more than five years old.

Temporomandibular joint dysfunction (TMJD): TMJD is considered an illness and has limited coverage only under the Medical Benefit Options (see page 63).

U. S. government services or supplies: Charges for services or supplies furnished by or for the U. S. government.

Usual and prevailing: Charges that exceed the usual and prevailing fee limits.

War-related: Services or supplies received as a result of a declared or undeclared act of war or armed aggression.

Work-related claims: Dental care received because of a work-related injury or illness sustained by you or your covered dependent, whether or not it is covered under Workers' Compensation, occupational disease law, or similar law.

Filing Claims

MetLife is the claims processor for the Dental Benefit; however, MetLife does not insure these benefits. Benefits for the Dental Benefit are self-funded, which means all claims are paid from the Company's general assets.

Completing the Dental Claim Form

The following is a summary of how to file claims for dental expense benefits:

- Complete the top portion of the Dental Expense Claim Form available on *Jetnet*. Follow the instructions that accompany the form and then present the form to your dentist, who completes the remaining portion.
- Mail the completed claim form to MetLife at the address on the form.
- All dental claims payments are sent to you along with an Explanation of Benefits (EOB) explaining the amount paid. Payments may, however, be sent directly to your dentist or other dental provider if your provider accepts *Assignment of Benefits* (see page 163). If you assign benefits to the service provider, the EOB will be mailed to you and the payment mailed to your provider.

Claim Filing Deadline

You must submit all dental claims within two years of the date the expenses were incurred. Claims submitted more than 24 months after expenses were incurred will not be considered for payment. Notwithstanding the above, the Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") or any other agency under the HHS may file claims under the Medicare Secondary Payer Statute within 36 months of the date on which the expense was incurred.

Additional Rules

The following sections apply to the Dental Benefits.

- Qualified Medical Child Support Order See page 74
- Coordination of Benefits See page 78
- Coordination with Medicare See page 80
- Continuation of Coverage See page 81

Vision Benefits

The Company offers two vision options — the Vision Discount Plan and the Spectera Vision Insurance Benefit.

EyeMed Vision Discount

This Vision Discount Plan is a preferred provider discount program contracted through EyeMed. EyeMed has a national network of more than 7,000 chain and independent optical stores.

With EyeMed you'll receive savings averaging 37% on lenses and frames, a 20% savings on contact lenses and any sundry items and a 10% savings on disposable contacts. EyeMed preferred pricing limits the amount EyeMed providers can charge for a comprehensive eye examination. The EyeMed preferred pricing cannot be used in conjunction with any other promotion.

How the EyeMed Vision Discount Works

You receive an annual EyeMed membership card to present at participating optical stores. Presenting the card at the time of purchase entitles you to discounts on eyeglass lenses, frames, contact lenses, and sundry items. No claim form or special paperwork are required. To find the nearest participating EyeMed optical store, call the toll-free number listed on your membership card and ask for the location nearest you.

Spectera Vision Insurance Benefit

How the Spectera Vision Insurance Benefit Works

The Company offers employees and their eligible dependents the opportunity to participate in the Spectera Vision Insurance Benefit. Spectera vision insurance is insured and administered by Spectera, a national vision care company, and offers a network of providers and copayments for certain vision services.

Spectera's network of providers includes retail chains, such as Eyemasters, as well as independent providers. You can locate participating providers by visiting Spectera's Web site at www.spectera.com, or you can contact Spectera at 800-638-3120 directly to locate a provider. To review the Spectera Vision Care Program, refer to the Spectera Rates and Services chart and Spectera's Vision Care Brochure on the website.

ID cards are not necessary under the Spectera Vision Insurance Benefit. The provider's office is responsible for obtaining the pre-authorization to perform services and provide glasses, frames, etc., and will request the covered employee's Social Security number, in addition to the patient's name and date of birth.

Spectera Vision Insurance Benefits

If you use a network provider, the Spectera Vision Insurance Benefit covers the following services, available once per twelve-month period, for each covered member. (The insurance also offers access to discounted laser eye surgery procedures.)

Spectera Vision Insurance Network Provider Benefits

Covered Services	You Pay…
Comprehensive Vision	$10 copayment
Pair of lenses[1] (for glasses)	
Clear single vision	$25 copayment
Clear lined bifocal	$25 copayment
Clear lined trifocal	$25 copayment
Frames[1] Minimum frame allowance is $120 for frames purchased at a network retail chain provider, i.e., Wal-Mart, Eyemasters	
Selection[2] frame	$25 copayment
Non-Selection[2] Frame	$25 copayment, plus the difference (if any), of Spectera's preferred price.
Contact Lenses (in lieu of lenses and frame)	
Selection[2] contact lenses	$25 copayment
Non-Selection[1] contact lenses	$105 allowance toward the evaluation, fitting fees and contact lenses
Patient Options	
Progressive lenses and tints, etc	Spectera's preferred price, which is typically 20%-40% less than retail
Scratch-coating protection for lenses	No charge

Out-of-Network Provider Benefits

Service	Reimbursement Schedule
Exam	Up to $40
Single Vision Lenses	Up to $40
Bifocal Lenses	Up to $60
Trifocal Lenses	Up to $80
Lenticular Lenses	Up to $80
Frame	Up to $45
Elective Contact Lenses	Up to $105
Medically Necessary Contact Lenses	Up to $210

Participating Providers (network) copayments and non-covered patient options are paid to participating providers by Spectera Vision Insurance Benefits participants.

[1] Single $25 copayment covers one (1) pair of lenses and frame.
[2] Retailer will have a select group of vision products available for this $25 copayment. If you elect a product that is not in the selection group, you will pay an additional out-of-pocket amount.

Non-participating providers (Out-of-Network) participants pay the full fee to the provider and file claims with Spectera. Spectera reimburses the participant for services rendered up to the maximum allowance.

Copayments do not apply to out-of-network benefits. Call Spectera at 800-638-3120 to obtain a claim form for out-of-network services.

Cost

Like the Medical Benefit Options offered by the Company, you may participate in the Spectera Vision Insurance Benefit, and your contributions will be payroll-deducted. If you elect a Medical Benefit Option, the same dependents that are covered under your Medical Benefit Option must also be covered under the Vision Insurance Benefit.

Additional Rules

The following sections apply to the Spectera Vision Insurance Benefit.

- Qualified Medical Child Support Order See page 74
- Coordination of Benefits See page 78
- Coordination with Medicare See page 80
- Continuation of Coverage See page 81

Life and Accident Insurance Benefits

Overview

The Company offers eligible employees the opportunity to participate in an Employee Term Life Insurance Benefit as well as Spouse and Child Term Life Insurance Benefit. Employee Term Life Insurance coverage is for you only and pays a benefit to your designated beneficiary in the event of your death. Spouse and Child Term Life Insurance covers your eligible spouse and children only and pays you a benefit if your covered spouse or child dies. Optional levels of Contributory Term Life Insurance coverage are also available (see page 117). All life and accident insurance benefits are paid solely by and through the insurance policies by the insurer. No life or accident benefits are available outside of the insurance policy.

If you plan to cover a Domestic Partner under this life insurance, you must submit the MetLife Affidavit of Domestic Partnership available from MetLife.

“Term Life Insurance” is coverage that pays a death benefit, but has no cash value and remains in effect only during the time premiums are being paid. These coverages are insured by MetLife and you pay your share of the cost of Contributory coverage, if any, through payroll deduction.

Employee Term Life Insurance

Basic Life Insurance Benefits

As an eligible employee, the Company provides you Basic Term Life Insurance coverage of one times your base annual salary when you enroll in a medical benefit option.

Contributory Term Life Insurance Benefits

The Company provides you Basic Term Life coverage equal to one times your base annual salary. When you are first eligible for benefits, you may elect up to one level above the Company-provided coverage without providing proof of good health. You must submit a Statement of Health to MetLife if you wish to elect amounts greater than this. Coverage that requires proof of good health becomes effective only after MetLife approves your application and only after you (the employee) pay the first contribution, either directly or through payroll deduction. Rates for contributory life insurance are based on your age.

After you enroll, you may only increase your coverage by one level per year with proof of good health. You may not waive your Basic Term Life Insurance Benefits. The maximum Contributory Term Life Insurance allowed is $350,000 not including the Basic Life Insurance.

Below are the options that are available:

Amount
Basic plus 1 times your base annual salary
Basic plus 2 times your base annual salary
Basic plus 3 times your base annual salary
Basic plus 4 times your base annual salary
Basic plus 5 times your base annual salary
Basic plus 6 times your base annual salary

Coverage After Age 65

Basic Life Insurance coverage for active employees age 65 and over decreases annually as shown below. Although the amount of the benefit decreases, employees pay the full cost for the benefit they elect.

Age	Percentage Of Total Benefit Elected	Age	Percentage Of Total Benefit Elected
65	92%	**71**	56%
66	85%	**72**	52%
67	78%	**73**	48%
68	72%	**74**	44%
69	66%	**75**	41%
70	61%	**76 and over**	38%

Coverage If You Become Disabled

If you become permanently and totally disabled while covered, all of your Term Life Insurance coverage continues at no cost to you. To qualify for this benefit, you must become permanently and totally disabled before age 60 and be absent from work at least nine consecutive months because of your disability.

Permanent and total disability exists if all of the following requirements are met:

- You are not engaged in any gainful occupation
- Because of illness, injury, or both, you are completely unable to engage in any occupation for which you are reasonably fit
- Your disability is such that your inability to work will probably continue for the rest of your life.

To apply for a waiver of Basic and Contributory Term Life Insurance contributions, you must file your claim with MetLife between the 9th and 12th month after the date your disability began. Claims filed after the 12th month will not be considered. Call HR Employee Services at 800-447-2000 to request a claim form.

If you became disabled before January 1, 1995, and are approved for this waiver, your Basic and Contributory Term Life Insurance coverage continues at no cost to you as long as you remain permanently and totally disabled.

If you became disabled on or after January 1, 1995, your Basic Term Life Insurance coverage will stop at age 65.

MetLife will require you to submit proof of your continuing disability at least once a year. Proof may include examination by doctors designated by the insurance company. If this proof is not submitted, coverage will terminate.

Accelerated Benefit Option

The Accelerated Benefit Option (ABO) allows terminally ill people the opportunity to receive a portion of their life insurance during their lifetime. This money can be used to defray medical expenses or replace lost income during the last months of an illness and is not subject to income tax. The remaining portion of the life insurance benefit is payable to the named beneficiary when the covered person dies.

The ABO benefit is available to employees who have Company-provided Term Life Insurance (active or on sick leave) and their spouses covered under Spouse Term Life Insurance. Employees who are approved as permanently and totally disabled (as defined in Permanent and Total Disability and who continue the active amount of life insurance) are also eligible for an ABO.

To qualify for an ABO payout, the covered person must have an injury or illness that is expected to result in death within six months, with no reasonable prospect for recovery. A physician's certification is required, and all applications are subject to review and approval by MetLife's medical department. Based on this review, the claim is either paid or denied. If it is paid, you may not later change the amount of your life insurance coverage.

ABO payout for approved claims is 50% of your total Employee Term Life Insurance (Basic and Contributory) or Spouse Term Life coverage, up to a maximum of $250,000. Therefore, any life insurance coverage in excess of $500,000 is not eligible for the ABO. In addition, a minimum of $15,000 in life insurance coverage is required to be eligible.

Your life insurance premiums must be current at the time of the ABO application. If you are on sick leave and have allowed your coverage to default to the Company-provided amount, you are only eligible to receive ABO benefits on that coverage amount. After an ABO payout, you are no longer permitted to change life insurance coverage levels. Employees who have irrevocably assigned their life insurance benefits (as explained below) are not eligible for ABO benefits. Call HR Employee Services at 800-447-2000 for information and assistance in filing an application for an ABO.

Requesting the Accelerated Benefit Option

Contact HR Employee Services at 800-447-2000 for information on filing a request for an Accelerated Benefits Option (ABO).

Filing a Claim

MetLife insures all life insurance benefits under a group insurance policy. They also process all claims. The following is a short summary of the procedures for filing a claim for Term Life Insurance benefits:

- Upon receiving notice of an active employee's death, the supervisor should call HR Employee Services at 800-447-2000 to provide notification of the death or consult N*EMPLOYEE DEATH in SABRE for guidelines and responsibilities in processing the death. The supervisor's guide directs him or her to complete the Death Notification Form available in SABRE record N*EMP DEATH NOTIF FORM and fax it to HR Employee Services at the number on the form.
- HR Employee Services notifies other applicable areas of the Company of your death and begins to process insurance claims or other survivor benefits and privileges.
- HR Employee Services determines your most recently named beneficiary and confirms the amount of life insurance.
- HR Employee Services sends a letter to the designated beneficiary contact verifying the amount of life insurance payable by the plan. They will enclose a Beneficiary Life Insurance Claim Statement and any other forms that each beneficiary must complete.
- When HR Employee Services receives the completed Beneficiary Life Insurance Claim Statement and a certified copy of the death certificate, they will ensure a claim is filed with MetLife on behalf of your beneficiary.

The life insurance claim will be paid approximately four to six weeks after MetLife receives all necessary documentation.

Spouse and Child Term Life Insurance Benefits

You may cover either your spouse (under Spouse Term Life Insurance) or your children (under Child Term Life Insurance), or you may cover both your spouse and your children.

Spouse and Child Term Life Insurance options are as follows:

Option	Amount of Benefit
Spouse Term Life Insurance	
ES1	1 times your pay
ES2	2 times your pay
ES3	3 times your pay
WAV	No coverage
Child Term Life Insurance	
EC1	$15,000 for each covered child
WAV	No coverage

Benefit amounts for Employee and Spouse coverage are rounded to the next highest $100 (if not already an even multiple). Benefit amounts and contributions may increase (or decrease) during the year if you experience a pay increase (or decrease).

To add or increase Spouse Term Life Insurance, your spouse must complete a Statement of Health form. You must then forward the completed form to MetLife for review. Upon approval from MetLife, coverage will be added or increased. Coverage that requires proof of good health becomes effective only after MetLife's approval and only after you (the employee) pay the first contribution, either directly or through payroll deduction.

The following table defines pay for Employee Term Life Insurance:

Employee Status	Definition of Pay
Regular Full-time Employee	Base annual salary or annualized hourly pay plus market rate differentials, but excluding bonus and overtime
Converted Part-time Employees	Annualized hourly pay
Regular Part-time Employees	Average base salary
Employees on Temporary Assignment	Pay for the last permanent position held

You pay the entire cost for any Spouse and Child Term Life coverage you select. You elect coverage at the rate shown on your Enrollment Worksheet and pay for this coverage with after-tax contributions. Your spouse's rate is based on your spouse's age, but coverage for your child(ren) is based on a flat rate, regardless of the number of children covered.

The cost of coverage for both the employee and spouse plans will increase or decrease during the year if the amount of your coverage fluctuates due to changes in your pay.

Filing a Claim

All life insurance benefits are provided under a group insurance policy issued by MetLife. MetLife also processes and pays all claims.

The following is a short summary of the procedures for filing a claim for Spouse or Child Term Life Insurance benefits:

- Upon the death of your covered spouse or child, you or your supervisor should inform HR Employee Services of the death. You are the sole beneficiary for your spouse or child's term life insurance.
- After HR Employee Services is notified of the death, it sends you a letter verifying the amount of life insurance payable. The letter will include a *Beneficiary Life Insurance Claim Statement*.
- Complete the *Beneficiary Life Insurance Claim Statement* and return it, along with a certified copy of the death certificate, to HR Employee Services. Upon receipt of both items, HR Employee Services will submit the claim to MetLife on your behalf.
- The life insurance claim will be paid in approximately four to six weeks after MetLife receives all necessary documentation. You may assign part of the benefits to pay funeral expenses, (see page 163 for information on *Assignment of Benefits.*)
- When a spouse or covered dependent dies, you may want to make changes to your benefits coverages. To process these changes, contact HR Employee Services at 800-447-2000. For a list of allowable changes that may be appropriate at this time, refer to Life Events (see page 28). For your convenience, the letter you receive from Employee Services includes a Beneficiary Designation Form. The form is also available on *Jetnet*. You can use this form to make any necessary changes to the beneficiary designations you have on file, if appropriate and as applicable.

Total Control Account

When a claim is processed, MetLife establishes a Total Control Account for you if your share is $5,000 or more (smaller amounts are paid in a lump sum). MetLife then deposits all insurance proceeds into the account, which is an interest-bearing checking account that earns interest at competitive money market rates and is guaranteed by MetLife. MetLife sends you a personalized checkbook, and you may withdraw some or all of the proceeds and interest whenever necessary. In addition, MetLife sends you a description of alternative investment options. The Total Control Account gives you complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

For income tax purposes, proceeds deposited into the Total Control Account are treated the same as a lump-sum settlement. Because the tax consequences of life insurance proceeds may vary, the Company strongly recommends that you consult a tax advisor.

MetLife will only pay interest on life insurance claims (to cover the time between death and date of payment) if you live in a state that requires interest payments. Because state insurance laws vary, calculation of interest differs from state to state.

Accident Insurance Benefit

Overview

As an eligible employee, you automatically receive Accidental Death & Dismemberment Insurance (AD&D) equal to 1x your annual salary from the Company, at no cost to you. You may also elect to purchase Voluntary Personal Accident Insurance (VPAI) for yourself and your family. In the event of an accidental injury, VPAI and AD&D pay benefits to:

- You in the case of certain accidental injuries to you
- You in the event of your covered dependent's death (VPAI only)
- Your named beneficiary in the event of your death.

VPAI coverage also includes the following features:

- You pay premiums through convenient before-tax payroll deduction
- Coverage is available for you, your spouse and dependent children (if any)
- You may select coverage in $10,000 increments up to $500,000 for employee coverage and up to $350,000 for spouse coverage. Child AD&D provides $10,000 coverage for each dependent child, regardless of the number of children covered.
- Coverage is available without regard to previous health history
- The plan provides broad 24-hour protection, year round, including coverage during travel
- Benefits are payable in addition to any other insurance you may have
- With VPAI coverage, you are also eligible for Travel Assistance Services (see page 125).

Covered Losses and Accident Benefits

A covered loss includes death, paralysis, or loss of limb, sight, speech, or hearing. The Accidental Death and Dismemberment Insurance (AD&D) Voluntary Personal Accident Insurance (VPAI) coverages pay a benefit if you (or a covered dependent for VPAI) have a loss within one year of an accidental injury. If you experience more than one loss from the same accident, the coverages pay the largest amount applicable to one loss.

The following table explains when an injury is covered as a loss:

If Injury Is To:	It Must Be:
Hand or foot	Severed through or above the wrist or ankle joint
Arm or Leg	Severed through or above the elbow or knee joint
Eye	The entire, irrecoverable loss of sight
Thumb and index finger	Severed through or above the metacarpophalangeal joint (the point where the finger is connected to the hand)
Speech	An irrecoverable loss of speech that does not allow audible communication in any degree
Hearing	An irrecoverable loss of hearing in both ears, that cannot be corrected with any hearing aid or device

AD&D and VPAI Benefits

The following table shows the portion of benefits that the AD&D and VPAI coverages pay if you (or your covered dependent for VPAI) have an accidental injury that results in a loss:

If Injury Results In:	Benefit Is:
Death	Full benefit amount
Loss of two or more members (hand, foot, eye, leg, or arm)	Full benefit amount
Loss of speech and hearing in both ears	Full benefit amount
Quadriplegia (total paralysis of both upper and both lower limbs)	Full benefit amount
Paraplegia (total paralysis of both legs)	Full benefit amount
Hemiplegia (total paralysis of the arm and leg on one side of the body)	Full benefit amount
Loss of one arm	3/4 benefit amount
Loss of one leg	3/4 benefit amount
Loss of one hand, foot, or eye	1/2 benefit amount
Loss of speech	1/2 benefit amount
Loss of hearing in both ears	1/2 benefit amount
Loss of thumb and index finger on the same hand	1/4 benefit amount

If your accidental injury results in the loss of use of a limb (arm or leg) within one year from the date of an accident, the AD&D and VPAI Insurance Benefits pay the following benefits:

Injury	Benefit
Loss of Use of two limbs	2/3 benefit amount
Loss of use of one limb	1/2 benefit amount

Loss of use must be complete and irreversible in the opinion of a competent medical authority.

Special VPAI Benefit Features

The Voluntary Personal Accident Insurance (VPAI) offers several special features. **These features do not apply to Accidental Death & Dismemberment (AD&D).**

Child care benefit: If you or your spouse dies as the result of an accident and your child is covered under the family VPAI, the coverage pays the surviving spouse an annual benefit of 5% of the total coverage amount (up to $7,500 per year) for the cost of surviving children's care in a licensed child care facility. This benefit is payable up to five years or until the child enters first grade, whichever occurs first.

COBRA reimbursement: If you die as a result of an accident an your spouse and child are covered under the family VPAI, the coverage pays your dependents an additional annual benefit of 3% of your VPAI coverage amount to assist them in paying for continuation of group medical coverage, up to $6,000 per year. This COBRA reimbursement benefit may be paid for up to three years or for the duration of your dependents' COBRA eligibility. To be eligible for this benefit, your spouse and dependent children must be covered under the family VPAI as well as your Medical Benefit Option.

Coma benefit: If you or a covered dependent becomes comatose as the result of an accident within 31 days of the accident, you receive 1% per month of the VPAI death benefit amount each month for up to 11 months. This benefit ends the earliest of:

- The month the covered person dies
- The end of the 11th month for which the benefit is payable
- The end of the month in which the covered person recovers.

This benefit is payable after a 31-day waiting period which begins on the day the covered person becomes comatose.

If the covered person remains comatose after 11 months, the coverage pays the amount of coverage for accidental death reduced by benefits already paid for injury or paralysis. If the covered person dies as the result of the accident while the coma benefit is payable, the coverage pays benefits for accidental death.

In addition to other VPAI exclusions, the coma benefit has one other exclusion. Benefits are not payable for a loss resulting from illness, disease, bodily infirmity, medical or surgical treatment, or bacterial or viral infection, regardless of how it was contracted. However, a bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning is covered.

Coma benefits are paid to the legal guardian or person responsible for the care of the comatose patient. The claims processor determines who is most responsible if a legal guardian is not named.

Payment of the coma benefit to the legal guardian or person responsible for care does not change the designated beneficiary in the event of death.

Common disaster benefit: If you elect family VPAI coverage and, as the result of a common accident, you or your spouse dies within one year of the covered accident, the spouse's loss of life benefits will be increased to 100% of your amount of coverage. However, the combined benefits of you and your spouse will not be more than $1 million.

Counseling and bereavement benefits: VPAI pays an additional benefit if you or an insured family member dies, becomes comatose, or is paralyzed or suffers accidental dismemberment as a result of a covered accident. VPAI will pay for up to five sessions of medically necessary bereavement and trauma counseling, at a maximum of $50 per session, for expenses incurred within one year of the date of the covered accident. Benefits are payable for the insured and any of the insured's immediate family members including mothers/fathers-in-law, and brothers/sisters-in-law.

Double benefit for dismemberment of children: If a covered child experiences a loss as the result of an accident, the benefit amount is double (to a maximum benefit of $60,000). This provision does not apply if death occurs within 90 days of the accident.

Escalator benefit: Your VPAI benefits will automatically increase by 3% of your elected benefit amount each year up to a maximum of 15% after five continuous years. This increased coverage is provided at no additional cost. If coverage ends for any reason, such as layoff, unpaid sick leave of absence, or termination of contributions, any previous escalator benefit is lost. A new five-year escalator benefit period starts if you decrease your coverage or re-enroll. If you increase your level of coverage, you will retain the escalator benefit that has accrued on the previous amount and will begin a new five-year escalator period for the additional amount of coverage.

Seat belt benefit: If you or your covered dependent dies in an accident as the driver or passenger of any land vehicle (including Company-owned cars, pickups, and commercial vehicles) and the covered person was properly wearing a seat belt at the time of the accident, the coverage pays an additional 20% of the benefit applicable to you or your dependent, to a maximum of $25,000. If the vehicle was not equipped with seat belts or the accident report shows seat belts were not in proper use, no seat belt benefit is payable.

Special education benefit: If either parent dies as the result of an accident and you, your spouse, and your children are all covered by the family VPAI, the coverage pays 5% of that parent's total coverage amount (up to $10,000 per year) to each dependent child for higher education. This benefit is payable for up to four consecutive years, as long as the child is enrolled in school beyond 12th grade. If coverage is in force but there are no children who qualify at the time of the accident, the coverage pays an additional $1,000 to the designated beneficiary.

Spouse critical period: If you or your covered spouse dies as a result of an accident, VPAI pays the surviving spouse an additional monthly benefit of 0.5% of the deceased person's coverage amount. This benefit, provided to help the surviving spouse cope with the difficult period immediately following a death, is paid monthly for 12 months.

Spouse retraining benefit: If you die accidentally and your spouse is also covered by the family VPAI, the coverage pays up to a maximum of $10,000 for your spouse to enroll as a student in an accredited school within 365 days of your death. This benefit is in addition to all other benefits.

Waiver of premium: If you elect VPAI coverage for you and your dependents and you die as the result of an accident, any VPAI coverage you have elected for your spouse and children continues without charge for 24 months.

Travel Assistance Services

If you elect Voluntary Personal Accident Insurance (VPAI) coverage for yourself, you may also take advantage of travel assistance services when you and your covered family members travel internationally. This package of valuable services and benefits is called CIGNA Secure Travel and is provided by Worldwide Assistance Services, Inc.

Through CIGNA Secure Travel, you have access to more than 250,000 service professionals in over 200 countries. These agents are available 24 hours a day, seven days a week to provide you with the highest level of service whenever you need it.

CIGNA Secure Travel offers the following services for international travel:

- Services before your departure, including:
    - Immunization requirements
    - Visa and passport requirements
    - Foreign exchange rates
    - Embassy/consular referral
    - Travel/tourist advisories
    - Temperature and weather conditions
    - Cultural information
- Prescription assistance to refill a prescription that has been lost, stolen, or depleted
- Assistance in replacing lost luggage, documents, and personal items

- Legal referrals to local attorneys, embassies, and consulates
- Medical referrals to local physicians, dentists, and medical treatment centers in the event of an accident or illness (The legal referral services listed in the preceding bullet are a benefit of VPAI coverage; however, you will need to pay for any professional services rendered. You must also follow your Medical Benefit Option rules in order to receive reimbursement for any eligible expenses.)
- Emergency message relay to notify friends, relatives, or business associates if you have a serious accident or illness while traveling
- Emergency medical evacuation for transportation to the nearest adequate hospital or treatment facility if medically necessary
- Repatriation of remains in the event of death overseas to cover the cost of returning remains to the place of residence and arranging necessary government authorizations to transfer remains
- Return of dependent children (who are under age 16) traveling with a covered member and who are left unattended when the covered member is hospitalized (Worldwide Assistance Services will arrange and pay for their transportation home. If someone is needed to accompany the children, a qualified escort will be arranged and expenses paid. Children do not have to be covered under Accidental Death and Dismemberment for this benefit.)

If a covered member is traveling alone and must be hospitalized for 10 or more consecutive days, arrangements will be made and paid to provide round-trip economy class transportation for an immediate family member or friend designated by the covered member from his/her home to the place where the covered member is hospitalized. (Worldwide Assistance Services will also arrange and pay for a maximum of $100 per day for up to seven days for meals and accommodations for the family member or friend while they are visiting the hospitalized covered member.)

Take care of all your beneficiary designations in one efficient online process. Visit *My Beneficiaries* under the Benefits & Pay section on *Jetnet*. Please keep in mind that wording is important when designating a beneficiary, and you can designate an unlimited number of beneficiaries. Once the online form is completed and submitted, it supercedes all previous designations. See page 130 for more information on designating beneficiaries.

Exclusions

The AD&D and VPAI Insurance policies do not cover loss caused by or resulting from any of the following:

- Intentionally self-inflicted injuries, suicide, or attempted suicide
- Declared or undeclared act of war within the U.S. or any nation of which you are a citizen
- An accident that occurs while you are serving full-time active duty for more than 30 days in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than bacterial infection caused by an accidental cut or wound

- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting from the vehicle or device while:
    - The vehicle is being used for experimental purposes
    - You are operating, learning to operate, or serving as a member of the crew of an aircraft other than an aircraft operated by or under contract with the Company
- Voluntary self-administration of any drug or chemical substance not prescribed by, and taken according to the directions of, a licensed physician (accidental ingestion of a poisonous substance is covered, as well as accidents caused by use of legal, over-the-counter drugs)
- Commission of a felony including, but not limited to: robbery, rape, arson, murder, kidnapping, or burglary.

Filing a Claim

Voluntary Personal Accident Insurance (VPAI) and Accidental Death & Dismemberment Insurance(AD&D) are provided under group insurance policies issued by the Life Insurance Company of North America (LINA). CIGNA processes all claims for LINA. The following is a short summary of the procedure for filing a claim for VPAI and AD&D benefits:

- Contact HR Employee Services at 800-447-2000 to request a CIGNA claim form within 30 days of the death or injury. (In the event of your death, your supervisor will notify Survivor Support Services, who will coordinate filing for VPAI and AD&D benefits, similar to the procedures outlined for life insurance claims in Term Life Insurance on page 119.) Complete the form according to accompanying directions. All claims must be submitted on CIGNA forms.
- Send the completed claim form to HR Employee Services along with documentation of the claim (such as a police report of an accident and a certified copy of the death certificate). HR Employee Services sends the claim to CIGNA for processing.
- CIGNA processes claims within 90 days from the day they are received. In some cases, however, more time may be needed. If this is the case with your claim, CIGNA notifies you that an additional 90 days will be required. At any point during the claim review period, you may be asked to supply additional information and/or submit to a medical examination at LINA's expense.
- If your claim is approved the insurance proceeds will be deposited into a CIGNA Resource Manager Account (similar to a money market checking account) which earns interest.
- If your claim is denied, you or your beneficiary will be notified in writing. Notification explains the reasons for the denial and specifies the provisions of the LINA group policy that prevent approval of the claim. The notification may also describe what additional information, if any, could change the outcome of the decision.
- If your claim is denied or you have not received a response by the end of the second 90-day review period, you may request a review of your claim.
- No one may take legal action regarding the claim until 60 days after filing the claim. No legal action may be taken more than three years after filing the claim (five years in Kansas or six years in South Carolina). You must exhaust your administrative appeals before filing any legal action regarding a claim denial.

Conversion Rights

You can convert up to $250,000 in VPAI coverage for you and your spouse and up to $10,000 in coverage for each eligible child to individual policies offered by Life Insurance Company of North America (LINA) within 31 days of termination of coverage if coverage terminates for one of the following reasons:

- Your employment ends
- Your eligibility ends (However, a dependent who is no longer eligible for coverage may not convert to an individual policy while you remain eligible for coverage.)
- The coverage ends.

Contact LINA at 800-238-2125 for details on conversion.

Insurance Policy

The terms and conditions of this AD&D and VPAI coverages are set forth in the group insurance policies issued by Life Insurance Company of North America (LINA). These group policies are available for review from LINA. In the event of a conflict between the description in this Guide and the provisions of the insurance policies, the insurance policies will govern.

Other accident insurance, including Terrorism & Hostile Action Accident Insurance and Special Purpose Accident Insurance, is provided under group insurance policies issued by LINA (see *Other Accident Insurance* below). CIGNA processes and pays all claims for LINA. To file a claim, you (or your supervisor for your beneficiary, in the event of your death) should contact HR Employee Services at 800-447-2000.

Other Accident Insurance

The Company provides other accident insurance for certain situations described in this section. Other accident insurance programs include Terrorism & Hostile Action Accident Insurance (T&HAAI) and Special Purpose Accident Insurance (SPAI). These insurance coverages all have the following features:

- Premiums are paid by the Company.
- Coverage is provided without regard to your health history.
- The insurance provides 24-hour protection while you are traveling on Company business, from the time you leave until you return home or to your base, whichever occurs first.
- Benefits are payable in addition to any other insurance you may have.
- Covered losses include death or loss of limb, sight, speech, or hearing. The insurance pays a benefit if you have a loss within one year of an accidental injury. For a description of injuries and how benefits are paid, see *Voluntary Personal Accident Insurance* (page 123).
- No more than one Other Accident Insurance Benefit will be paid with respect to injuries resulting from one accident. If you have more than one loss from the same accident, you are entitled to the largest benefit amount for a single loss.
- Benefits payable under these other accident coverages do not reduce any accident benefits you may receive under the AD&D and VPAI insurance coverages.

The Company also provides other accident insurance under certain situations. These programs include Management Personal Accident Insurance (MPAI), Special Risk Accident Insurance (SRAI) and Special Purpose Accident Insurance (SPAI). Benefits from these programs are payable in addition to any benefits you may receive under the AD&D and VPAI plans.

MPAI Benefits

MPAI provides coverage for management employees while traveling on Company business and for non-occupational accident including any land or water vehicle coverage is three times your salary up to a maximum of $200,000.

SRAI Benefits

SRAI provides coverage for management, agent, support staff and TWU employees for accidental death and dismemberment that occurs as a result of terrorism, sabotage or felonious assault while performing your duties anywhere in the world. SRAI pays a benefit of five times your annual base salary up to a maximum of $500,000.

SRAI pays a benefit of five times your annual base salary up to a maximum of $500,000. This coverage only applies to employees on active payroll. SRAI benefits are reduced by any benefits you receive under MPAI.

SPAI Benefits

This coverage applies to management, agent, support staff and TWU employees. It pays up to $100,000 to each employee who is injured in an accident while engaging in an organized search because of a bomb threat or warning of the presence of an explosive device. Coverage does not apply to an aircraft that is airborne.

The plan also pays up to $10,000 to non-flight employees injured in an accident while riding on Company business as passengers, mechanics, observers or substitute flight attendants in any previously tried, tested and approved aircraft operated by a properly certified pilot.

Policy Aggregates

An accident may involve more than one employee. Total benefits to all covered employees involved in a single incident are limited to:

- $5,000,000 per aircraft under MPAI
- $10,000,000 per accident under SRAI
- $2,000,000 per aircraft accident under SPAI.

If benefits for one incident would exceed the limit, benefits are distributed to beneficiaries in proportion to the amounts of insurance covering all employees who suffer losses in the same incident.

Exclusions

These accident insurance policies do not cover losses caused by or resulting from any of the following:

- Suicide, attempted suicide, or intentional self-inflicted injuries
- Declared or undeclared act of war (Under SRAI, hostile acts of foreign governments are not covered within the U.S.)
- An accident that occurs while you are serving on full-time, active duty in the armed forces of any country or international authority
- Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection other than bacterial infection caused by an accidental cut or wound
- Travel or flight in any vehicle or device for aerial navigation, including boarding or alighting, while:
    - The vehicle is used for test or experimental purposes

- You are operating, learning to operate, or serving as a member of the crew except while riding solely as a passenger, mechanic, substitute flight attendant, or acting as a crewmember on any aircraft owned by or under contract to American Airlines
- Being operated under the direction of any military authority other than transport-type aircraft operated by the Military Airlift (MAC) of the United States of America or a similar air transport service of any other country

- Commuting to and from work (SRAI Plan)
- While a driver/occupant of any conveyance engaged in race/speed test (MPAI Plan)

Insurance Policy

The terms and conditions of the Other Accident Insurance coverages are set forth in the group insurance policies issued by the Life Insurance Company of North America (LINA). The group policies are available for review from the Plan Administrator.

In the event of a conflict between the description in this Guide and the provisions of the insurance policies, the insurance policies will govern.

Additional Rules

Designating Beneficiaries

In the event of your death, Life Insurance coverage benefits are paid to the named beneficiaries on file with HR Employee Services.

Unless prohibited by law, your life insurance benefits are distributed as indicated on your *Beneficiary Designation Form* on file with HR Employee Services. For this reason, you should consider updating your beneficiary designation periodically, especially if you get married, declare a Domestic Partner, or you or your spouse give birth or adopt a child, or if you get divorced or cease to have a Domestic Partner relationship.

The table below provides sample wording for the most common beneficiary designations:

Type Of Designation	Sample Wording[1]
One person, related	Jane Doe, spouse
One person, not related	Jane Doe, friend
Your estate	Estate
Member of a given religious order	Mary L. Jones, known in religious life as Sister Mary Agnes, niece
Two beneficiaries with the right of survivorship	John J. Jones, father, and Mary R. Jones, mother, equally or to the survivor
Three or more beneficiaries with the right of survivorship	James O. Jones, brother, Peter I. Jones, brother, Martha N. Jones, sister, equally or to the survivor(s)
Unnamed children	My children living at my death
One contingent beneficiary	Lois P. Jones, wife, if living; otherwise, Herbert I. Jones, son
Unnamed children as contingent beneficiaries	Lois P. Jones, wife, if living; otherwise, my children living at my death
Trustee (a trust agreement must be in existence)	ABC Trust Company of Newark, NJ, Michael W. Jones, Trustee, in one sum, under Trust Agreement dated (insert date)

[1]Always include your beneficiary's address

If none of the suggested designations meets your needs, contact an attorney for assistance.

When a beneficiary is a minor (under the legal age defined by the beneficiary's state of residence), a guardian must be appointed in order for the life insurance benefits to be paid. MetLife requires a certified court document appointing the guardian of the minor's estate or property. If the beneficiary does not have a guardian, the life insurance benefits will be retained by MetLife and interest will be compounded daily until the minor child reaches the legal age.

To avoid complications in paying beneficiaries, an organization or endowment should not be named unless it is a legal entity (has a legal existence, such as a corporation or trust that has been legally established). If you designate a trust, MetLife assumes that the designated trustee is acting in proper fiduciary capacity unless written notice to the contrary is received at the home office of MetLife. MetLife and the Company are not liable for any payment made to a trustee before receiving such written notice. If the full amount of your insurance is not payable to the trustee or if a testamentary trustee is named, write to MetLife for assistance in proper documentation.

If your beneficiary is not living at the time of your death, the benefits under your coverage are paid to the first class of surviving family members in the order outlined below:

- Spouse
- Children or stepchildren (or children or stepchildren of Domestic Partner)
- Parents
- Brothers and sisters
- Estate

For dependent coverage, you are the sole beneficiary. If a covered dependent dies at the same time or within 24 hours of your death, benefits are divided equally among members of the first class of beneficiaries in which there is a relative of the covered dependent. The classes of beneficiaries are listed above in the order they would be considered.

If your beneficiary does not survive you (for example, you are both killed in a common disaster) benefits are paid to your estate according to the terms of the policy.

Take care of all your beneficiary designations in one efficient process available online at *My Beneficiaries* under the *Benefits & Pay* section of *Jetnet*. Please keep in mind that wording is important when designating your beneficiary, and you can designate an unlimited number of beneficiaries. Once the online form is completed and submitted, it supercedes all previous designations. If your marriage or Domestic Partner relationship ends, you should immediately complete new beneficiary designations.

Accident Insurance Beneficiaries

You are the beneficiary for all covered losses resulting from accidental injury. You should designate a beneficiary to receive benefits in the event of your accidental death. If you do not designate a beneficiary, your beneficiary is the same as your Term Life Insurance beneficiary. If your beneficiary is not living at the time of your death, benefits are paid according to the terms of the insurance policy.

Taxation of Life Insurance

If your total coverage is more than $50,000, you may owe taxes on the value of your coverage over $50,000. This value is called imputed income. IRS regulations require the Company to report employee federal wages and deduct Social Security taxes (FICA) on imputed income from your paycheck and report it on your Form W-2 each year (see example).

Under IRS regulations, imputed income is based on your age and the monthly cost per $1,000 of life insurance over $50,000. To determine your monthly amount of imputed income, multiply the rate in the following IRS table by the amount of your insurance coverage over $50,000.

Age of Employee on December 31	Monthly Cost of $1,000 of Insurance
Under 25	$.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.66
65-69	1.27
70 and over	2.06

An example of how imputed income works:

Assume a 30-year-old employee earning $3,000 per month selects three times salary of Contributory Term Life Insurance coverage. The following calculations show the employee's taxable imputed income:

1. Figure the amount of Term Life Insurance coverage:

   $36,000 salary x 3 = $108,000

2. Figure the taxable amount of coverage (amount over $50,000):

   $108,000 – $50,000 = $58,000

3. Divide that amount by $1,000:

   $58,000 / $1,000 = 58

4. Multiply the result by the IRS rate from the table above for an employee who is age 30:

   58 x $0.08 = $4.64

The monthly imputed income shown on this employee's paycheck will be $4.64. This is the amount that is subject to federal income and Social Security taxes. Spouse and Child Term Life Insurance is purchased after-taxes. Therefore, it is not subject to taxation as imputed income.

Portability and Conversion

Portability

Term Life Insurance has a portability feature which means you may continue your life insurance coverage if you leave the Company or retire. The rates for this continuing coverage are not the same as those you pay as an active employee, but they are preferred group rates based on your age. MetLife will provide the rate schedule if you apply for portability. The minimum amount of coverage you may continue is $20,000 and the maximum amount is your current contributory amount of life insurance coverage. Spouse, Child and Basic Life Insurance may not be continued under the portability feature. (However, Spouse, Child and Basic Life Insurance may be converted to an individual policy.) To apply for this continuing coverage, you must submit an application form to MetLife within 31 days after you leave or retire from the Company.

Call MetLife toll free at 877-275-6387 to discuss portability and to request a portability application.

Conversion

Subject to policy provisions, you can convert all or any part of your Basic and/or Contributory Term Life Insurance coverage to a personal policy (other than term life insurance) offered by MetLife without providing proof of good health, if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for Term Life Insurance coverage
- The coverage ends, and you have been covered under this insurance for at least five years
- Coverage for your particular job classification ends, and you have been covered under this insurance for at least five years

If you are applying for a personal policy because your employment terminated, the amount of the policy may not be more than the amount of your Term Life Insurance on the day your coverage ended.

If you are applying for a personal policy because this Plan ended or changed, and you have been covered for at least five years, the amount of your policy will not be more than the lesser of the following:

- The amount of your coverage on the day it ended, less any amount of life insurance you may be eligible for under any group policy that takes effect within 31 days of the termination of this coverage
- $10,000.

You or your spouse or child can convert all or any part of the Spouse or Child Term Life Insurance coverage to a personal policy (other than term life insurance) offered by MetLife if coverage terminates for one of the following reasons:

- Your employment ends or you are no longer in a class that is eligible for Spouse or Child Term Life Insurance coverage
- The coverage ends and your spouse or child has been covered under this insurance for at least five years
- Coverage for your particular job classification ends and your spouse or child has been covered under this insurance for at least five years
- You die
- Your spouse or child no longer qualifies as a dependent.

Requesting Portability or Conversion

To convert to a personal policy, you must submit a *Conversion Form* and pay the first payment within 31 days of the date coverage terminates. Call MetLife toll free at 877-275-6387 to discuss conversion and request a form.

If you or your dependent should die during the 31-day period, whether or not you have applied for the conversion policy or portability, MetLife will pay the appropriate beneficiary a death benefit equal to the amount of life insurance you had on the date coverage terminated.

Contact MetLife toll free at 877-275-6387 to discuss both portability and conversion options and to request forms.

Verbal Representations

Nothing you say or that you are told regarding this insurance is binding on anyone unless you or your beneficiary have something in writing from the Company and MetLife confirming your coverage.

Assignment of Benefits

You may irrevocably assign the value of your life insurance coverage. This permanently transfers all right, title, interest, and incidents of ownership, both present and future, in the benefits under this insurance coverage. Anyone considering assignment of life insurance coverage should consult a legal or tax advisor before taking such action.

If you assign your benefits, you are obligated to fulfill any conditions you have agreed to with your assignee. MetLife's only obligation is to pay the life insurance benefits due at your death.

Your beneficiary may assign a portion of his or her benefit directly to the funeral home to cover the cost of the funeral. To assign benefits to a funeral home, the beneficiary signs an agreement with the funeral home. The funeral home sends a copy of the signed agreement and an itemized statement of funeral expenses to HR Employee Services. When MetLife processes the claim, a separate check for this portion of the benefit will be paid directly to the funeral home.

When a claim is processed, MetLife establishes a Total Control Account for each beneficiary whose share is $5,000 or more. (Smaller amounts are paid in a lump sum.) All insurance proceeds are deposited into this interest-bearing checking account that pays competitive money market interest rates and is guaranteed by MetLife.

MetLife sends a personalized checkbook to your beneficiary, who may withdraw some or all of the proceeds and interest whenever necessary. In addition, MetLife sends descriptions of alternative investment options to your beneficiary. The Total Control Account gives your beneficiary complete control over the money, while eliminating the need to make immediate financial decisions at a difficult time.

For income tax purposes, proceeds deposited into the Total Control Account are treated the same as a lump-sum settlement. Because the tax consequences of life insurance proceeds may vary, the Company strongly recommends that you or your beneficiary contact your tax advisor.

MetLife will only pay interest on a life insurance claim (to cover the time between death and date of payment) if the beneficiary lives in a state that requires interest payments. Because state insurance laws vary, calculation of interest differs from state to state.

Disability Benefits

Overview

The following table helps you understand the benefits you may be eligible to receive in the event of an illness or disability.

Program Name	When Benefits Begin	When Benefits End	Amount of Benefit
Optional Short Term Disability Insurance (OSTD)	The later of: • eighth day of your illness or disability • when sick pay[1] is exhausted.	The earlier of the date: • the claims processor determines you are no longer disabled • you become gainfully employed in any type of job except under the Return-to-Work Program (see page 144) • the 26-week maximum period ends • you die.	The amount of benefit: • 50% of adjusted monthly salary (reduced by any state disability benefits you are eligible to receive).
Long Term Disability Plan (LTD)	The latest of: • the date you are disabled for four consecutive months • the latest day you received salary/pay from the Company (both salary continuance [if applicable] and sick pay)—**sick pay must be exhausted** • the last day you receive other benefits for this disability.	The earlier of the date: • the claims processor determines you are no longer disabled • you become gainfully employed in any type of job for any employer, except under the Return-to-Work Program (see page 144) • the date you reach age 65 (unless disabled after age 60) • you reach the maximum benefit period (see Exclusions and Limitations) • you die.	The amount of benefit: • 60% of base monthly salary (reduced by benefits from other sources (see page 144) • If you are enrolled in Long Term Disability (LTD) coverage, you will receive the full OSTD benefit, plus you will receive a minimum benefit from LTD (to begin the later of 4 months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD are exhausted, the full LTD benefit will be payable.

[1] Refer to the Employee Policy Guide for a summary of these benefits.

Optional Short Term Disability Insurance Benefit

How the OSTD Insurance Benefit Works

Optional Short Term Disability Insurance (OSTD) protects you in the event you are not able to work due to a non-occupational illness or injury. The OSTD benefit will pay 50% of your adjusted monthly salary. For regular, full-time employees, adjusted monthly salary is defined as your annual base salary or annualized hourly pay plus skill and license premiums and market differentials. It does not include profit sharing, bonus, overtime, or incentive pay. All OSTD benefits are paid solely by and through the insurance policies by the insurer. For converted and part-time employees, “adjusted monthly salary” is based on average weekly earnings for the last six (6) months.

No OSTD benefits are available outside of the insurance policy.

Before electing OSTD insurance, you should consider your accrued sick time because OSTD benefits are not payable until all of your accrued sick pay is used.

The OSTD insurance also offers a *Return-to-Work Program* (see page 144) that allows you to go back to work on a trial basis while recovering from a disability.

The cost of OSTD insurance is collected through payroll deductions. If you enroll, your selection remains in effect for two (2) calendar years. If you choose not to enroll when you are first eligible and decide to enroll later, proof of good health is required. You may add coverage if you experience a qualifying Life Event. Your OSTD insurance will not become effective until you are actively at work and a payroll deduction has been taken.

If you are unable to work your normal work schedule for any reason, you must address your work status with your supervisor. This is true regardless of whether you receive OSTD pay.

Definition of Total Disability

You are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties pertaining to your own occupation because of sickness or accidental bodily injury.

The Company’s approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

OSTD Insurance Benefits

If you have a qualifying disability, the OSTD benefit covers the difference between any state-provided benefit and 50% of your adjusted weekly monthly salary. The maximum covered salary is $200,000.

In some cases, OSTD benefits may be limited:

- If you are based in California, Hawaii, New Jersey, New York, Rhode Island, or Puerto Rico, you may be eligible for state disability benefits. Employees based in California, Hawaii, and Rhode Island must apply directly to the state for benefits.
- If you have accrued a significant number of unused sick days, you would not be able to collect OSTD until you have used all those days.

- If you are enrolled in the Long Term Disability Plan (LTD) Plan, you will receive the full benefit of the OSTD benefit, plus you will receive a minimum benefit from LTD (to begin the later of four months from the date of disability or when sick pay is exhausted). Once the 26 weeks of OSTD are exhausted, the full LTD benefit will be payable.

The OSTD benefits you receive are not taxable income because you pay for this coverage with after-tax contributions.

Filing a Claim

If your disability continues for eight or more days, you should file your disability claim immediately. Do not wait until your sick pay is used up; *file by the eighth day of your disability*. The sooner you file, the sooner your claim can begin processing. However, the latest you can file your claim is one year after your disability began. If you are covered under a state-mandated short-term disability plan, and the state requires you to file sooner, the state's filing deadline overrides the Company's deadline. If you file your disability claim beyond the one year deadline (or the state-mandated deadline, if sooner), your claim will not be accepted, and you will not be eligible for benefits.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD Insurance Benefit, state disability plans (other than California, Rhode Island, and Hawaii, which have their own forms that must be filed directly with the respective states), and LTD Plan. You or your supervisor should request the Disability Claim Form available online through *Jetnet*, as soon as you become disabled.
- You, your supervisor, and your attending physician must each complete part of the form:
    - *Disability Claim Employer Statement:* Your supervisor completes this page.
    - *Disability Claim Employee Statement:* You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see *Benefits from Other Sources* on page 144).
    - *Disability Claim Attending Physician Statement:* Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

MetLife is the claims processor for the Optional Short Term Disability Insurance Benefit. The OSTD and state disability coverages are insured plans (including state plans in New Jersey, New York, and Puerto Rico). The states of California, Hawaii, and Rhode Island administer their own disability plans.

When Benefits Begin

Provided you qualify, OSTD is payable on the eighth day of disability or when your accrued paid sick time is exhausted, whichever is later. If you are collecting vacation pay when OSTD benefits become payable, OSTD will not begin until your vacation pay ends. Benefits are payable for a maximum of 26 weeks.

There is no limit to the number of times you may receive these benefits for different periods of disability. However, successive periods of disability separated by less than one week of full-time active work are considered a single period of disability. The only exception is if the later disability is unrelated to the previous disability and begins after you return to full-time active work for at least one full day.

When Benefits End

Your OSTD Insurance Benefit payments end automatically on the earliest of the following dates:

- The date the claims processor determines you are no longer disabled
- The date you become gainfully employed in any type of job for any employer, except under the Return-to-Work Program (see page 144)
- The end of the maximum benefit period of 26 weeks, or
- The date you die.

If and when you return to work, you or your supervisor must notify MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for reimbursing the OSTD Insurance for any overpayments you receive.

Exclusions and Limitations

OSTD Insurance Benefit has the following exclusions and limitations:

- If you are based in California, Hawaii, New York, New Jersey, Puerto Rico, or Rhode Island, then OSTD benefits are offset. Employees based in these states receive similar benefits that are provided in compliance with applicable state law. If the state benefit is less than the OSTD benefit, an OSTD benefit is payable. If the state benefit is more than the OSTD benefit, an OSTD benefit is not payable.
- Benefits are not payable if you are disabled as a result of a work-related accident or sickness. An injury or illness is not considered work-related for OSTD purposes if the claim is denied by Workers' Compensation.
- If you become disabled before the effective date, you are not covered under this insurance until you return to work and deductions are taken from your pay.
- Benefits are payable to employees. Dependents are not eligible for this benefit.
- Benefits are not payable if you are disabled as a result of committing or trying to commit a felony, assault or other serious crime.
- Benefits are not payable if you are disabled as a result of self-inflicted injuries or attempted suicide.
- Benefits are not payable if caused by a declared or undeclared act of war.
- Benefits are not payable unless you are receiving appropriate and reasonable care for your disabling condition from a duly qualified physician.
- Benefits may be reduced if you participate in a return-to-work program.

Long Term Disability Plan

How the Plan Works

The Company offers eligible employees the opportunity to participate in a Long Term Disability (LTD) Plan.

LTD benefits replace a portion of your salary when you are unable to work as a result of a disability. Most absences from work due to disability are generally of short duration and covered by paid sick time or Optional Short Term Disability (OSTD) benefits. However, some absences may continue for longer periods. LTD coverage provides you protection during these extended absences. LTD coverage also provides you the opportunity to return to work on a trial basis and to participate in a rehabilitation program. You pay the cost of LTD coverage through payroll deductions with after-tax contributions. If you choose not to enroll when you are first eligible and later decide to enroll, proof of good health is required.

MetLife is the claims processor. The LTD Plan is self-funded through employee contributions deposited to a Voluntary Employees Beneficiary Association (VEBA) trust established under Section 501(c)(9) of the Internal Revenue Code. Benefits are paid from trust assets. You pay the cost of LTD coverage through payroll deductions with after-tax contributions. If you choose not to enroll when you are first eligible and later decide to enroll, proof of good health is required.

The Company provides limited salary protection for non-work related disabilities through accrued sick pay and Optional Short Term Disability Insurance (OSTD) benefits. OSTD Insurance benefits end after a maximum period of 26 weeks. If you also participate in the LTD Plan, your LTD benefits begin after the latest of:

- the date you are disabled for four consecutive months; the latest day you received salary/pay from the Company (both salary continuance [if applicable] and sick pay); or
- the last day you receive other benefits for this disability.

Definition of Total Disability

During the elimination period and the first 24 months for which LTD benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for wage or profit and are unable to perform major and substantial duties of your own occupation because of sickness or accidental bodily injury.

After 24 months for which benefits are payable, you are considered totally disabled if you are not gainfully employed in any type of job for any employer and are unable to perform major and substantial duties of any occupation or employment for wage or profit for which you have become reasonably qualified by training, education, or experience.

The only conditions under which you may be gainfully employed in any type of job for wage or profit and still be considered totally disabled are described under the Return-to-Work Program (see page 144).

The Company's approval of your sickness or injury leave of absence is independent of disability benefit determination and should not be construed as validation of your disability claim or any guarantee of benefits payable for your disability claim.

LTD Benefits

LTD benefits are not taxable income because you pay for this coverage with after-tax contributions.

Full-time employees: Your monthly LTD benefit, together with benefits from other sources, equals 60% of your base monthly salary (up to $6,666.67) on your last day paid, plus 50% of the portion of your base monthly salary that is greater than %6,666.67, up to the maximum allowed by federal law.

Part-time employees: You monthly LTD benefit, together with benefits from other sources, is 60% of your base monthly salary on your last day worked. (Average monthly salary is based on average weekly earnings for the last six (6) months up to a maximum allowed by Federal Law.)

The minimum LTD benefit for both full-time and part-time employees is the greater of 10% of your pre-disability base monthly salary on your last day worked or $100 per month.

Whether you are a full-time or part-time employee, the amount you receive from the LTD Plan is reduced by your income from other sources, including, but not limited to, other disability plans, unemployment benefits, Social Security Disability Benefits, and benefits from Workers' Compensation, occupational disease law, or other similar law. If you have a family and are eligible for family Social Security Disability Benefits, total payments from all sources will not be more than 80% of your base monthly salary on your last day paid.

The LTD Plan may provide you the opportunity to return to work or enter a LTD Plan-paid rehabilitation program without losing your LTD benefits. However, if you are approved to participate in the Return-to-Work Program, your monthly LTD benefit is decreased by 50% of your earnings during the return-to-work period.

The Return-to-Work Program is separate from the Workers' Compensation Transitional Duty program for employees with a work-related injury or illness. Employees participating in the Transitional Duty program are not eligible for this Return-to-Work Program or the Vocational Rehabilitation Benefit. For details, see the *Return-to-Work Program* and *Vocational Rehabilitation Benefit* on pages 144 and 145.

Elimination Period

The elimination period is the waiting period before LTD benefits are payable. It extends until the latest of the following:

- The date you have been continuously totally disabled for four (4) consecutive months
- The last day of salary continuation (injury-on-duty pay, sick pay or vacation pay) during total disability.

Duration of Benefits

After you qualify for LTD benefits, if you remain disabled, you receive a monthly benefit for the following maximum period:

Age at Which Disability Begins	Maximum Duration of Benefits
60 or younger	To age 65
62	3½ years
63	3 years
64	2½ years
65	2 years
66	1¾ years
67	1½ years
68	1¼ years
69 to 74	1 year
75 and over	6 months

During your disability, you may be required to provide additional medical information or submit to periodic physical exams to confirm your continuing disability. LTD benefits end if you do not agree to undergo a physical exam or provide the required information.

Filing a Claim

You should file your Long Term Disability (LTD) claim as soon as you become disabled. Do not wait until your sick pay is used up or until your four-month elimination period expires — *file your claim immediately.* The latest you can file your LTD claim is one (1) year after your disability began. If you file your disability claim beyond this one-year deadline, your claim will not be accepted and you will not be eligible for LTD Plan benefits.

MetLife is the claims processor for the Long Term Disability Plan. The LTD Plan is funded by employee contributions and managed by the Company through a trust. Benefits are paid from trust assets.

The following is a summary of how you file a claim for disability benefits:

- You only need to file one claim to request benefits under the OSTD, state disability plans (other than California, Rhode Island, and Hawaii which have their own forms that must be filed directly with the respective states), and LTD programs. You or your supervisor should request the Disability Claim Form available online through *Jetnet*, as soon as you become disabled.
- You, your supervisor, and your attending physician must each complete part of the form:
    - Disability Claim Employer Statement: Your supervisor completes this page.
    - Disability Claim Employee Statement: You complete this page. Be sure to sign the Reimbursement Agreement on the back of the form (see *Benefits from Other Sources* on page 144).
    - Disability Claim Attending Physician Statement: Your physician completes this page.

The completed sections may be mailed together or separately to the claims processor at the address on the form.

After the claims processor receives the form, your claim will be processed. Sometimes the claims processor may request additional information. You will be notified of the decision regarding your claim. Notification and/or payment is made directly to you.

When Benefits Begin

Provided you qualify, LTD benefits are payable at the end of the elimination period — the latest of the following dates:

- the date you are disabled for four consecutive months;
- the latest day you received salary/pay from the Company (both salary continuance and sick pay) — **sick pay must be exhausted**; or
- the last day you receive other benefits for your disability.

If you are collecting vacation pay when LTD benefits become payable, your LTD benefits will not begin until your vacation pay ends. If you return to work in a capacity comparable to your pre-disability status during the elimination period, you are still considered continuously disabled if you become totally disabled again due to the same or related sickness or injury within 60 days after returning to work in your pre-disability occupation or other comparable work. However, days worked do not count toward your elimination period.

If you have received LTD benefits for an earlier disability and become totally disabled again, your most recent disability is considered part of the previous disability. However, this provision does not apply if you have returned to work in a capacity comparable to your pre-disability status for at least three months, or, if the cause of the later disability is totally unrelated to the earlier disability. If it is considered a separate period of disability, you must satisfy a new elimination period.

When Benefits End

Your LTD benefits automatically end on the earliest of the following dates:

- The date your benefits expire, as explained in Duration of Benefits
- The date you reach age 65 (unless disabled after age 60)
- The date you are no longer disabled
- The date you become gainfully employed in any type of job, except under the Return-to-Work Program (see page 144)
- The date you die
- The date benefits end, if disability is due to a mental health disorder subject to the Exclusions and Limitations described below.

If and when you return to work, you or your supervisor must contact MetLife to stop benefit payments. This ensures proper closure of your claim and avoids possible overpayment. You are responsible for repayment of any overpayments you receive.

If your employment terminates from a sickness or injury Leave of Absence (LOA) and you are receiving LTD benefits, these LTD benefits will continue until you meet one or more of the conditions listed above. However, when you meet one or more of these conditions and your LTD benefits terminate, your LTD coverage also terminates at the same time. After your LTD benefits and LTD coverage terminate, any later recurrence or relapse of your disabling condition, or your development of any other disabling condition, will not reactivate your LTD coverage, will not result in any reinstatement of LTD benefits, and will not cause any LTD benefits to resume.

Exclusions and Limitations

The LTD Plan has the following exclusions and limitations:

- If you become disabled before the effective date, you are not covered under the LTD Plan until you return to work and deductions are taken from your pay.
- You are not covered under the LTD Plan for a disability if you received medical care or treatment for the disability within the three months before the effective date of coverage. However, after you have been covered for 12 months, this limitation on disability no longer applies, and you may receive benefits.
- If you are disabled due to a mental health disorder (this includes mental health disorders, emotional disease, and/or alcohol/chemical/substance abuse/dependency), disability benefits under this coverage will end when you have received a maximum of 24 months of LTD Plan benefits for the entire time you are covered under the LTD Plan. This maximum benefit applies to the duration of your participation in this coverage. As part of a mental health disability, chemical abuse/dependency includes, but is not limited to, both prescription and over-the-counter medications, as well as illicit/illegal drugs; substance abuse/dependency includes, but is not limited to, any other non-drug substances such as aerosol propellants, glue, etc.

This 24-month maximum disability benefit applies whether or not you have been hospitalized, with the following exceptions:

- If you are confined in a hospital at the end of this 24-month maximum benefit period, benefits continue as long as you are confined.
- To enable a necessary recovery period, benefits also continue for up to 90 days following your release from hospital confinement, provided you were confined for at least 14 consecutive days.
- If you are reconfined during this 90-day recovery period, benefits continue during your reconfinement, together with another 90-day recovery period, provided you are reconfined for at least 14 consecutive days.
- Benefits are not payable if you are not receiving appropriate and reasonable care for your disabling conditions from a duly-qualified physician.
- Benefits are not payable if the Plan Administrator determines in its sole discretion that you are disabled as a direct or indirect result of committing or trying to commit a felony, assault, or other serious crime, or are engaged in an illegal occupation, regardless of whether or not you are ever charged with a crime or for engaging in an illegal occupation.
- Benefits are not payable if you are disabled as a result of intentionally self-inflicted injuries or an attempted suicide.
- Benefits are not payable if you are disabled as a result of a declared or undeclared act of war.
- Benefits are payable only to employees. Dependents are not eligible for this benefit.
- The Plan Administrator in its sole discretion shall determine whether any exclusion or limitation applies.

Benefits from Other Sources

If you qualify for disability benefits from other sources, your LTD benefits are reduced by the amount of the following periodic benefits. Your LTD benefits are reduced if you are either receiving these other benefits or are entitled to receive these benefits upon your timely filing of respective claims:

- Periodic benefits for loss of time because of this disability under:
    - Any employee benefit coverage for which the Company has paid any part of the cost or made payroll deductions, including a Company-sponsored annuity contract or disability retirement benefits plan
    - Any government law including no-fault motor vehicle insurance, other than a law providing benefits for military services.
- Periodic benefits for loss of time due to a work-related injury or illness or by reason of any Workers' Compensation, occupational disease law, or other similar law.
- Unemployment benefits.
- Social Security Disability Benefits (SSDB) based on the amount of SSDB in effect as of the LTD benefit start date. This may not apply if your disability is a result of a pregnancy or if your disability lasts less than one year. Periodic increases in monthly SSDB income (through cost-of-living increases) and additional Social Security retirement and survivor benefits are not subtracted from LTD benefits.
- Earnings from employment activity not approved under return-to-work guidelines.

To alleviate potential financial hardship while waiting for a determination on a claim for Social Security, Workers' Compensation, or other such benefits described above, you may request that such benefits not be deducted from your LTD benefits. The Reimbursement Agreement is within page 2 of the Disability Claim Form available through *Jetnet*. It states that you agree to reimburse the appropriate amount of LTD benefits paid if Social Security, Workers' Compensation, or other such benefits are later payable.

Social Security Disability Benefits

Because the amount of LTD benefits you receive is influenced by Social Security Disability Benefits (SSDB), you must apply for SSDB as soon as possible.

Within six months after your LTD claim is approved, you must provide evidence to the claims processor that you have filed for SSDB or that your application has been denied. This does not apply if your disability is the result of pregnancy or is expected to last less than one year. Otherwise, your SSDB benefits will be estimated and your LTD benefits will be reduced by the estimated amount.

Evidence may include a denial of benefits by the Social Security Administration, failure to qualify because of the length of your disability, or a copy of the *Receipt of Claim Form* given to you by the Social Security Administration at the time of application. Please note that if your initial application is denied, you must file for reconsideration and/or appeal to the Social Security Administration.

Return-to-Work Program

The Return-to-Work Program, administered by MetLife, is a voluntary program that allows you, as a disabled employee collecting LTD benefits, to work in an occupation or job for wage or profit for a trial period without losing your LTD benefits. Your return to work must be approved by the claims processor and may not exceed one year. The claims processor will monitor your progress under this program. If you fully recover and are no longer disabled before the end of that year, you will no longer be eligible for the program.

During your trial work periods, you continue to receive LTD benefits; however, your benefits are reduced by 50% of your earnings from employment. If your attempt to return to work is unsuccessful, you may return to your former LTD status and receive your former benefit, provided you remain disabled and satisfy all other coverage provisions.

Employees who are participating in the Workers' Compensation Transitional Duty program are not eligible for this Return-to-Work Program, and vice versa.

Following are the steps required to participate in the Return-to-Work Program:

- A request for consideration is initiated either by you, your supervisor, your physician, or the claims processor.
- The request is distributed to all parties above, and all must agree that you may return to work on a trial basis.
- When your return-to-work plan has been approved by all parties, MetLife will document the plan for signature. Documentation will include the following:
    - Written agreement from your physician, supervisor, and you that you may return to work
    - Statement of approximate length of time for the trial work period
    - Statement of hours to be worked per day and rate of pay. (If hours per day vary, the claims processor will need regular bi-weekly or semi-monthly reports of earnings and hours worked.)
- The claims processor notifies you or your supervisor whether your return-to-work request has been approved.

If you are allowed to participate in the Return-to-Work Program, your supervisor must notify the claims processor of the date you return to work. In addition, if and when you can no longer work, both your supervisor and physician must send written notification to the claims processor of this change. If you return to work for the Company under this program, your supervisor should indicate "Returning to Work" on your Payroll Transaction Request (PTR).

Your LTD payroll deductions will not resume until you are actively at work under the Return-to-Work Program for one consecutive year or when you are no longer disabled.

Vocational Rehabilitation Program

If you are receiving LTD benefits, you may be eligible to receive assistance through the Vocational Rehabilitation Benefit if approved by the claims processor. This benefit is not available for participants receiving OSTD.

Vocational Rehabilitation Benefits may cover expenses such as:

- Vocational counseling
- Job search assistance
- Occupational training
- Vocational education
- Prosthetic devices
- Psychotherapy, or
- Physiotherapy.

You may request consideration for this benefit by writing to MetLife, Attention: Rehabilitation Coordinator. After reviewing your request, the claims processor may require an in-depth field evaluation of your potential to return to work. If so, your supervisor will be notified with the necessary details. The claims processor may also request a complete job description and other documentation. After reaching a decision, the claims processor notifies you of the rehabilitation benefits to which you are entitled.

Flexible Spending Accounts

Overview

The Health Care and Dependent Day Care Flexible Spending Accounts (FSAs) allow you to direct part of your pay through payroll deductions into special accounts ***before*** it is taxed by the federal government. In most cases, this money is exempt from state and local taxes as well. You benefit by being able to pay for certain expenses with tax-free money. The amount of tax savings depends on your personal situation and your effective tax percentage.

If you establish an FSA during the year, you are only eligible for reimbursement of expenses you incur after becoming an FSA participant. Additionally, you receive reimbursement from your FSAs only for eligible expenses incurred during the same calendar year in which you deposit money into your account.

Eligible expenses that can be reimbursed from your Health Care FSA (HCFSA) include medical, dental, and vision expenses, and other expenses not paid by your Medical Benefit Option, such as deductibles, copayments/coinsurance, oral contraceptives, physical examinations, and infertility treatment. Any amounts above the usual and prevailing fee limits may be reimbursed from your HCFSA. IRS rules specify the types of expenses eligible for reimbursement from your HCFSA.

The Dependent Day Care FSA (DDFSA) pays eligible day care expenses for your children and certain adult dependents while you and your spouse (if you are married) work.

Effective January 1, 2005, employees who elect participation in an HCFSA and/or a DDFSA will be issued an FSA debit card — the UnitedHealthcare Consumer Accounts Debit Card. This FSA debit card will be loaded with the year's elected deposit amounts (based on your FSA elections made during enrollment) for the selected HCFSA and/or DDFSA. Then, you may use the debit card to pay for copayments or fees incurred during the year for HCFSA- and/or DDFSA-reimbursable expenses.

Effective January 1, 2005, the FSA administrator changed from FBD Consulting to UnitedHealthcare — for both HCFSAs and DDFSAs. UnitedHealthcare offers additional methods of claim submission, direct deposit (to your bank account) of FSA reimbursements, and automatic rollover of certain expenses. UnitedHealthcare's Web site, www.myuhc.com, allows you to check contributions and account balances, view claim information, verify eligible expenses, download forms, access "Frequently Asked Questions (FAQs)," and manage direct deposit and automatic rollover features.

Health Care FSA

Enrolling in a Health Care Flexible Spending Account

You may enroll in either a Health Care or Dependent Day Care FSA or both (if you have eligible dependents participating in day care) during the following times:

- As a new employee when first enrolling for benefits
- If you experience a qualifying Life Event such as a marriage, birth, adoption or adding an eligible dependent to your household (process your Life Event or enroll online on *Jetnet)*
- During annual enrollment.

NOTE: Effective January 1, 2005, the Flexible Spending Accounts administrator changed from FBD Consulting to UnitedHealthcare. Claims for eligible expenses incurred on or after January 1, 2005, should be submitted to UnitedHealthcare. If you elect both a Health Care and Dependent Day Care Flexible Spending Account, you should understand that the deposits and accounts are maintained separately. This means deposits to one account cannot be used to pay expenses that are eligible under the other account.

Please note that the FSA administrator cannot enroll you in an FSA. You can only enroll in an FSA on *Jetnet*.

How the Health Care FSA Works

Maximum Annual Allowable Deposit

You may deposit up to $5,000 per calendar year to you HCFSA. Because of the IRS rules, you lose any money in your HCFSA that is not used during the year in which it was deposited.

Changing HCFSA Options

If you stop or reduce the amount of your deposits mid-year due to a Life Event, claims from your HCFSA (for eligible health care expenses incurred before the change) are payable up to the original amount you elected to deposit. Claims for expenses incurred after the change are payable up to the amount of your newly-elected deposit amount. You forfeit part of your balance when the deposits made before your change are greater than your claims before the change.

You lose any money in your HCFSA not used during the year it was deposited. In addition, you can only stop or reduce your election midyear if you experience certain Life Events. (See *Making Changes During the Year* on page 26.) For this reason, you should give careful thought and planning to your enrollment decision and your election amount.

Who Is Covered

You may receive reimbursement of expenses for a different range of dependents, other than those covered under the your selected Medical Benefit Option. Eligible dependents for the HCFSA include your spouse and children, as defined in your Medical Benefit Option (even if you don't elect coverage for them), and your parents or other dependents if you claim them as dependents on your federal income tax return.

Because of IRS rules, Domestic Partners are not considered eligible dependents under your HCFSA.

HCFSA Funds Availability: Following your first deposit, the full amount of your intended deposits for the entire year is available for your use. This benefit specifies which expenses may be paid out of your HCFSA. In addition, the Company maintains some limits on reimbursements for items such as orthodontia.

Eligible Expenses

You receive reimbursement from your HCFSA only for eligible expenses incurred during the same year in which you deposit money into your account. For example, if you deposit money into your *2005* HCFSA to help pay for a surgical procedure, you must undergo the surgical procedure and incur the related expenses by *December 31, 2005*. For the purposes of the HCFSA, you are deemed to have incurred expenses for a service or supply at the time the service or supply is provided (rendered).

HCFSA reimbursement rules for orthodontia expenses changed effective January 1, 2005. For additional information, please refer to *Covered Orthodontia Expenses* (see page 111) in the Dental Benefit section and to the information regarding reimbursement of orthodontia expenses found later in this section. Expenses that can be reimbursed through a HCFSA include the following:

- Out-of-pocket expenses, deductibles, coinsurance, and copayments not paid by your Medical or Dental Benefit Options or your Vision Insurance Benefit
- Out-of-pocket expenses, deductibles, coinsurance, and copayments incurred from other health, dental, or vision coverages.
- Certain types of OTC medicines and drugs purchased without a prescription and used to alleviate or treat personal injuries or sicknesses of the employee and the employee's covered dependents may be eligible for reimbursement through your HCFSA. Dietary supplements, cosmetics, and other products that are merely beneficial to the general health of the employee are not reimbursable. Some OTC medicines and drugs that are normally used for general health purposes may qualify as "dual purpose" and may be reimbursable when required for a specific medical health condition. These items require a letter of medical necessity from a medical practitioner stating the specific medical condition and that the OTC drug is recommended to treat the condition. You must submit the letter of medical necessity with your reimbursement claim. The types of OTC medicines that are reimbursable include antacids, allergy medicines, pain relievers, and cold medicines.
- Refer to the list of OTC drugs and medications by category — those that are reimbursable, those that are excluded, and dual purpose drugs and medicines that qualify under certain circumstances) **by visiting the claims administrator's Web** site (see *Contact Information* on page 1).

Reimbursable Medical Expenses

Some examples of medical expenses that *may not* be covered under your Medical Benefit Option but *may* be reimbursed under your HCFSA include, but are not limited to, the following:

- Acupuncture
- Ambulance service
- Artificial insemination
- Bandages, support hose, other pressure garments (when recommended by a physician to cure a specific ailment)
- Birth control (prescription only)
- Blood, blood plasma, or blood substitutes
- Braces, appliances, or equipment, including procurement or use
- Car controls for the handicapped
- Charges in excess of usual and prevailing fee limits
- Chromosome or fertility studies
- Confinement to a facility primarily for screening tests and physical therapy
- Experimental procedures
- Foot disorders and treatments such as corns, bunions, calluses, and structural disorders
- Halfway house care

- Home health care, hospice care, nurse, or home health care aides
- Hypnosis for treatment of illness
- Immunizations
- In-vitro fertilization
- Learning disability tutoring or therapy
- Nursing home care
- Physical exams
- Physical therapy
- Prescription drug copayments
- Prescription vitamins
- Psychiatric or psychological counseling
- Radial keratotomies and lasik procedures
- Sexual transformation or treatment of sexual dysfunctions or inadequacies
- Smoking cessation program costs and prescription nicotine withdrawal medications
- Speech therapy
- Syringes, needles, injections
- Transportation expenses to receive medical care, including fares for public transportation and private auto expenses (consult your tax advisor for the current IRS mileage allowance)
- Well-child care exams
- Work-related sickness or injury (not covered by Workers' Compensation).

Other expenses that may be reimbursed under your HCFSA include:

- Hearing expenses, including hearing aids, special instructions or training for the deaf (such as lip reading), and the cost of acquiring and training a dog for the deaf
- Vision expenses, including eyeglasses, contact lenses, ophthalmologist fees (not paid by the Vision Insurance Benefit), the cost of a guide dog for the blind, and special education devices for the blind (such as an interpreter).

Some examples of *dental expenses* that may not be covered under your *Dental Benefit* Option, but *may* be reimbursed under your HCFSA include, but are not limited to the following:

- Anesthesia
- Cleaning more than twice per year
- Charges in excess of usual and prevailing fee limits
- Drugs and their administration
- Experimental procedures
- Extra sets of dentures or other dental appliances
- Medically necessary orthodontia expenses for adults or dependents

- Myofunctional therapy
- Replacement of dentures or bridgework less than five years old
- Replacement of lost, stolen, or missing dentures or orthodontic devices.

Effective January 1, 2005, the total cost of the patient's orthodontic treatment (based upon receipt of the lump sum billing from the orthodontist) will be reimbursed from your HCFSA in one lump sum, up to the amount you elected to contribute for the year. Thus, your orthodontist should bill for the total cost of orthodontia treatment in one lump sum. For additional information about coverage for orthodontia, refer to the Covered Orthodontia Expenses section of the Dental Benefit.

Excluded Expenses

Expenses that may not be reimbursed through your HCFSA include, but are not limited to:

- Capital expenses
- Air conditioning units
- Structural additions or changes
- Swimming pools
- Whirlpool
- Wheelchair ramps
- Cosmetic medical treatment, surgery, and prescriptions and cosmetic dental procedures, such as cosmetic tooth bonding or whitening
- Electrolysis
- Health club fees and exercise classes (except in rare cases for treatment of medically — diagnosed obesity where weight loss is part of the program and other alternatives are not available
- Marriage and family counseling
- Massage therapy
- Medical insurance premiums
- Personal care items including cosmetics and toiletries
- Transportation expenses for the handicapped to and from work
- Vacation travel for health purposes
- Vitamins and nutritional supplements
- Weight loss programs (unless for treatment of medically diagnosed Obesity).

Receiving Reimbursement

You must submit your medical, dental, and vision claims under your respective coverages (i.e., your Medical Benefit Option, Dental Benefit Option, Vision Insurance Benefit), and those claims must be processed by the claim processor or insurer before you can submit those claims for reimbursement under your HCFSA. In some cases, amounts eligible for reimbursement will be transferred directly from your Medical Benefit Option or Dental Benefit Options to your HCFSA through the Automatic Reimbursement Feature.

Automatic Reimbursement Feature: If you are enrolled in any of the Medical Benefit Options offered to employees (other than HMOs), amounts that are not reimbursed under your Medical Benefit Option (such as deductibles and your coinsurance amounts or copayments) are, in most cases, automatically processed as reimbursements from your HCFSA. Similarly, amounts not reimbursed by the Dental Benefit will be automatically forwarded to your HCFSA for reimbursement.

You should stop the Automatic Reimbursement Feature if:

- You have other coverage. (You should file claims under your secondary coverage before you submit them for reimbursement under the Health Care Flexible Spending Account.)
- You cover a Domestic Partner under your Medical Benefit Option. You must stop the Automatic Reimbursement Feature to ensure that claims for your Domestic Partner are not automatically paid. (Domestic Partners are not eligible to participate in Flexible Spending Accounts.)

To stop the account's Automatic Reimbursement Feature, you must complete a *Discontinuation of Automatic Reimbursement Request* form available on *Jetnet.* (You may also call the claims administrator request the form or visit the Web site.) You must complete this form annually at the beginning of each year.

Filing Claims

NOTE: Effective January 1, 2005, the FSA administrator changed from FBD Consulting to UnitedHealthcare. Claims for eligible expenses incurred on or after January 1, 2005, should be submitted to UnitedHealthcare.

You ***must*** file a claim for reimbursement from your HCFSA in the following circumstances:

- You have an expense that is eligible for reimbursement from the HCFSA and the claim is not automatically reimbursed
- The expense is eligible for HCFSA reimbursement but is not covered by the Medical Benefit Option or Dental Benefit or the Vision Insurance Benefit (such as oral contraceptives or vision exams)
- Retail prescription drug copayments and all mail order prescription drug copayments must be submitted to the claims administrator with a claim for reimbursement.
- Certain types of over-the-counter (OTC) medicines and drugs purchased without a prescription and used to alleviate or treat personal injuries or sicknesses of the employee and the employee's covered dependents may be eligible for reimbursement through your HCFSA. Refer to the list of OTC drugs and medications by category (those that are reimbursable, those that are excluded, and dual purpose drugs and medicines that qualify under certain circumstances) by visiting the claims administrator's Web site.
- You are enrolled in an HMO
- You have stopped the account's Automatic Reimbursement Feature (explained above).

To file a claim you must complete a *Health Care FSA Withdrawal Form* available online through *Jetnet.* Be sure to attach documentation of your expenses, i.e., a receipt from the medical service provider, to the form.

For OTC expenses be sure your documentation includes the original receipt with the name of the over-the-counter product, the price, and the date of purchase. When a letter of medical necessity is required in order for an OTC product to qualify as a reimbursable expense, you must submit the letter with your reimbursement claim. To determine if your OTC medicine is reimbursable, refer to the OTC Drugs and Medications by Category list (on www.myuhc.com).

If you have other coverage, for example through your spouse's employer, you must first submit your claim to that coverage and receive the other plan's *Explanation of Benefits* (EOB) before filing for reimbursement from your HCFSA. You should stop the account's Automatic Reimbursement Feature by logging on to www.myuhc.com and clicking on "Managing My Accounts," or calling UnitedHealthcare (see *Contact Information* on page 1).

If your claim is approved, reimbursement checks are written to you when your claims total $50 or more. Claims under $50 are held until the $50 minimum is reached. Only at the end of the year will a check be written for less than $50. You will also receive a statement of your account with each reimbursement check.

You have until April 30th of the following year to submit claims incurred during the current calendar year. Claims not postmarked by April 30th are ineligible for reimbursement.

After you have made your first deposit to your HCFSA through payroll deduction, the entire amount you have agreed to deposit for the calendar year is available for your use. Expenses incurred before you began participating in the account are not reimbursable.

Continuation of Coverage (HCFSAs Only)

If your employment terminates for any reason (i.e., furlough, resignation, etc.), your FSAs are cancelled, along with your other benefits. You may elect to continue your HCFSA as part of your Continuation of Coverage options (see page 81) available through CONEXIS, the COBRA administrator. CONEXIS will mail a COBRA package to your home address (or to the address you provide) after your termination is processed. If you do not continue your HCFSA through COBRA, claims incurred after the date of your termination are not payable, and you forfeit any deposits that were made and not used before your termination date.

Dependent Day Care Flexible Spending Account

NOTE: Effective January 1, 2005, the FSA administrator changed from FBD Consulting to UnitedHealthcare. Claims for eligible expenses incurred on or after January 1, 2005, should be submitted to UnitedHealthcare.

How the DDFSA Works

You lose any money in your DDFSA not used during the year it was deposited. In addition, you can only change your election mid-year if you experience certain Life Events (see page 28). For this reason, you should give careful thought and planning to your enrollment decision and your election amount.

Conditions for Deposit and Maximum Allowable Deposit Amounts

You and your spouse (if you are married) must be employed or actively seeking employment to be eligible to receive reimbursement from your DDFSA. This benefit limits the amount you may deposit and the type of expenses that may be paid from your DDFSA.

Your family and tax filing status determine the maximum amount you can deposit per calendar year:

- A single employee may deposit up to $5,000.
- A couple filing a joint income tax return, where both spouses participate in DDFSAs, may deposit a combined amount of up to $5,000.
- A couple filing separate income tax returns may each deposit up to $2,500.
- A couple (if both individuals are employed) may deposit up to $5,000, or the income amount of the lower-paid spouse (if it is less than $5,000).

If your spouse has no income because he or she is a full-time student, is disabled and needs day care, or is unable to take care of your dependents because of a disability, you can still make deposits to your DDFSA. These circumstances allow you to deposit up to $200 per month if you have one eligible dependent, or up to $400 per month for two or more dependents.

Who Is Covered

You may claim dependent day care expenses for your eligible dependents including:

- Children under age 13
- A person over age 13 (including your child, spouse, or parent) if the person meets all of the following criteria:
    - Lives with you and depends on you for support, and
    - Is claimed as a dependent on your federal income tax return, and
    - Is physically or mentally incapable of self-care, and
    - Has a gross income less than the federal income tax personal exemption for the year ($3,200 in 2005)**.**

Because of IRS rules, Domestic Partners are not considered eligible dependents under your DDFSA.

DDFSA Guidelines

Because any unused money in your DDFSA is lost at the end of the year, consider the following guidelines when enrolling in this benefit:

- Carefully determine the number of weeks of dependent care you will purchase. Estimate and deduct weeks that might include vacation, illness, school or occasions when your dependents might have free care or not require care or as many hours of care.
- Do not anticipate expenses you are not sure about, such as day care for a child not yet born. The birth of a child is considered an eligible Life Event, and you may begin participation in a DDFSA.

Eligible Expenses

Expenses paid to the following providers may be reimbursed through your DDFSA, if you can provide their Social Security or taxpayer identification number:

- A licensed child-care center or adult day care center, including church or non-profit centers
- A private kindergarten — utilized for day care of the child(ren), rather than for educational purposes. If the private kindergarten provides both day care and educational services for your dependent child(ren), only the day care portion of the kindergarten's charges are eligible for reimbursement. The private kindergarten must separate and itemize its charges on its invoices for payment, clearly separating the day care expenses from the educational expenses. If the private kindergarten cannot or will not provide a separation/itemization of charges on its invoice, no reimbursement will be made from your DDFSA
- A babysitter inside or outside your home if the sitter does not care for more than six children at a time (not including the sitter's own dependents)
- A housekeeper whose duties include dependent day care
- A relative who cares for your dependents but is neither your spouse nor your dependent child under age 19
- Someone who cares for an elderly or disabled dependent inside or outside your home
- Au pairs (foreign visitors to the U. S. who perform day care and domestic services in exchange for living expenses, provided the au pair agency is a non-profit organization or the au pair obtains a U. S. Social Security number for identification purposes).

Receiving Reimbursement

You may receive reimbursement from your DDFSA through two different methods:

- File your claims, by mail, directly with UnitedHealthcare, and UnitedHealthcare will mail your reimbursement check to you (or will deposit the reimbursement amount into your bank account, if you have elected to receive reimbursement via direct deposit)
- Use your UnitedHealthcare Consumer Account Card to pay the day care provider directly from your DDFSA at the time you incur the cost of the day care services

DDFSA Claim Filing: When you incur a cost that is covered by the DDFSA, you may submit a claim to receive reimbursement from your account. File your claim by completing an FSA Claim Form (available on *Jetnet* or by requesting the form from UnitedHealthcare), attaching your original receipts, and submitting them to UnitedHealthcare (see *Contact Information* on page 1 for the address). UnitedHealthcare will process your DDFSA claim and make reimbursement payment to you (either by mailing you a check or by making a direct deposit to your bank account, if you have elected to receive reimbursement via direct deposit). Reimbursement of your first claim may take up to four weeks. Thereafter, claims are processed weekly.

Using the UnitedHealthcare Consumer Account Card: Effective January 1, 2005, all FSA enrollees began receiving the UnitedHealthcare Consumer Account Card. This Consumer Account Card (also referred to as the “FSA Card”) carries information about your FSA account(s) (both your HCFSA and your DDFSA, if applicable), including your account balance(s). Your FSA Card can be used at any day care provider that accepts MasterCard to pay for DDFSA-eligible expenses. Each year that you participate in a DDFSA, your FSA Card will be updated with your selected DDFSA amount, and you must activate the FSA Card (similar to activating a credit card) any time after January 1. Keep in mind that the FSA Card cannot be used until three business days after you activate it.

When you incur a DDFSA-eligible expense (for example, when you pay for a month’s day care for your child), simply present your FSA Card to the day care provider. The day care provider will bill a charge for the month’s day care, and run this charge against your FSA Card — the FSA Card will pay the billed amount directly from your DDFSA to the day care provider; thus, you don’t have to pay the bill from your own funds, you don’t have to submit the DDFSA claim to the FSA administrator, and you don’t have to wait for DDFSA reimbursement. You are not required to use the FSA Card if you prefer to file your DDFSA claims manually. *Keep in mind, however, that when you use the FSA Card, the day care provider must bill/run the charge to your FSA Card as a credit card, since the FSA Card cannot be assigned a PIN (Personal Identification Number) that is required for debit card transactions*

You may file claims for eligible expenses at any time. If your claim is for an amount less than $50, it will be held until you have accumulated at least $50 in expenses, or until year’s end. Unlike the HCFSA, you may only be reimbursed from the DDFSA up to the amount you have actually deposited at the time you submit the claim or use the FSA Card (less any claims that have already been paid). If your account balance is less than the amount you request, your reimbursement will only equal the amount in your account. However, unpaid amounts are automatically paid as additional deposits are made to cover them, subject to the $50 minimum described above.

Because most dependent day care expenses must be paid in advance, you may receive reimbursement for these services in advance, within certain guidelines. You can request reimbursement for services pre-paid up to 30 days in advance if the care provider verifies, in writing, that advance day care payments are non-refundable.

Any unauthorized transaction (any ineligible DDFSA expense) will be denied at the point of service, and you will be required to pay out of pocket for the portion of the expense that would have been paid by the FSA Card, had the expense been DDFSA-eligible. The card will also be denied at the point of service if the charge exceeds the balance in your DDFSA account.

Filing Claims

When you file a DDFSA claim, only money already deposited in your account is available to you. If your account holds less money than the amount of your claim, only the balance in your account is reimbursed to you. The remaining amount of your claim is paid to you automatically as additional deposits are made.

To file a claim, complete an FSA Claim Form available online through *Jetnet,* (or by requesting the form from UnitedHealthcare), and attach original receipts for your day care expenses. Be sure to include documentation of your expenses, including a paid receipt from your day care and the day care provider’s name, address, and Social Security or taxpayer identification number.

Your first claim may take up to four weeks to process. Thereafter, claims are processed weekly.

Because most employees are required to pay for dependent day care in advance, you may file a claim for prepaid expenses up to 30 days in advance, instead of waiting until services are rendered. To be reimbursed for prepaid expenses, the dependent day care provider must verify on the claim form that the advance day care payment has been received and is non-refundable. Advance payments are only reimbursable for services to be rendered within a 30-day period.

If your claim is approved, reimbursement checks are written to you when your claims total $50 or more. Claims under $50 are held until the $50 minimum is reached. Only at the end of the year is a check written for less than $50. You will receive a statement of your account with each reimbursement check. You may also view your account online by visiting the claims administrator's Web site. Plus, if you provide your e-mail address when you visit the claims administrator's Web site, you will receive e-mail confirmation that your claim has been processed.

You have until April 30th of the following year to submit claims incurred during the current calendar year. Claims not postmarked after April 30 are not eligible for reimbursement. Expenses incurred before you began participating in this benefit, or after you suspend/terminate this benefit are not reimbursable.

Long Term Care Insurance Plan

As an eligible employee, you may elect Long Term Care Insurance to help pay nursing home and home care costs if future illness, injury, or the effects of aging prevent you from living independently. This insurance is also available for your spouse, Domestic Partner, parents, parents-in-law, grandparents, and grandparents-in-law.

You may enroll in Long Term Care Insurance, without providing proof of good health, if you enroll within 60 days of the date you first become eligible to enroll. If you do not enroll for coverage when first eligible, you may add coverage at any time, but you will be required to provide proof of good health. However, spouses, Domestic Partners, parents, parents-in-law, grandparents, and grandparents-in-law must provide proof of good health in order to be covered by this insurance. Children are not eligible for participation in the Long Term Care Insurance Plan. All premiums for this coverage are paid by the employee/participant, and are paid with after-tax dollars.

MetLife insures and administers this insurance coverage. Contact MetLife for an enrollment form or for more information about Long Term Care Insurance.

Your Long Term Care Insurance becomes effective only after MetLife has approved your enrollment/application and you have paid the initial premium. MetLife will send you a certificate of insurance/coverage document that provides you with specific information and coverage provisions.

Plan Administration

Plan Information

The Plans listed below are sponsored by American Airlines, Inc. as that term is defined under ERISA Section 3(16)(B).

Plan Name	Plan Number

The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries
This plan includes:
• Medical Benefits
  o Out-of-Area Coverage Option
  o Minimum Coverage Option
  o PPO-Deductible Option
  o PPO-Copay Option
  o Health Maintenance Organizations
• Dental Benefit
• Vision Insurance Benefit
• Term Life Insurance Benefits
• Optional Term Life Insurance Benefits
• Spouse and/or Child Term Life Insurance Benefits
• Accidental Death & Dismemberment Insurance Benefits
• Voluntary Personal Accident Insurance Benefit
• Special Risk Accident Insurance Benefit
• Special Purpose Accident Insurance Benefit
• Management Personal Accident Insurance Benefit
• Optional Short Term Disability Insurance Benefit
• Health Care Flexible Spending Account Benefit
• Dependent Day Care Flexible Spending Account Benefit
	501

The Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries	503
American Eagle Airlines, Inc. Long Term Disability Plan	509
Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries	510

Administrative Information

American Airlines, Inc.
c/o American Eagle Airlines Inc. and Executive Airlines

(See below)

Plan Sponsor and Administrator

American Airlines, Inc.
Mailing address:
Mail Drop 5187-HDQ1
P. O. Box 619616
DFW Airport, Texas 75261-9616

Street address (do not mail to this address):
4333 Amon Carter Blvd.
Fort Worth, Texas 76155

The Plan Administrator for Second Level Claim Appeals

Pension Benefits Administration Committee (PBAC)
American Airlines
MD 5134-HDQ1
P.O. Box 619616
DFW Airport, TX 75261-9616

Agent For Service of the Legal Process

Managing Director, Total Rewards
American Airlines, Inc.

Mailing address:
Mail Drop 5187-HDQ1
P. O. Box 619616
DFW Airport, Texas 75261-9616

Express Delivery address:
4333 Amon Carter Blvd.
Fort Worth, Texas 76155

Claims Processor

The claims processors for each benefit or plan vary and are listed in *Contact Information* on page 1.

Trustee

The Trustee for the American Airlines, Inc. Health Benefits Trusts (prefunding trusts), the American Airlines, Inc. Supplemental Medical Benefits Trusts, and the American Airlines, Inc. Long Term Disability Plan Trust is:

State Street Bank & Trust
200 Newport Avenue
North Quincy, Massachusetts 02171

Employer ID Number

13-1502798

Plan Year

January 1 through December 31

Participating Subsidiaries

American Eagle Airlines, Inc.

Executive Airlines, Inc.

Plan Amendments

The Pension Benefits Administration Committee (PBAC), under the authority granted to it by the Board of Directors through the Chairman, has the sole authority to interpret, construe, determine claims, and adopt and/or amend employee benefit plans ("Plans"). The PBAC, in consultation with actuaries, consultants, Employee Relations, Human Resources, and the Legal Department, has the discretion to adopt such rules, forms, procedures, and amendments it determines are necessary for the administration of the Plans according to their terms, applicable law, regulation, collective bargaining agreements, or to further the objectives of the Plans. The PBAC may take action during a meeting if at least half the members are present or by a unanimous written decision taken without a meeting and filed with the Chairman of the PBAC.

The administration of the Plans shall be under the supervision of the Plan Administrator. The Employer hereby grants the PBAC the authority to administer and interpret the terms and conditions of the Plans and the applicable legal requirements related thereto. It shall be a principal duty of the PBAC to see that the administration of the Plans is carried out in accordance with its terms, for the exclusive purpose of providing benefits to Participants and their beneficiaries in accordance with the documents and instruments governing the Plans. The PBAC will have full power to administer the Plans in all of their details, subject to the applicable requirements of law. For this purpose, the PBAC's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by the Plans:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plans, including the establishment of any claims procedures that may be required by applicable provisions of law and to request extension of time periods hereunder and request additional information
- To interpret and construe the terms of the Plans, their interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plans

- To decide all questions concerning the Plans, and to determine the eligibility of any person to participate in or receive benefits under the Plans and to determine if any exceptional circumstances exist to justify any extensions
- To compute the amount of benefits that will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plans and the applicable requirements of law
- To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plans
- To allocate and delegate its responsibilities under the Plans and to designate other persons to carry out any of its responsibilities under the Plans, any such action to be by written instrument and in accordance with ERISA Section 405; and
- To delegate its authority to administer Claims for benefits under the Plans by written contract with a licensed third party administrator
- To the extent permitted by law, to rely conclusively upon all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the PBAC.

Plan Funding

The coverage for the following benefits is self-funded through both Company and employee contributions:

- Out-of-Area Coverage Option
- Minimum Coverage Option
- PPO-Deductible Option
- PPO-Copay Option
- Dental Benefit

The Supplemental Medical Plan and the Long Term Disability Plan are self-funded through employee contributions. Health Maintenance Organizations (HMOs) are fully insured and are funded through both Company and employee contributions.

Employee contributions as plan assets are held in Voluntary Employees' Beneficiary Association (VEBA) trusts established under Section 501(c)(9) of the Internal Revenue Code. Self-funded benefits are paid from trust assets. The claims processors are independent companies that provide claim payment services. They do not insure these benefits.

Coverage for the following benefits is fully insured and premiums are paid by the Company:

- Basic Term Life Insurance Benefit
- Basic Accidental Death & Dismemberment Insurance Benefit
- Special Risk Accident Insurance Benefit
- Special Purpose Accident Insurance Benefit
- Management Personal Accident Insurance Benefit.

The following benefits are fully insured and paid entirely by employee contributions:

- Optional (Contributory) Levels of Employee Life Insurance Benefit
- Spouse and/or Child Term Life Insurance Benefit
- Optional Short Term Disability Insurance Benefit
- Vision Insurance Benefit
- Voluntary Personal Accident Insurance Benefit
- Long Term Care Insurance Plan

Collective Bargaining Agreement

The types of benefits (medical and dental benefit, life insurance benefits, retiree medical benefits) described in this Guide are maintained subject to a collective bargaining agreement. A copy of the collective bargaining agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator. This agreement is also available for review during normal business hours at the corporate offices of American Airlines, Inc. (see *Contact Information* on page 1).

Assignment of Benefits

You may request that the claims processor pay your service provider directly by assigning your benefits.

You may assign medical, dental and Supplemental Medical Plan benefits for eligible expenses incurred for hospital care, surgery, dental care, or medical treatment for illness or injury. You may only assign benefits to the person or institution that provides the services or supplies for which these benefits are payable.

For information about assigning life insurance benefits, see *Assignment of Benefits* on page 134 of this Guide.

Claims

Confidentiality of Claims

The Company and its agents (including the claims processors) will use the information you furnish to substantiate your claim and determine benefits. The information may be forwarded to the Company medical director or other independent consultants for medical review or appropriate medical follow-up. In addition, certain individuals within the Company will have access to this information to carry out their duties to administer the coverages properly.

The Company treats your medical information as confidential and discloses it only as may be required for the administration of the Plans or as may be required by law. For additional information, see page 173.

Payment of Benefits

Benefits will be paid to you unless you have assigned payment to your service provider (see Assignment of Benefits). Benefits are paid after the claims processor receives satisfactory written proof of a claim. If any benefit has not been paid when you die, or, if you are legally incapable of giving a valid release for any benefit, the claims processor may pay all or part of the benefit to:

- Your guardian
- Your estate
- Any institution or person (as payment for expenses in connection with the claim)
- Any one or more persons among the following relatives: your spouse, parents, children, brothers, or sisters.

Payment of a claim to anyone described above releases the Plan Administrator from all further liability for that claim.

Right to Recovery

If claims payments are more than the amount payable under the Plans, the claims processor may recover the overpayment. The claims processor may seek recovery from one or more of the following:

- Any plan participant to or for whom benefits were paid
- Any other self-funded plans or insurers
- Any institution, physician, or other service provider, or
- Any other organization.

The claims processor is entitled to deduct the amount of any overpayments from any future claims payable to you or your service providers.

Subrogation

Subrogation is third party liability. Subrogation applies if the plans have paid any benefits for your injury or illness and someone else (including any insurance carrier) is, or may be, considered legally responsible.

The Plans have the right to collect payment from the third party (or its insurance carrier) for the medical treatment of your injury or illness. The Plans subrogate (substitute) their own rights for your rights and have a lien of first priority on any recovery you receive. This means the Plans must be paid first from any settlement or judgment you receive and the Plans shall have a lien of first priority over any recovery you receive that will not be reduced by any “make whole” or similar doctrine. The Plans may assert this right to pursue recovery independently of you.

As a condition for receiving benefits under the Plans, you agree to:

- Cooperate with the Plans to protect the Plans’ subrogation rights
- Provide the Plans with any relevant information they request
- Obtain consent of the Plans before releasing any party from liability for payment of medical expenses
- Sign and deliver documents regarding the Plans’ subrogation claim, if requested. (Refusal to sign these documents does not diminish the Plans’ subrogation rights.)
- Agree to hold amounts received in a constructive trust for the benefit of the Plans.

- The Plans' claims and lien shall not be reduced by any "make whole" or similar doctrine and shall not be reduced by the expenses you incur to obtain any recovery.

If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not directly or indirectly affect or influence the subrogation rights of the Plans.

The Plans will pay all legal costs of the plan regarding subrogation. You are responsible for paying your own legal costs. The Plans will not pay your or others' legal costs associated with subrogation.

Claim Processing Requirements

Time Frame for Initial Claim Determination

For claims for medical benefits, the processing rules vary by the type of claim. For urgent care claims (see definition on page 166) and pre-service claims (claims in which the service has not yet been rendered, and/or that require approval of the benefit or precertification before receiving medical care), the claims processor or benefit administrator will notify you of its benefit determination (whether adverse or not) within the following time frames:

- Seventy-two hours after receipt of a claim initiated for urgent care (a decision can be provided to you orally, as long as a written or electronic notification is provided to you within three days after the oral notification), or
- Fifteen days after receipt of a pre-service claim.

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

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

- The claims processor or benefit administrator's receipt of the requested information, or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

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

If an extension is necessary for pre- and post-service claims due to your or your authorized representative's failure to submit necessary information, the Plan's time frame for making a benefit determination is stopped from the date the claims processor or benefit administrator sends you an extension notification until the date you respond to the request for additional information.

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

- Is a communication by you or your authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters, and
- Is a communication that names you, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

Urgent Care Claims

Urgent care claims are those that, unless the special urgent care deadlines for response to a claim are followed, either:

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

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

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent care claim as defined earlier, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

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

Note: Any reduction or termination of a course of treatment will not be considered an adverse benefit determination if the reduction or termination of the treatment is the result of a Plan amendment or Plan termination.

If You Receive an Adverse Benefit Determination on a Health/Welfare Benefit Plan Claim

The claims processor or benefit administrator will provide you with a notification of any adverse benefit determination, which will set forth:

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

Disability Claims

All disability benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the claims processor. After the claims processor has reviewed the claim for disability benefits and obtained any other information that it deems necessary or relevant, the claims processor shall notify you within a reasonable period of time not to exceed 45 days after receipt of the acceptance or denial of the claim. The 45-day period during which a claim for disability benefits is reviewed may be extended by the claims processor for up to 30 days, provided the claims processor both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 45-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 30-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 30-day period provided the claims processor notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for Disability Benefits is denied, in whole or in part, the claims processor shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial;
- Specific references to the Plan provisions on which the denial is based;
- (A description of any information or material necessary to perfect the claim;
- An explanation of why this material is necessary;
- An explanation of the Plan's appeal and review procedure, including a statement of your right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review; and

- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request.

Effect of Failure to Submit Required Claim Information

If the claims processor determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for Disability Benefits as of the date you fail or refuse to comply and you shall not be entitled to any further Disability Benefits. However, your claim shall be reinstated upon your compliance with the claims processor's request for information or upon a demonstration to the satisfaction of the claims processor that under the circumstances the claims processor's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the claims processor, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the claims processor deems relevant.

All Other Claims

All benefit claims must be submitted in such written or electronic format and must contain such information as may be prescribed by the claims processor. After the claims processor has reviewed the claim for benefits and obtained any other information which it deems necessary or relevant, the claims processor shall notify you within a reasonable period of time not to exceed 90 days after receipt of the acceptance or denial of the claim. The 90-day period during which a claim for benefits is reviewed may be extended by the case manager or claims processor for up to 90 days, provided the claims processor both determines that such an extension is necessary due to matters beyond the control of the Plan and you are notified of the extension prior to the expiration of the initial 90-day period of the time and date by which the Plan expects to render a decision. If prior to the end of the initial 90-day extension the Plan Administrator determines that a decision cannot be reached within the initial extension period, the period for making the decision can be extended for up to an additional 90-day period provided the claims processor notifies you or your designated representative of the circumstances requiring the extension and the date by which a decision will be made. If your claim for disability benefits is denied, in whole or in part, the claims processor shall notify you of the denial in writing and shall advise you of the right to appeal the denial and to request a review. The Notice shall contain:

- Specific reasons for the denial
- Specific references to the Plan provisions on which the denial is based
- A description of any information or material necessary to perfect the claim
- An explanation of why this material is necessary
- An explanation of the Plan's appeal and review procedure, including a statement of the Participant's right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, following an adverse benefit determination on review; and
- If an internal rule, guideline or protocol was used in making the decision, either a copy of such rule, guideline or protocol must be provided or a statement that such rule, guideline or protocol was used and that it will be provided upon request.

Effect of Failure to Submit Required Claim Information

If the claim processor determines you failed or refused to comply in a timely manner with any reasonable request for information in connection with your claim (including, but not limited to, claim forms, medical examinations, medical information or reports and appropriate medical information release forms) you shall be deemed to have abandoned your claim for benefits as of the date you fail or refuse to comply and you shall not be entitled to any further benefits. However, your claim shall be reinstated upon your compliance with the claims processor's request for information or upon a demonstration to the satisfaction of the claims processor that under the circumstances the claims processor's request is not reasonable. If a claim is abandoned and subsequently reinstated, payments otherwise due you for the period between abandonment and reinstatement may be paid retroactively at the sole and exclusive discretion of the claims processor, taking into consideration the cause or reason for your failure or refusal, the length of the period, and other facts or circumstances the claims processor deems relevant.

Appealing a Denial

Procedures for Appealing an Adverse Benefit Determination

American Airlines, Inc., as Sponsor and Administrator for the Company-sponsored health and welfare benefit plans, has a two-tiered appeal process — referred to as First Level and Second Level Appeals. First Level Appeals are conducted by the claims processor or benefit administrator that rendered the adverse benefit determination. Second Level Appeals are conducted by the Pension Benefits Administration Committee (PBAC) at American Airlines, Inc.

This two-tiered appeal process applies to adverse benefit determinations made on all self-funded benefits or plans, as follows:

- Medical Benefits (including prescription drug coverages/options)
- Dental Benefit
- Supplemental Medical Plan
- Flexible Spending Account Benefits
- Long Term Disability Plan,

and for administrative, eligibility, and enrollment issues on any and all employee welfare benefits or plans offered.

With respect to adverse benefit determinations made on fully insured benefits, as follows:

- Term Life Insurance Benefit (Employee, Spouse, and Child)
- Accidental Death and Dismemberment Insurance Benefits (Employee, Spouse, Child, VPAI, and all Company-provided accident insurance benefits)
- HMOs
- Optional Short Term Disability Insurance Benefit
- Long Term Care Insurance Plan,

the appeal process is defined by the respective insurers and HMOs (thus, it might not be a two-tiered process). The PBAC cannot render a decision involving fully insured benefits (except for administrative, eligibility, and enrollment issues, as stated previously). The insurers and HMOs make the final appeal determinations for their respective insured coverages/benefits. Each insurer or HMO has its own appeal process, and you should contact the respective insurer or HMO for information on how to file an appeal (see *HMO Contact Information* on page 54).

If you receive an adverse benefit determination, you must ask for a First Level Appeal review from the claims processor or benefit administrator. You or your authorized representative have 180 days following the receipt of a notification of an adverse benefit determination within which to file a first Level Appeal. If you do not file your First Level Appeal (with the claims processor or benefit administrator) within this time-frame, you waive your right to file the First and Second Level Appeals of the determination.

To file a First Level Appeal with the claims processor or benefit administrator, please complete an Application for First Level Appeal, and include with the Application all comments, document, records, and other information relating to the denied/withheld benefit. (The Application for First Level Appeal provides information about what to include with your appeal. You can download and print this Application from the "Forms" site on *Jetnet* – Benefits and Pay, or you can request the form from Employee Services at (800-447-2000 or employee.services@aa.com).

The claims or benefit administrator will review your First Level Appeal and will communicate its First Level Appeal decision to you in writing,

- for pre-service claims – within 30 days of receipt of your First Level Appeal
- for post-service claims – within 60 days of receipt of your First Level Appeal
- for urgent care claims – within 72 hours of receipt of your First Level Appeal
- for disability claims, within 45 days of receipt of your First Level Appeal. If the claims processor or benefit administrator requires additional time to obtain information needed to evaluate your First Level Appeal for disability, it may have an additional 45 days to complete your First Level Appeal (the claims processor or benefit administrator will notify you if this additional time period is needed to complete a full and fair review of your case).
- for all other claims for all benefits other than medical or disability, within 60 days of receipt of your First Level Appeal, if the claims processor or benefit administrator requires additional time to obtain information needed to complete your First Level Appeal for non-medical and non-disability benefits, it may have an additional 60 to complete your First Level Appeal (the claims processor or benefit administrator will notify you that this additional time period is needed to complete a full and fair review of your case).

Upon your receipt of the First Level Appeal decision notice upholding the prior denial — if you still feel you are entitled to the denied/withheld benefit — you must file a Second Level Appeal with the PBAC.

If you receive an adverse benefit determination on the First Level Appeal, you must ask for a Second Level Appeal review from the Pension Benefits Administration Committee ("PBAC") at American Airlines, Inc. 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 (with the PBAC) within this time frame, you waive your right to file the Second Level Appeal of the determination.

To file a Second Level Appeal with the PBAC, please complete an Application for Second Level Appeal, and include with the Application all comments, documents, records, and other information — including a copy of the First Level Appeal decision notice — relating to the denied/withheld benefit. (The Application for Second Level Appeal provides information about what to include with your appeal. You can download and print this Application from the "Forms" site on *Jetnet* – Benefits and Pay, or you can request the form from Employee Services at 800-447-2000 or employee.services@aa.com).

The PBAC will review your Second Level Appeal and will communicate its Second Level Appeal decision to you in writing:

- For pre-service claims, within the 30-day time period allotted for completion of both levels of appeal
- For post-service claims, within the 60-day time period allotted for completion of both levels of appeal
- For urgent care claims, within the 72-hour time period allotted for completion of both levels of appeal.

Example: A participant appeals an adverse benefit determination (post-service claim). For both levels of appeal – First and Second Levels, the combined time taken by the claims processor or benefit administrator and the PBAC to review and complete the appeals must be no more than 60 days. If the First Level Appeal review is completed by the claims processor or benefit administrator in 15 days, then the PBAC has the remaining 45 days (for a total of 60 days) to complete its review and render its decision.

Upon its receipt, your Second Level Appeal will be reviewed in accordance with the terms and provisions of the Plans and the guidelines of the PBAC. Appointed officers of American Airlines, Inc. are on the PBAC. In some cases, the PBAC designates another official to determine the outcome of the appeal. Your case, including evidence you submit and a report from the claims processor or benefit administrator, if appropriate, will be reviewed by the PBAC or its designee(s).

The Second Level Appeal is a voluntary appeal only for urgent care claims and disability claims. The Second Level of Appeal is mandatory for all other claims, unless otherwise stated in this Guide. American Airlines, Inc. encourages all employees to use both levels of appeal to exhaust all avenues to resolve any claim issues in the quickest manner possible.

You have the right to:

- Submit written comments, documents, records and other information relating to the claim for benefits
- Request, free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. For this purpose, a document, record, or other information is treated as "relevant" to your claim if it:
    - Was relied upon in making the benefit determination
    - Was submitted, considered or generated in the course of making the benefit determination, regardless of whether such document, record or other information was relied upon in making the benefit determination
    - Demonstrates compliance with the administrative processes and safeguards required in making the benefit determination
    - Constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for your diagnosis, regardless of whether such statement was relied upon in making the benefit determination

- A review that takes into account all comments, documents, records and other information submitted by you related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination
- A review that does not defer to the initial adverse benefit determination and that is conducted neither by the individual who made the adverse determination, nor that person's subordinate
- A review in which the named fiduciary consults with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the initial adverse benefit determination, nor the subordinate of any such individual. This applies only if the appeal involves an adverse benefit determination based in whole or in part on a medical judgment (including whether a particular treatment, drug or other item is experimental)
- The identification of medical or vocational experts whose advice was obtained in connection with the adverse benefit determination, regardless of whether the advice was relied upon in making the decision
- In the case of a claim for urgent care, an expedited review process in which:
    - You may submit a request (orally or in writing) for an expedited appeal of an adverse benefit determination
    - All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly prompt method.

You must use and exhaust Plans' administrative claims and appeals procedure before bringing a suit in federal court. Similarly, failure to follow the 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.

No action may be brought more than two years after the adverse benefit determination is made on final appeal (or Second Level Appeal) with the PBAC.

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.

Compliance with Privacy Regulations

Notice of Privacy Rights – Health Care Records

This notice applies to all Plan Participants of the participating company of American Eagle Airlines, Inc. and Executive Airlines, Inc. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice is effective as of April 14, 2003, and applies to health information received about you by the healthcare components of the Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (particularly, the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible and PPO-Copay Options, the HMOs, Dental Benefit, Vision Insurance Benefit, Health Care Flexible Spending Accounts Benefit), The Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries and any other group health plan for which American Airlines, Inc. ("American") serves as Plan Administrator (collectively, the "Plan"). You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claims for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop-loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by AMR Corporation and its subsidiaries for any of the purposes described above.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you (for example, if your doctor requests information on what other drugs you are currently receiving).

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop-loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances.

When Required by Law. The Plan may also be required to disclose or use your PHI for certain other purposes (for example, if certain types of wounds occur that require reporting, or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena).

For Workers' Compensation. The Plan may disclose your PHI as authorized by you or your representative and to the extent necessary to comply with laws relating to Workers' Compensation and similar programs providing benefits for work-related injuries or illnesses if either, (1) the health care provider is a member of the employer's workforce and provides health care to the individual at the request of the employer, the PHI is provided to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace, and the information is required for the employer to comply with OSHA or with laws with similar purposes, or (2) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

Pursuant to Your Authorization. Any other use or disclosure of your PHI will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

For Appointment Reminders and Health Plan Operations. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health-related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. Information may be provided to the Sponsor of the Plan, provided that the Sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment-related activities.

Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your Protected Health Information to family members, other relatives and your close Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family's or friend's involvement with your care or payment for that care, and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.
- The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose PHI for research, subject to certain conditions.

When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. state laws may provide you with additional rights or protections.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your PHI in writing. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the following officer: Managing Director, Human Resources Delivery.

To Access. You have the right to request access to your PHI and to inspect and copy your PHI in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: Managing Director, Human Resources Delivery at American Airlines, MD 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your PHI in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made to the following officer: Managing Director, Human Resources Delivery at American Airlines, MD 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. You or your personal representative will be required to complete a written form to request amendment of the PHI in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your PHI, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Obtain a Paper Copy of This Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Plan’s Privacy Officer by calling the Managing Director, Human Resources Delivery, or by writing to American Airlines, MD 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

To Request Confidential Communication. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the following officer: Managing Director, Human Resources Delivery, American Airlines, MD 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616.

A Note About Personal Representatives

You may exercise your rights through a personal representative (e.g., having your spouse call for you). Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public
- a signed authorization completed by you
- a court order of appointment of the person as the conservator or guardian of the individual, or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the Secretary of the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a "Limited Data Set" that may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set. Disclosures of a Limited Data Set need not be included in any accounting of disclosures by the Plan.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, MD 5134-HDQ, P.O. Box 619616, DFW Airport, TX 75261-9616, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. You may obtain the address of the appropriate regional office of the Office for Civil Rights from the Privacy Complaint Official. If you would like to receive further information, you should contact the Privacy Official, the Managing Director, Human Resources Delivery at American Airlines, MD 5144-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616, or the Privacy Complaint Official, Chair, HIPAA Compliance Subcommittee, c/o PBAC Appeals Group, at American Airlines, MD 5134-HDQ1, P.O. Box 619616, DFW Airport, TX 75261-9616. This notice will first be in effect on April 14, 2003 and shall remain in effect until you are notified of any changes, modifications or amendments.

How AMR Corporation and Its Subsidiaries, Including American Airlines, American Eagle Airlines, Inc. and Executive Airlines, Inc. May Use Your Health Information

American Airlines, Inc. ("American"), administers many aspects of the American Group Health Plans (the "Plans"), which are listed below, on behalf of AMR Corporation and its Subsidiaries, including American Airlines and American Eagle. American, as the plan sponsor and/or plan administrator of the Plans may use and disclose your personal medical information (called "Protected Health Information") created and/or maintained by the Plans that it receives from the Plans as permitted and/or required by, and consistent with the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations found at 45 CFR Part 164, Subpart A. This includes, but is not limited to, the right to use and disclose a participant's PHI in connection with payment, treatment and health care operations.

The American Airlines Group Health Plans include the health plan components of:

- The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries[1] (Plan 501)
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503)
- Trans World Airlines, Inc. Retiree Health and Life Benefits Plan (Plan 511)
- American Airlines, Inc. Retiree Dental Plan (Plan 512), and
- Any other Group Health Plan for which American serves as Plan Administrator.

[1] This is the formal name of the benefit plan. Only the health plan components of this benefit plan are covered by this section. Life insurance and other non-Health benefits are not subject to this section.

This Applies To

The information in this section applies only to health-related benefit plans that provide "medical care," which means the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body, transportation primarily for and essential to medical care, and insurance covering medical care. This means that, for the Plans listed above, only the health-related benefits, including medical, dental, vision, prescription drug, mental health, and health care flexible spending account benefits, are subject to the limitations described in this section. The EAP is included only to the extent that it is involved in the administration of medical benefits.

This Section Does Not Apply To

By law, the HIPAA Privacy rules, and the information in this section, do *not* apply to the following benefit plans:

- Disability plans (short-term and long-term disability)
- Life insurance plans, including accidental death & dismemberment (AD&D)
- Workers' compensation plans, which provide benefits for employment-related accidents and injuries
- Property and casualty insurance.

In addition, AMR Corporation and its subsidiaries may have personal medical information about you that is used for routine employment activities. Medical information held or used by AMR Corporation and its subsidiaries in its employment records for employment purposes is *not* subject to the HIPAA Privacy rules.

This includes, but is not limited to, medical information, files or records related to compliance with government occupational and safety requirements, the Americans with Disabilities Act (ADA) or other employment law requirements, occupational injury, disability insurance eligibility, sick leave requests or justifications, drug or alcohol screening results, workplace medical surveillance, fitness-for-duty test results, or other medical information needed to meet Federal Aviation Administration (FAA), Department of Transportation (DOT), or other company policy or government requirements. Information used by the EAP in its role in administering employment-related programs, such as drug and alcohol testing, is not subject to the HIPAA Privacy rules.

The Plans will disclose PHI to the employer Plan Sponsor (American Airlines, or other current or former AMR subsidiary) only upon receipt of a certification by the employer that the plan documents have been amended to incorporate all the required provisions as described below. To the extent that PHI is maintained by one of the Plans, American and all other participating current or former subsidiaries of AMR Corporation for which American administers the Plans have agreed to:

- Not use or further disclose the information other than as permitted or required by this Employee Benefits Guide, as it may be amended by American from time-to-time, or as required by law
- Ensure that any agents, including a subcontractor, to whom the Plans give PHI, agree to the same restrictions and conditions that apply to the employer Plan Sponsor with respect to such information
- Not use or disclose PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor employer, unless that use or disclosure is permitted or required by law (for example, for Workers Compensation programs) or unless such other benefit is part of an organized health care arrangement with the plan

- To the extent that the employer Plan Sponsor becomes aware that there is any use or disclosure of PHI that is inconsistent with the permitted uses or disclosures, to report such improper uses or disclosures to the Plan
- Make available PHI in accordance with individual rights to review their PHI
- Make available PHI for amendment and consider incorporating any amendments to PHI consistent with the HIPAA rules
- Upon request and to the extent mandated by applicable law, make available the information required to provide an accounting of disclosures in accordance with the HIPAA rules
- Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Plan
- Agree to the same restrictions and conditions that apply to the Plan with respect to such information and enter into Business Associate agreements that comply with the standards for such agreements in the Privacy Regulations
- Enter into limited data set use agreements when the Plan discloses data de-identified in compliance with the requirements for a limited data set as provided in the Privacy Regulations pursuant to a Limited Data Set use or disclosure agreement which meets the standards of the Privacy Regulations
- Terminate any Business Associate agreement or Limited Data Set agreement in the event the Plan becomes aware of a pattern of noncompliance with the terms of the agreement
- Provide the individual who is the subject of the PHI with the opportunity to request restrictions on the PHI's disclosure in accordance with the Plan's policy on requesting restrictions on disclosure of PHI
- Provide the individual who is the subject of the PHI with the opportunity to request confidential communication of PHI from the Plan to the individual in accordance with the Plan's policies and procedures
- Incorporate any amendments or corrections to PHI when such amendment is determined to be required by the Plan's policy on amendment of PHI
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the Plans
- If feasible, return or destroy all PHI received from the Plans that the employer Plan Sponsor still maintains in any form. The employer Plan Sponsor will retain no copies of PHI when no longer needed for the purpose for which disclosure was made. An exception may apply if the return or destruction is not feasible, but the Plans must limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible, and
- Ensure that there is an adequate separation between the Plans and the employer Plan Sponsor as will be set forth below.

Separation of AMR Corporation and Its Subsidiaries, Including American Airlines, American Eagle Airlines, Inc. and Executive Airlines, Inc. and the Group Health Plans

The following employees or classes of employees or other persons under the control of American Airlines or another AMR subsidiary shall be given access to Protected Health Information (PHI) for the purposes related to the Plan:

- Health Strategy employees involved in health plan design, vendor selection, and administration of the Plans, and including the Plan Managers, and administrative assistants, secretarial and support staff; as well as any Retirement Strategy employees involved in health plan issues
- Pension Benefits Administration Committee (PBAC), its delegated authority, and PBAC Advisory Committee members, due to their role in governing health plan matters, including reviewing and approving plan design changes, rendering appeal decisions, and other health plan administrative matters
- Benefits Compliance and the PBAC Appeals group personnel involved in receiving, researching, and responding to health plan member appeals filed with the PBAC
- Employee Services personnel who assist with day-to-day health plan operations, including Vendor Relations personnel; Retirement Counselors, who assist with retiree medical coverage questions; employees involved in receiving, reviewing and processing Qualified Medical Child Support Orders; and all call center personnel, case coordinators and support staff who assist employees by answering questions, researching issues and resolving health plan problems, including those administering the Travel program; Leave of Absence coordinators working with health plan enrollment issues; Survivor Support counselors, who assist with health plan issues for survivors; and administrative assistants, secretarial and support staff for the employees listed
- Instructors who train Employee Services personnel, and thus have access to the call center systems
- HR Records Room personnel responsible for managing benefit plan record storage
- Certain Management Advisory Services (MAS) personnel, but only those involved in investigating health plan fraud or abuse
- Executive Compensation employees, including secretarial and support staff, who assist Company executives and certain other employees with health plan enrollment and payment issues on a day-to-day basis
- Occupational Health Services/Clinical Services employees, including the Corporate Medical Director, EAP Manager, EAP nurses and support staff providing services through the Employee Assistance Program (EAP), including review and approval of mental health and substance abuse claims under the Plans, but only to the extent of their involvement with the Group Health Plans
- Legal department employees, including Employment Attorneys, ERISA counsel, Labor Attorneys, and Litigation Attorneys, and any other attorneys involved in health plan legal matters, and including paralegals and administrative assistants, and Legal Records Room personnel who manage record storage
- Human Resource (HR) Quality Assurance personnel responsible for financial management of the health plans, including the HR Controller; HR Delivery Operations personnel; health plan Benefits Analysts monitoring financial trends; and their administrative assistants, secretarial and support staff

- Financial Reporting Group employees involved in audits and financial reporting for the group health plans, and including the secretarial and support staff for these employees
- Employee Relations personnel, but only those involved in grievance processes or mediation/arbitration processes
- Internal Audit employees, but only for purposes of auditing administrative processes related to the group health plans, and including the secretarial and support staff for these employees
- Benefits & Travel Technology personnel who maintain key human resource and benefits systems used to transmit, store or manage PHI, and including the secretarial and support staff for these employees
- Information Technology Services (ITS) management personnel, including certain team leads and other designated personnel managing IT infrastructure for systems used by HR and Benefits, including administrative staff, key vendor managers and certain management personnel responsible for disaster recovery procedures
- American Eagle personnel involved in benefit plan administration for that subsidiary
- Privacy Compliance Council and HIPAA Subcommittee members, due to their role in understanding and investigating the flow of PHI for the Group Health Plans, in order to ensure compliance with HIPAA and other privacy rules; and
- On a need-to-know basis, appropriate personnel employed by the employer Plan Sponsor as independent contractors who have executed Business Associate agreements with the plan to provide other necessary administrative services to the Plan that include, but are not limited to:
    - Insurance agents retained to provide consulting services and obtain insurance quotes
    - Actuaries retained to assess the Plan's ongoing funding obligations
    - Data aggregation specialists engaged to facilitate the collection and organization of Plan liabilities
    - Consulting firms engaged to design and administer Plan benefits
    - Financial accounting firms engaged to determine Plan costs; and
    - Claims processing companies engaged to assist the Plan Administrator in the processing of claims made against the Plan.

Access to and use of PHI by such employees and other persons described above is restricted to administration functions for the Plans performed by American or another employer Plan Sponsor, including payment and health care operations.

American and other AMR subsidiaries shall provide an effective mechanism for resolving any issues of noncompliance by such employees or persons. American Airlines' Rules of Conduct as outlined in the Employee Policy Guide, including disciplinary procedures, will apply to such issues of employee noncompliance.

Non-compliance Issues

If the persons described above do not comply with the requirements included in this portion of the Plan, the Plan Sponsor shall provide a mechanism for resolving issues of non-compliance, including disciplinary sanctions for the individuals involved in the violation, which sanctions are included in the policy on sanctions for violation of the privacy policies and procedures. The Plan's Policy Regarding Sanctions for Violation of the HIPAA Privacy Policies and Procedures shall be followed along with the Group Health Plan's Policy and Procedure on Mitigation of Damages for Violative Disclosure of Protected Health Information in the event of any violation of the Plan's HIPAA Privacy Provisions in this Article.

Organized Health Care Arrangement

The Plan is part of an organized health care arrangement with the following other health plans maintained by AMR Corporation and its subsidiaries.

The Group Life and Health Benefits Plan for Employees of Participating AMR Corporation subsidiaries with respect to the benefits and benefit options providing medical benefits, dental benefit, vision benefits, retiree medical benefits, health care flexible spending accounts and the HMOs offered hereunder, the Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries and any other Group Health plan for which American serves as Plan Administrator.

The health plans or health care components that are part of this organized health care arrangement may disclose or use PHI to the other plans within the organized health care arrangement for the purposes described in the regulations and in the section entitled “Notice of Privacy Rights – Health Care Records” above.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of the Plan's benefits that relate to an individual to whom health care is provided. A disclosure for payment will be limited to the minimally necessary information unless the disclosure occurs in the form of the standard for the electronic transactions. An authorization is not required to permit a disclosure or use for payment unless the disclosure involves psychotherapy notes or the use of the information for marketing. Payment activities include, but are not limited to, the following:

- Determination of eligibility, coverage and cost sharing amounts (for example, the reasonable or usual and customary cost of a service or supply, benefit plan maximums, coinsurance, deductibles and copayments as determined for an individual's claim);
- Coordination of benefits;
- Adjudication of health benefit claims (including appeals and other payment disputes);
- Subrogation of health benefit claims;
- Establishing employee contributions;
- Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- Billing, collection activities and related health care data processing;
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- Determining medical necessity, experimental or investigational treatment or other coverage reviews or reviews of appropriateness of care or justification of charges (including hospital bill audits);
- Processing utilization review, including precertification, preauthorization, concurrent review, retrospective review, care coordination or case management;
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for such purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- Obtaining reimbursements due to the Plan.

Health Care Operations – A disclosure for Health Care Operations will be limited to the amount minimally necessary. Health Care Operations include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating providers and plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including but not limited to:
    - Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
    - Participant service, including the provision of data analyses for participants or the plan sponsors;
- Resolution of internal grievances; and
- The sale, transfer, merger, or consolidation of all or part of the Plan with another covered entity, or an entity that following such activity will become a covered entity, and due diligence related to such activity.

Treatment – Disclosures for treatment are not limited by the minimally necessary requirement if the disclosures are made to, or the requests are made by a health care provider for the treatment of an individual. Treatment means the provision, coordination or management of health care and related services by one or more health care provider(s). Treatment includes:

- The coordination or management of health care by a health care provider and a third party;
- Consultation between health care providers about an individual patient; or
- The referral of a patient from one health care provider to another.

***Limited Data Set*.** The Plan may disclose PHI in the form of a limited data set as provided in 45 CFR §164.514(e) provided that the disclosure is in accordance with such provisions.

Your Rights Under ERISA

Information About Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements 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 collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension 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.

Normally, the Plan Administrator should be able to help resolve any problems that might develop or answer any questions about rights to benefits under the Plan. We believe that the Plan that has been developed is only good if you receive the benefits to which you are entitled. We encourage you to come to us if you have any questions or problems. In addition, as already noted, the Plan documents and other related information will be made available if you wish to study these materials. However, if you feel your rights under ERISA have been violated, 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 from the Plan 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 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 relations 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 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, NW, Washington, DC 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.

For general information contact:

HR Employee Services
MD 5141-HDQ1
American Airlines, Inc.
P. O. Box 619616
DFW Airport, Texas 75261-9616
(800) 447-2000

E-mail to: Employee.Services@aa.com

Web Address: *Jetnet*.aa.com. (Select “Benefits and Pay” from the *Jetnet* main landing page).

For information about your claims, contact the appropriate claims processor or benefits plan administrator at the addresses and phone numbers located in *Contact Information* on page 1.

Glossary

Term	Definition
Accidental injury	An injury caused by an outside and unforeseen traumatic force, independent of all other causes.
Alternative and/or Complementary Medicine	Diverse medical health care systems, practices, and products that are not considered to be part of conventional medicine. Alternative and/or complementary medicine have not been proven safe and effective through formal scientific studies and scientific clinical trials conducted by the National Institutes of Health (National Center for Complementary and Alternative Medicine) or that are not recognized in Reliable Evidence as safe and effective treatments for the illness or injury for which they are intended to be used. Alternative and/or complementary medicine lack proof of safety and efficacy through formal, scientific studies or scientific clinical trials conducted by the National Institutes of Health or similar organizations recognized by the National Institutes of Health. Some examples of complementary and/or alternative medicine are: • Mind-body interventions (meditation, mental healing, creative outlet therapy etc.) • Biological therapies (herbal therapy, naturopathic or homeopathic treatment, etc.) • Manipulative or body-based treatment (body-work, massage, rolfing, etc.) • Energy therapies (qi-gong, magnetic therapies, etc). These examples are not all inclusive, as new forms of alternative and/or complementary medicine exist and continue to develop. Other terms for complementary and/or alternative medicine include (but are not limited to) unconventional, non-conventional, unproven, and irregular medicine or health care.
Alternative mental health care centers	These centers include residential treatment centers and psychiatric day treatment facilities (see definitions in this section).
Ancillary charges	Charges for hospital services, other than professional services, to diagnose or treat a patient. Examples include fees for x-rays, lab tests, medicines, operating rooms, and medical supplies.
Assignment of benefits	You may authorize the claims processor to directly reimburse your medical service provider for your eligible expenses by requesting that the provider accepts assignment of benefits. When you request assignment of benefits, you avoid paying the full cost of the medical service up front, filing a claim, and waiting for reimbursement. Your medical service provider generally files your medical claim for you if he or she accepts assignment.
Bereavement counseling	Counseling provided by a licensed counselor (usually a certified social worker, advanced clinical practitioner, or clinical psychologist) to assist the family of a dying or deceased plan participant with grieving and the psychological and interpersonal aspects of adjusting to the participant's death.

Term	Definition
Chemical dependency treatment center	An institution that provides a program for the treatment of alcohol or other drug dependency by means of a written treatment plan that is approved and monitored by a physician. This institution must be: • Affiliated with a hospital under a contractual agreement with an established system for patient referral • Accredited by the Joint Commission on Accreditation of Health Care Organizations • Licensed, certified, or approved as an alcoholism or other drug dependency treatment program or center by any state agency that has the legal authority to do so.
Chiropractic care	Medically necessary diagnosis, treatment, or care for an injury or illness when provided by a licensed chiropractor.
Coinsurance	You pay a percentage of eligible expenses and the Medical Benefit Option pays the remaining percentage. For example, after you satisfy your deductible under the PPO-Deductible Option, you pay 20% coinsurance for most covered medical services and the PPO-Deductible Option pays 80%.
Common accident	With regard to Accidental Death and Dismemberment (AD&D), this refers to the same accident or separate accidents that occur within one 24-hour period.
Company	Participating AMR Corporation subsidiaries.
Convalescent or skilled nursing facility	A licensed institution that: • Mainly provides inpatient care and treatment for persons who are recuperating from illness or injury • Provides care supervised by a physician • Provides 24-hour nursing care by nurses who are supervised by a full-time registered nurse • Keeps a daily clinical record of each patient • Is not a place primarily for the aged or persons who are chemically dependent • Is not an institution for rest, education, or custodial care.
Conventional Medicine	Medical health care systems, practices, and products that are proven and commonly accepted and used throughout the general medical community of medical doctors, doctors of osteopathy, and allied health professionals such as physical therapists, registered nurses, and psychologists. Conventional medicine has been determined safe and effective, and has been accepted by the National Institutes of Health, United States Food and Drug Administration, Centers for Disease Control or other federally recognized or regulated health care agencies, and has been documented by Reliable Evidence as both safe and effective for the diagnosis and/or treatment of the specific medical condition. Other terms for conventional medicine include (but are not limited to) allopathy, western, mainstream, orthodox, and regular medicine.
Copayments	You pay a specific dollar amount for certain covered services when you use network providers. For example, under the PPO-Copay Option you pay $20 for an office visit to your primary care physician (PCP) and $30 for a specialist visit.
Custodial care	Care that assists the person in the normal activities of daily living and does not provide any therapeutic value in the treatment of an illness or injury.
Deductible	The amount of eligible expenses a person or family must pay before a benefit or plan will begin reimbursing eligible expenses.

Term	Definition
Dental	Dental refers to the teeth, their supporting structures, the gums, and/or the alveolar process.
Detoxification	Twenty-four hour medically directed evaluation, care, and treatment of drug-and alcohol-addicted patients in an inpatient setting. The services are delivered under a defined set of physician-approved policies and procedures or clinical protocols.
Developmental therapy	Therapy for impaired childhood development and maturation. Examples of developmental therapy include treatments that assist a child in walking, speech proficiency (word usage, articulation, and pronunciation), and socialization skills. Developmental therapy is not considered rehabilitative unless the function had been fully developed and then lost due to injury or illness.
Durable medical equipment (DME)	Medical equipment intended for use solely by the participant for the treatment of his or her illness or injury. DME is considered to be lasting and would have a resale value. DME must be usable only by the participant and not the family in general. The equipment must be medically necessary and cannot be primarily for the comfort and convenience of the patient or family. A statement of medical necessity from the attending physician and a written prescription must accompany the claim. DME includes, but is not limited to: prosthetics, casts, splints, braces, crutches, oxygen administration equipment, wheelchairs, hospital beds, and respirators.
Eligible medical expenses **or Eligible expenses**	The benefit or plan covers the portion of regular, medically necessary services, supplies, care, and treatment of non-occupational injuries or illnesses up to the usual and prevailing fee limits, when ordered by a licensed physician acting within the scope of his or her license and that are not for services or supplies that are excluded from coverage.
Emergency	An injury or illness that happens suddenly and unexpectedly and could risk serious damage to your health or is life threatening if you do not get immediate care. Examples include poisoning, drug overdose, multiple trauma, uncontrolled bleeding, fracture of large bones, head injury, severe burns, loss of consciousness, and heart attacks.
Enter-on-duty date	The first date that you are on the U.S. payroll of American Eagle Airlines, Inc. as a regular employee.
Experimental or investigational service or supply	A service, drug device, treatment, procedure, or supply is experimental or investigational if it meets any of the following conditions: • It cannot be lawfully marketed without approval of the U. S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished; • Reliable evidence shows that the drug, device, procedure, or medical treatment is the subject of ongoing phase I, II, or III clinical trials or under study (or that the consensus of opinion among experts is that further studies or clinical trials are necessary) to determine its maximum tolerated dose, toxicity, safety, or efficacy, both in diagnosis and treatment of a condition and as compared with the standard means of treatment or diagnosis; • The drug or device, treatment or procedure, has FDA approval, but is not being used for an indication or at a dosage that is accepted and approved by the FDA or the consensus of opinion among medical experts; • Reliable Evidence shows that the medical service or supply is commonly and customarily recognized throughout the physicians profession as accepted medical protocol, but is not being utilized in accordance or in compliance with such accepted medical protocol and generally recognized standards of care; • The drug, device, treatment or procedure that was reviewed and approved (or
Experimental or	

Term	Definition
investigational service or supply (continued)	that is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure that is used with a patient informed consent document that was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function • A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis • The treatment or procedure is less effective than conventional treatment methods; or • The language appearing in the consent form or in the treating Hospital's protocol for treatment indicates that the Hospital or the Physician regards the treatment or procedure as experimental. "Reliable Evidence" is defined on page 195, and when used herein, refers to "Reliable Evidence" as defined on page 195.
Explanation of benefits	A statement provided by the claims processor that shows how a service was covered by the plan, how much is being reimbursed, and what portion (if any) is not covered.
Free-standing surgical facility	An institution primarily engaged in medical care or treatment at the patient's expense and that is: • Eligible to receive Medicare payments • Supervised by a staff of physicians and provides nursing services during regularly scheduled operating hours • Responsible for maintaining facilities on the premises for surgical procedures and treatment • Not considered part of a hospital.
Home health care agency	A public or private agency or organization licensed to provide home health care services in the state in which it is located.
Home health care	Services that are medically necessary for the care and treatment of a covered illness or injury furnished to a person at his or her residence.
Hospice care	A coordinated plan of care that treats the terminally ill patient and family as a family unit. It provides care to meet the special needs of the family unit during the final stages of a terminal illness. Care is provided by a team of trained medical personnel, homemakers, and counselors. The hospice must meet the licensing requirements of the state or locality in which it operates.
Incapacitated child	A child who is incapable of self-support because of a physical or mental condition and who legally lives with the employee and wholly depends on the employee for support.
Infertility treatment or testing	Includes medical services, supplies, and procedures for or resulting in impregnation, and testing of fertility or for hormonal imbalances which cause male or female infertility (regardless of the primary reason for the hormone therapy). Infertility treatment or testing includes, but is not limited to: all forms of in-vitro fertilizations, artificial insemination, embryo transfer, embryo freezing, gamete transfer, zygote transfer, and reversals of tubal ligations or vasectomies, drug therapy, including drug treatment for ovarian dysfunction, and infertility drugs, such as Clomid or Pergonal.

Term	Definition
Inpatient or hospitalization	Medical treatment or services provided at a hospital when a patient is admitted and confined, for which a room and board charge is incurred.
Life Event	Certain circumstances or changes that occur during an employee's life that qualify the employee or dependents for specific changes in coverage options.
Loss or impairment of speech or hearing	Those communicative disorders generally treated by a speech pathologist, audiologist, or speech language pathologist licensed by the state board of healing arts or certified by the American Speech-Language and Hearing Association (ASHA), or both, and that fall within the scope of his or her license or certification.
Mammogram or mammography	The x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube filter compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views of each breast.
Maximum medical benefit	The maximum medical benefit is the most a benefit or plan will pay for eligible expenses during the entire time a person is covered by the benefit or plan. When you have exhausted your maximum medical benefit your medical coverage terminates, and you do not receive the annual restoration of benefits. You are not eligible for any future increases in the maximum medical benefit. Even if you have exhausted your maximum medical benefit, your covered eligible dependents may continue their existing medical coverage under the benefit or plan up to their maximum medical benefit (as long as they meet the eligibility requirements). If your selected medical coverage (for both the employee and covered eligible dependents) is one of the self-funded medical coverages (Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or PPO-Copay Options), and you and/or your eligible dependents exhaust the maximum medical benefit under the self-funded medical coverage, neither you nor your eligible dependents who exhaust the maximum medical benefit can elect any medical coverage (including an HMO) under the Plan. If you and your covered eligible dependents exhaust the maximum medical benefit, you may continue other coverages/benefits in the benefit or plan, e.g., life and/or accident insurance, dental coverage, flexible spending accounts, or the disability coverages. The medical coverage is the only coverage that terminates for the affected individual.
Medical Benefit	The Company offers eligible employees the opportunity to elect medical coverage that provides protection for you and your covered dependents in the event of an illness or injury. You may choose the Out-of-Area Coverage, Minimum Coverage, PPO-Deductible or PPO-Copay Options, a Health Maintenance Organization (HMO), or you may waive coverage completely. The Medical Options and HMOs are not offered in all locations.

Term	Definition
Medical necessity or medically necessary	A medical or dental service or supply required for the diagnosis or treatment of a non-occupational, accidental injury, illness, or pregnancy. The benefit or plan determines medical necessity based on and consistent with standards approved by the claims processor's medical personnel. To be medically necessary, a service, supply, or hospital confinement must meet all of the following criteria: • Ordered by a physician (although a physician's order alone does not make a service medically necessary) • Appropriate (commonly and customarily recognized throughout the physician's profession) and required for the treatment and diagnosis of the illness, injury, or pregnancy • Unavailable in a less intensive or more appropriate place of service, diagnosis, or treatment that could have been used instead of the service, supply, or treatment given Either: • Safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications • Provided in a clinically controlled research setting using a specific research protocol that meets standards equivalent to those defined by the National Institute of Health for a life-threatening or seriously debilitating condition. The treatment must be considered safe with promising efficacy as demonstrated by accepted clinical evidence reported by generally recognized medical professionals or publications. A service or supply to prevent illness must meet the above conditions to be considered medically necessary. A service is not considered medically necessary if it is educational, experimental, or unproven in nature. In the case of hospital confinement, the length of confinement and hospital services and supplies are considered medically necessary to the extent the claims processor, QuickReview, or your network administrator determines them to be: • Appropriate for the treatment of the illness or injury • Not for the patient's scholastic education, vocation, or training • Not custodial in nature. • A determination that a service or supply is not medically necessary may apply to all or part of the service or supply.
Mental Health Disorder	A neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disease or disorder of any kind listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, or any subsequent edition which constitutes the most recent edition of this manual.
Multiple Surgical Procedures	Surgical procedures performed at the same time as the primary surgical procedure, which are medically necessary but were not the primary reason for surgery.
Network	A group of physicians, hospitals, pharmacies, and other medical service providers who have agreed to provide discounted fees for their services.

Term	Definition
Nurse	This term includes all of the following professional designations: • Registered Nurse (R.N.) • Licensed Practical Nurse (L.P.N.) • Licensed Vocational Nurse (L.V.N.) Nursing services are covered only when medically necessary and the nurse is licensed by the State Board of Nursing and if the nurse is not living with you or related to you or your spouse.
Obesity	A condition in which an individual either (i) has a body weight greater than 30% above the ideal or desirable weight on standard height-weight tables, or (2) is male and has a body mass index greater than 27.8 or is female and has a body mass index of greater than 27.3. Obesity includes obesity that constitutes morbid obesity as well as all other forms of obesity.
Original Medicare	The term used by the Health Care Financing Administration to describe the coverage available under Medicare Parts A and B.
Outpatient	Medical treatment or services provided at a hospital or clinic for a patient who is not admitted to the hospital for an overnight stay.
Over-the-Counter (OTC)	Drugs, products, and supplies that do not require a prescription by federal law.
Primary Care Physician	A network physician who specializes in family practice, internal medicine, or pediatrics and who coordinates all of the network medical care for a participant in a PPO Option or an HMO.
Physician	A licensed practitioner of the healing arts acting within the scope of his or her license. The term does not include: • You • Your spouse • A parent, child, sister, or brother of you or your spouse. The term physician includes, but is not limited to, the following licensed individuals, listed alphabetically: • Audiologist • Certified social worker or advanced clinical practitioner • Chiropractor • Clinical psychologist • Doctor of osteopathy (D.O.) • Doctor of Medicine (M.D.) • Nurse anesthetist • Nurse practitioner • Physical or occupational therapist • Physician Assistant (PA) • Speech pathologist or speech language pathologist or therapist.
Pre-existing condition (or pre-existing condition limitation)	A pre-existing condition includes any physical or mental condition that was diagnosed or treated before the participant's original coverage effective date (the date first enrolled in coverage) in a health plan and which will not be covered under that plan for a specified period after enrollment.

Term	Definition
Preferred Provider Organization (PPO)	A group of physicians, hospitals, and other health care providers who have agreed to provide medical services at negotiated rates. The Medical Options' Medical Discount Program and the Dental Benefits Preferred Dentist Program are both PPOs.
Pre-retirement monthly salary	Your base monthly salary in effect on your retirement date. Pre-retirement monthly salary does not include overtime pay, premium pay, shift differential, bonuses, approved expenses, or other allowances. Your pre-retirement monthly salary may determine the amount of your Retiree Life Insurance coverage.
Prescriptions	Drugs and medicines that must, by federal law, be accompanied by a physician's written order and dispensed only by a licensed pharmacist. Prescription drugs also include injectable insulin and prenatal vitamins while pregnant.
Primary Surgical Procedure	The surgery prescribed based on the primary diagnosis.
Prior authorization for prescriptions	Authorization by the prescription drug program administrator that a prescription drug for the treatment of a specific condition or diagnosis meets all of the medical necessity criteria.
Proof of Good Health, **Statement of Health**	Some benefit plans require you to provide "proof of good health" when you enroll for coverage at a later date (if you do not enroll when you are first eligible), or when you increase levels of coverage. Proof of good health (or a Statement of Health) is a form you must complete and return to the appropriate benefit Plan Administrator when you: • Increase levels of Life Insurance • Add Long Term Disability Plan or Optional Short Term Disability Insurance Benefit (for workgroups that offer this Plan and/or benefit) • Add Supplemental Medical Plan coverage if you marry or *declare a Domestic Partner* (and are part of a workgroup that offers this coverage) Coverage amounts will not increase nor will you be enrolled in these coverages until the Plan Administrator approves your Proof of good health or Statement of Health form. If a death or accident occurs before your enrollment for coverage or increase in coverage is processed, the amount of Life Insurance and Accidental Death and Dismemberment coverage that will be payable is your current amount of coverage or default coverage (if you have not enrolled following your eligibility). You may obtain a Statement of Health or Proof of Good Health from the Plan Administrator for each benefit plan or online through *Jetnet* under the Forms menu.
Provider	The licensed individual or institution that provides medical services or supplies. Providers include physicians, hospitals, pharmacies, surgical facilities, dentists, and other covered medical or dental service and supply providers.
Psychiatric day treatment facility	A mental health institution that provides treatment for individuals suffering from acute mental health disorders. The institution must: • Be clinically supervised by a physician who is certified in psychiatry by the American Board of Psychiatry and Neurology • Be accredited by the Program of Psychiatric Facilities of the Joint Commission on the Accreditation of Health Care Organizations • Have a structured program utilizing individual treatment plans with specific attainable goals and objectives appropriate both to the patient and the program's treatment format.

Term	Definition
Psychiatric hospital	An institution licensed and operated as set forth in the laws that apply to hospitals, which: • Is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons, either by or under the supervision of a physician • Maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided • Is licensed as a psychiatric hospital • Requires that every patient be under the care of a physician • Provides 24-hour nursing service. The term psychiatric hospital does not include an institution, or that part of an institution, used mainly for the following: • Nursing care • Rest care • Convalescent care • Care of the aged • Custodial care • Educational care.
Regular employee	An employee hired for work that is expected to be continuous in nature. Work may be full-time, part-time, depending on the business needs of the organization or the terms of the applicable labor agreement. A regular employee is eligible for the benefits and privileges that apply to his/her workgroup or as outlined in his/her applicable labor agreement.
Reliable evidence	Reliable evidence includes: • Published reports and articles in the authoritative peer reviewed medical and scientific literature (including, but not limited to: AMA Drug Evaluation, American Hospital Formulary Service Drug Information, U.S. Pharmacopoeia Dispensing Information, and National Institutes of Health) • Written protocols used by the treating facility studying substantially the same drug, device, medical treatment, or procedure • Written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure. • Reliable evidence does not include articles published only on the internet.
Residential treatment center	A facility that offers 24-hour residential programs that are usually short-term in nature and provide intensive supervision and highly structured activities through a written individual treatment plan to persons undergoing an acute demonstrable psychiatric crisis of moderate to severe proportions. The center must be licensed by the state as a psychiatric residential treatment center and accredited by the Joint Commission on the Accreditation of Health Care Organizations.

Term	Definition
Restoration of Medical Maximum Benefit	Each January 1, you are eligible to have part of your medical maximum benefit automatically restored. The amount restored will be the lesser of: • $3,500, or • the amount necessary to restore your full medical maximum benefit.
Restorative and rehabilitative care	Care that is expected to result in an improvement in the patient's condition and restore reasonable function. After improvement ceases, care is considered to be maintenance and is no longer covered.
School	An educational institution, including a vocational or technical school, if the student is enrolled: • In a program leading to a degree or certificate • On a full-time basis (generally 12 credit hours at colleges and universities).
Secondary Surgical Procedure	A surgical procedure performed at the same time as the primary surgical procedure, which is medically necessary but was not included in the primary diagnosis.
Special Dependent	A foster child or child for whom you are the legal guardian.
Summary Plan Description	In our efforts to provide you with full multi-media access to benefits information, American Airlines, Inc., has created online versions of the Summary Plan Descriptions for our benefit plans and they are included in this Guide. The Summary Plan Descriptions also the formal legal plan documents. If there is any discrepancy between the online version and the official hard copy of this Guide, then the official hard copy, plus official notices of plan changes/updates will govern.
Urgent care	Care required because of an illness or injury that is serious and requires prompt medical attention, but is not life threatening. Examples of situations that require urgent care include high fevers, flu, cuts that may require stitches, and sprains.
Unproven Service, Supply or Treatment	Any medical or dental service, supply, or treatment that has not been proven both safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications, or has not been proven both safe and effective by Reliable Evidence. “Reliable Evidence” is defined on page 195, and when used herein, refers to “Reliable Evidence” as defined on page 195.

Term	Definition
Usual and prevailing fee limits	The maximum amount that the Plan will consider as an eligible expense for medical or dental services and supplies. The following are the primary factors considered when determining if a charge is within the usual and prevailing fee limits: • The range and complexity of the services provided • The typical charges in the geographic area where the service or supply is rendered/provided and other geographic areas with similar medical cost experience. The Plan Administrator, in its sole discretion, has retained the claims processor to determine usual and prevailing fees. These usual and prevailing fees are based on the claims processor's database of prevailing health care charges, or if that data is not applicable, the usual and prevailing fees are based on a relative unit value methodology. Under the relative unit value method, every procedure is assigned a specific unit value based on a professional reference standard. Unit values are assigned by this reference according to the relative complexity of a procedure. The unit value is then multiplied by a dollar value per unit, in accordance with professional fee data taken from the geographic area where the medical services were rendered. (This dollar value is referred to as the "area conversion factor", and is determined by statistical calculations that take into account all charges from this multiplication (unit value times area conversion factor) is the maximum charge allowed under the Plan. The usual and prevailing fee limits can also be impacted by number of services or procedures you receive during one medical treatment. Under the Plan, when the claims processor reviews a claim for usual and prevailing fees, it looks at all of the services and procedures billed. Related services and procedures performed at the same time can often be included in a single, more comprehensive procedure code. Coding individual services and procedures by providers (called "coding fragmentation" or "unbundling") usually results in higher physician charges than if coded and billed on a more appropriate combined basis. In such cases, the Plan will pay for the services as a group under a comprehensive procedure code, not individually. For example, the appendix is often removed by the surgeon during a hysterectomy. The appropriate code for the hysterectomy procedure includes removal of the appendix. However, some physicians will bill separately for a hysterectomy and an appendectomy as if these procedures had been separately performed at different times. Recognizing this, when multiple surgical procedures are performed at the same time, the Plan pays benefits up to the usual and prevailing fee limit of the appropriate combined code rather than calculating and awarding benefits for each surgical procedure separately.

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