

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 in 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.aetnavigators.com Provider directory: www.aetna.com/docfind/custom/american eagle
	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/american eagle
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.aetnavigators.com Provider directory: www.aetna.com/docfind/custom/american eagle

		caneagle
	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/american eagle
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.aetn navigator.com Provider directory: www.aetna.com/docfind/custom/american eagle
	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/american eagle
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.aetn navigator.com Provider directory: www.aetna.com/docfind/custom/american eagle
	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/american eagle
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.

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

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 effective 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 ...
<i>PPO Co-Pay Plan</i>	<i>The Health Care FSA (HCFSA) and the Dependent Day Care FSA (DDFSA)</i>	<i>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.</i>
<i>PPO Deductible/OOA Plan</i>	<i>The Health Care FSA (HCFSA) and the Dependent Day Care FSA (DDFSA)</i>	<i>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.</i>

Your Medical Option Election	If you have ...	Your reimbursement method is ...
<i>Minimum Coverage Plan</i>	<i>The Health Care FSA (HCFSA) and the Dependent Day Care FSA (DDFSA)</i>	<i>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.</i>
<i>HMOs</i>	<i>The Health Care FSA (HCFSA) and the Dependent Day Care FSA (DDFSA)</i>	<i>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.</i>

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
- Protheses.

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

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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						

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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

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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) beginning 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