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").

<u>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:</u>

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

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

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, <u>you must</u> 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. <u>If you do not, you must wait until the next annual enrollment period to enroll your baby in coverage.</u> 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. <u>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.</u>*

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. <u>If you miss the 60-day deadline, you will not be able to add the terminated spouse to your coverage.</u>*

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