

**Index of benefit plan information dated March 15, 2006:  
(Click on the links below to view the sections of this document.)**

- I. [Technical Corrections to the Employee Benefits Guide](#)
- II. [Technical Corrections to the Summary of Material Modifications \(SMM\)  
dated December 15, 2005](#)



**NOTICE AND DOCUMENTATION OF TECHNICAL CORRECTIONS TO THE EMPLOYEE BENEFITS GUIDE FOR American Eagle Airlines, Inc, CORRECTIONS TO THE DECEMBER 15, 2005 SUMMARY OF MATERIAL MODIFICATIONS, AND TRIENNIAL HIPAA NOTICE OF PRIVACY PRACTICES (March 15, 2006)**

This document serves as notice to American Eagle Airlines, Inc. active and Leave-of-Absence employees of technical corrections and summary of material modifications made to your summary plan descriptions. This Notice and Summary of Material Modifications, together with the Employee Benefit Guide and Summaries of Material Modifications, make up the official plan documents and summary plan descriptions. **Please read this notice carefully, and place this notice with your summary plan description(s). The Summary Plan Descriptions are contained in the Employee Benefit Guide for American Eagle, Inc. (“EBG”).**

- Group Life and Health Benefits Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 501, EIN #13-1502798)
- Supplemental Medical Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 503, EIN #13-1502798)
- Long Term Care Insurance Plan for Employees of Participating AMR Corporation Subsidiaries (Plan 510- EIN #13-1502798)
- American Airlines Inc. Long Term Disability Plan ( Plan 509, EIN #13-1502798)

**Eagle Group Life and Health Benefits Plan**

**I. TECHNICAL CORRECTIONS TO THE EMPLOYEE BENEFIT GUIDE**

- All references to the “Benefits and Pay” page on Jetnet throughout the EBG are replaced with “Benefits”.
- Under “Medical Benefits Options” (page 5) first paragraph is revised as follows:  
**Some Medical Options are not offered in all locations. The PPO Options are offered in most locations, but if you live outside the UnitedHealthcare access area, you are not eligible for the PPO Options and may choose the Out of Area Option for medical coverage. The enrollment section on Jetnet will reflect which Options are available to you.**
- Under “Dependents of Deceased Employees” (page 16) the first sentence of the third paragraph is revised as follows:  
**Your Covered dependents can elect to continue Dental Benefits and certain other benefits (if applicable) under COBRA at the full COBRA rate, if they had Dental Benefits at the time of your death.**
- Under “Enrollment” section, “When Coverage Begins” (page 21) the first sentence of the first paragraph is revised as follows:  
**If you enroll by the enrollment deadline, your selected coverage (if different from default coverage) is retroactive to the date you are first eligible for benefits and your paycheck is adjusted as necessary.**
- Under “Taxation of Benefits” (page 24) change the last entry at the end of the chart is revised as follows:

Type of Benefits	Before Tax?	May Waive?
Long Tern Care Insurance Plan	No	Yes

- Under “Benefit ID Card” (page 25) first sentence of the first paragraph is revised as follows:  
**If you have elected to participate in a Medical Benefits Option (other than an HMO), or if you are a new participant to a Medical Benefit Option, UnitedHealthcare will mail your benefit ID cards to you.**

- Under “Special Enrollment Rights” (page 26) the last phrase of the first sentence is revised as follows:  
**...you have 60 days from the date of the event to enroll yourself and/or your dependents in a Medical Benefits Option.**
- Under “Special Enrollment Rights” (page 26) under the existing three bullets after the first paragraph, four additional bullets are added as follows:
  - **You and/or one of your dependents exhaust a lifetime maximum in another employer’s health plan or in other health insurance coverage.**
  - **Your employer and/or your dependent’s employer ceases to offer health benefits to the class of employees through which you (or one of your dependents) have coverage.**
  - **You and/or one of your dependents were enrolled under an HMO or other group or individual plan or coverage arrangement that will no longer cover you and/or one of your dependents) because you and/or your dependent no longer reside, live, or work in its service area.**
  - **You have a new dependent as a result of your marriage, your child’s birth, adoption, or placement for adoption with you.**
- Under “Special Enrollment Rights” (page 26) second paragraph is revised as follows:

As an employee, you may enroll **yourself and your new spouse and any dependents** within 60 days of your marriage and a new child within 60 days of his or her birth, adoption or placement for adoption. In addition, if you are not enrolled in the employee benefits as an employee, you also must enroll in the employee benefits when you enroll any of these dependents. And, if your spouse is not enrolled in the employee benefits, you may enroll **yourself and/or** him or her in the employee benefits when you enroll a child due to birth, adoption or placement for adoption. In the case of marriage, coverage will begin on the first day of the first calendar month after the completed enrollment form is received. In the case of birth, adoption or placement for adoption coverage is retroactive to the date of birth, adoption or placement for adoption. **To request special enrollment or obtain more information, HR Employee Services (see Contact Information).**

- Under “Life Events” the first Life Event at the top (page 31) is revised as follows:

<b>If...</b>	<b>Then, You Can...</b>
<p><i>Change in spouse’s employment or other health coverage, or</i></p> <p><i>Your spouse’s employer no longer contributes toward health coverage, or</i></p> <p><i>Your spouse’s employer no longer covers employees in your spouse’s position</i></p>	<ul style="list-style-type: none"> <li>• <b>Medical and Dental Options and Vision Insurance Benefit:</b> Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time, <b>if you were already enrolled. If you were not enrolled, you may enroll yourself and your spouse and eligible dependents in any Medical Benefit Option</b></li> <li>• <b>Supplemental Medical Plan:</b> Stop coverage for your spouse, yourself, or you and your spouse</li> <li>• <b>Optional Short Term Disability Insurance Benefit:</b> Start coverage; however, this coverage applies to the employee only</li> <li>• <b>Long Term Disability Plan: Start or stop coverage;</b> however, this coverage applies to the employee only</li> <li>• <b>Contributory Term Life Insurance Benefit:</b> Start or stop coverage</li> <li>• <b>Voluntary Personal Accident Insurance Benefit:</b> Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage</li> <li>• <b>Flexible Spending Accounts Benefits:</b> Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions</li> </ul>

- Under “Life Events” (page 31) add a new category under the first Life Event as follows:

<b>If...</b>	<b>Then, You Can...</b>
<p><b><i>You or your dependent exhausts a lifetime limit in another medical plan</i></b></p> <p><b><i>You or your dependents were enrolled in an HMO or another arrangement that will no longer cover you due to your failure to live, work or reside in the arrangement’s service area</i></b></p>	<ul style="list-style-type: none"> <li>• <b>Medical and Dental Options and Vision Insurance Benefit:</b> Add coverage for your spouse and eligible dependents, or yourself; stop coverage for spouse, your dependent, or yourself. You cannot change benefit options at this time, if you were already enrolled. If you were not enrolled, you may enroll yourself and your spouse and eligible dependents in any Medical Benefit Option</li> <li>• <b>Supplemental Medical Plan:</b> Stop coverage for your spouse, yourself, or you and your spouse</li> <li>• <b>Optional Short Term Disability Insurance Benefit:</b> Start coverage; however, this coverage applies to the employee only</li> <li>• <b>Long Term Disability Plan: Start or stop coverage;</b> however, this coverage applies to the employee only</li> <li>• <b>Contributory Term Life Insurance Benefit:</b> Start or stop coverage</li> <li>• <b>Voluntary Personal Accident Insurance Benefit:</b> Start or stop coverage for your spouse, your dependent, or yourself; increase or decrease existing coverage</li> <li>• <b>Flexible Spending Accounts Benefits:</b> Start or stop Flexible Spending Accounts; increase or decrease Flexible Spending Account contributions</li> </ul>

- Under “Maximum Medical Benefit” (page 39) third paragraph, first sentence, a comma is added after the first phase of the sentence as follows:

**When you have exhausted your maximum medical benefit, your medical coverage terminates.**

- Under “Medical Benefit Options Comparison” (page 40) first paragraph, second sentence is revised as follows:

**Benefits are available for Eligible Expenses that are medically necessary and within the usual and prevailing fee limits for the Out-of-Area Coverage Option (or within 140% of MGRP under the PPO Copay, PPO Deductible, Minimum Coverage Options).**

- Under “Medical Benefit Options Comparison” (page 40) second sentence of first bullet is revised as follows:

**The out-of-pocket maximum does not include deductibles or copayment amounts, amounts not covered, amounts exceeding the usual and prevailing fee limits for the Out-of-Area Coverage Option (or 140% of MGRP under the PPO Copay, PPO Deductible, Minimum Coverage Options), or services covered at 50%.**

- Under “Leaving the service area.” (page 52) second paragraph, the last sentence is replaced with:

**If you do not notify HR Employee Services of your election, you will be enrolled in a plan offered in your new location. (See table on page 20, under Default Coverage)**

- Under “Filing Claims” (page 74) the final two sentences are replaced as follows:

**If you have questions about your coverage or your claim, call UnitedHealthcare or Medco.**

- Under “Continuation of Coverage” section “Enrolling for Coverage” (page 83) replace the first sentence of second paragraph with the following sentence:

**You (or your dependents) must provide written notification of your desire to elect to purchase continuation of coverage within 60 days of the date postmarked on the notice in order to purchase continuation of coverage. You must elect to continue coverage within 60 days of the date post marked on the notice, or you lose your right to elect to continue coverage. (See Contact Information for CONEXIS’ address for sending your written notice.)**

- Under “Supplement Medical”, “Enrollment” (page 90) add at the end of the first paragraph a sentence as follows:

**To see more on the enrollment rules, see Life Events beginning on page 28.**

- Under “Enrollment” (page 90) the following section is added immediately after “Enrollment”

### **Special Enrollment Rights**

***The following special enrollment rights are available and apply to participants in the Supplemental Medical Plan. These enrollment rights apply after satisfaction of, and subject to the eligibility requirements the Supplemental Medical Plan beginning on page 88.***

**If you or your spouse declined coverage under the Supplemental Medical Plan because you or they have medical coverage elsewhere and one of the following events occurs, you have 60 days from the date of the event to enroll yourself and/or your dependents in Supplemental Medical Plan coverage.**

- **You and your spouse lose the other medical coverage because eligibility was lost for reasons including legal separation, divorce, death, termination of employment or reduced work hours (but not due to failure to pay premiums on a timely basis, voluntary disenrollment or termination for cause).**
- **The employer contributions for the other coverage have stopped.**
- **The other coverage was COBRA and the maximum COBRA coverage period ends.**
- **You and/or your spouse exhaust a lifetime maximum in another employer’s health plan or other health insurance coverage**
- **Your employer and/or your spouse’s employer ceases to offer benefits to the class of employees through which you (or one of your dependents) had coverage**
- **You and/or your spouse were enrolled under a HMO or other group or individual plan or arrangement that will no longer cover you (and/or your spouse) because you and/or your spouse no longer reside, live, or work in its service area.**
- **You have a new spouse as a result of your marriage.**

**In addition, if you are not enrolled in the employee benefits as an employee, you also must enroll in the employee benefits when you enroll your spouse. And, if your spouse is not enrolled in the employee benefits, you may enroll yourself, and/or him/her in the employee benefits. In the case of marriage, coverage will begin on the first day of the first calendar month after the completed enrollment form is received. To request special enrollment or obtain more information, HR Employee Services (see Contact Information).**

**If you are adding a new spouse to your benefits during the special enrollment rights period, keep in mind that you must submit to HR Employee Services proof that your spouse qualifies as your eligible dependent. Proof that the spouse you enroll qualifies as your eligible dependent includes (but is not limited to) official government-issued birth certificates, marriage licenses, joint income tax returns, etc. The proof of eligibility requirements is listed on Jetnet, under Benefits, under “Dependent, Benefit Eligibility”, or you may contact HR Employee Services for proof of eligibility requirements (see Contact Information).**

- Under “Covered Orthodontia Expenses” (page 111) change first sentence in first paragraph to read as follows:

**The Dental Benefit plan covers orthodontic treatment for an eligible dependent child only and covers 50% of eligible and necessary expenses, to a maximum orthodontia benefit of \$1,500 during the entire time the child is covered by the Plan.**

- Under “Covered Orthodontia Expenses” section “Payment of claims” (page 111) change the second sentence in the first bullet to read as follows:

**The Dental Benefit will pay up to the maximum orthodontia benefit of \$1,500, in one lump sum, based upon the orthodontist’s lump sum billing for orthodontia treatment (provided the treatment is determined to be an eligible expense under the Dental Benefit).**

- Under “Covered Orthodontia Expenses” section “Payment of claims” (page 112) change the second sentence in the second bullet to read as follows:

**If the patient has primary coverage under another plan, the amount paid for orthodontia under that plan will be deducted from the \$1,500 maximum orthodontia benefit.**

- Under “Travel Assistance Services” (page 126) the ninth bullet, last sentence is revised as follows:

**Children do not have to be covered under VPAI for this benefit.**

- Under “Insurance Policy” (page 128) the first sentence of the second paragraph is revised as follows:

**Other accident insurance, including Special Risk Accident Insurance and Special Purpose Accident Insurance, is provided under group insurance policies issued by LINA (see Other Accident Insurance below).**

- Under “Assignment of Benefits” (page 134) the last four paragraphs of this section are grouped together under a subheading entitled as follows:

**“Total Control Account”**

- Under “Optional Short Term Disability Insurance Benefit”, “OSTD Insurance Benefits” (page 136) the first sentence of the first paragraph is revised as follows:

**If you have a qualifying disability, the OSTD benefit covers the difference between any state-provided benefit and 50% of your adjusted monthly salary on your last day worked.**

- Under “How the Health Care FSA Works”, “HCFSA Funds Availability” (page 148) the following sentence is deleted:

**In addition, the Company maintains some limits on reimbursements for items such as orthodontia.**

- Under “Receiving Reimbursement”, section “Automatic Reimbursement Feature” (page 152) the last paragraph of this section is deleted and replaced with the following paragraph:

**To stop the Automatic Rollover Feature, access UnitedHealthcare’s web site at [www.myuhc.com](http://www.myuhc.com) (click on “Manage My Accounts”) or call UnitedHealthcare (see Contact Information).**

- All references to “Automatic Reimbursement Feature” (pages 151-153) are deleted and replaced with:

**“Automatic Rollover Feature”**

- Under “Filing Claims”, under “You must file a claim for reimbursement from your HCFSA in the following circumstances:” (page 152) the third bullet:

**“Retail prescription drug copayments and all mail order prescription drug copayments must be submitted to the claims administrator with a claim for reimbursement” is deleted.**

- Under “Collective Bargaining Agreement” (page 163) the first sentence of the paragraph is revised as follows:

**The types of benefits (medical and dental benefit, life insurance benefits) described in this Guide are maintained subject to a collective bargaining agreement.**

**II. TECHNICAL CORRECTIONS TO THE SUMMARY OF MATERIAL MODIFICATION (“SMM”) DATED DECEMBER 15, 2005**

- In the Chart on page 7 of the 12/15/2005 SMM, under “Using the UnitedHealthcare Consumer Account Card”, the text is revised as follows:

<b>Type Of Expense</b>	<b>Can You Use FSA Card?</b>	<b>Can You Use Automatic Rollover?</b>	<b>Must You File FSA Claim Manually?</b>
<b>Medical Expenses—PPO-Copay Option</b>			
<i>Copayments</i>	Yes	Yes	No
<i>Deductibles (UHC network providers)</i>	Yes	Yes	No
<i>Coinsurance Amounts (UHC network providers)</i>	Yes	Yes	No
<b>Retail Prescription Drugs (Walgreens Retail Pharmacies ONLY)</b>	<i>You can, but it's better if you don't (see footnote 1 below)</i>	No	<i>Is better if you do (see footnote 2 below)</i>
<i>Mail Order Prescription Drugs (Medco by Mail)</i>	Yes	Yes	No

- If you pay for your Walgreens retail prescription with your FSA card, the entire cost will be charged to your HCFSA account, and the cost isn't reconciled against what your Medical Option's prescription drug coverage would pay. Thus, your HCFSSA is depleted at a greater rate, leaving you fewer HCFSA fund available for other health care expenses.
  - In this case, it's better for your HCFSA balance if you wait until your Medical Option pays its benefit, and then manually submit your out of pocket prescription drug expense to your HCFSA.
- On page 2 of the 2/15/05 SMM, under “Increase maximum member coinsurance amounts in the Prescription Drug Benefit”, under “Mail Service Prescription Drug Option”, (page 68 of EBG) the paragraph is replaced with two bullets that read as follows:
    - Generic Drugs: \$20 per prescription or refill for generic drugs (or the actual cost of the drug, if the prescription cost is less than \$20)**
    - Brand Name Drugs: 30% of the cost of the drug, up to a \$250 maximum per prescription or refill if no generic is available or, 50 % of the cost of the brand drug when there is a generic available.**
  - The attached “Medical Benefit Option Comparison Chart” replaces the appendix attached to the Summary of Material Modifications sent on 12/15/05.

## 2006 American Eagle Medical Plan Comparison Chart

### 2006 Plan Features

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
<b>DEDUCTIBLES / MAXIMUMS</b>					
Individual Annual Deductible	\$250	\$250	None	\$1,000	\$500
Family Annual Deductible	\$750	\$750	None	\$2,000	Not Applicable
Individual Annual Out-of-Pocket Maximum*	\$1,500	\$1,500	\$1,500	\$3,000	\$4,000
Individual Lifetime Medical Maximum	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000	\$5,000,000
<b>PREVENTIVE CARE</b>					
Annual Routine Physical Exam	Not Covered	20% coinsurance after satisfying annual deductible	\$20 copayment*	Not Covered	Not Covered
Well Child Care	20% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)	20% coinsurance after satisfying annual deductible	\$20 copayment*	20% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)	40% coinsurance for initial hospitalization, immunizations, and up to 7 well-child care visits (for children up to age 2)
<b>MEDICAL SERVICES</b>					
Primary Care Physician's Office Visit	20% coinsurance	20% coinsurance	\$20 copayment*	20% coinsurance	40% coinsurance
Specialist Office Visit	20% coinsurance	20% coinsurance	\$30 copayment*	20% coinsurance	40% coinsurance
Gynecological Care Visit	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	\$20 copayment* (for preventive visits) \$30 copayment* (if not a preventive diagnosis)	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Pap Test	20% coinsurance if medically necessary (preventive care not covered)	20% coinsurance after satisfying annual deductible	No cost if part of office visit 20% coinsurance if performed at a hospital	20% coinsurance if medically necessary (preventive care not covered)	40% coinsurance if medically necessary (preventive care not covered)
Mammogram	20% coinsurance if medically necessary (routine coverage begins at age 35)	20% coinsurance after satisfying annual deductible	No cost if part of office visit 20% coinsurance if outpatient hospital	20% coinsurance if medically necessary (routine coverage begins at age 35)	40% coinsurance if medically necessary (routine coverage begins at age 35)
Pregnancy - Physician Services	20% coinsurance	20% coinsurance	\$30 copayment* per visit \$300 max copayment per pregnancy (includes prenatal/postnatal/delivery)	20% coinsurance	40% coinsurance
Second Surgical Opinion	20% coinsurance	20% coinsurance	\$20 copay PCP \$30 copay Specialist	20% coinsurance	40% coinsurance
Urgent Care Center Visit	20% coinsurance	20% coinsurance	\$25 copayment*	20% coinsurance	40% coinsurance
Chiropractic Care Visit	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	\$30 copayment* (max of 20 visits per year in-network and out-of-network combined)	20% coinsurance (max of 20 visits per year in-network and out-of-network combined)	40% coinsurance (max of 20 visits per year in-network and out-of-network combined)



## 2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Speech, Physical, Occupational, Restorative, and Rehabilitative Therapy	20% coinsurance	20% coinsurance	\$30 copayment* per visit (max copayment of \$300 per person per year)	20% coinsurance	40% coinsurance
Allergy Care	20% coinsurance	20% coinsurance	\$30 copayment* per visit (max copayment of \$300 per person per year)	20% coinsurance	40% coinsurance
Diagnostic X-ray and Lab	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office or a network laboratory/radiology center	20% coinsurance	40% coinsurance
<b>OUTPATIENT SERVICES</b>					
Outpatient Surgery in Physician's Office	20% coinsurance	20% coinsurance	\$20 copay PCP \$30 copay Specialist	20% coinsurance	40% coinsurance
Outpatient Surgery in a Hospital or Free Standing Surgical Facility	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance
Pre-admission Testing	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	40% coinsurance
<b>HOSPITAL SERVICES</b>					
Inpatient Room and Board, including intensive care unit or special care unit	20% coinsurance	20% coinsurance	\$150 copayment* per year, plus 20% coinsurance for all other hospital based services	20% coinsurance	40% coinsurance
Ancillary services (including x-rays, pathology, operating room, and supplies)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance
Newborn Nursery Care (Considered under the baby's coverage, not the mother's. You must add the baby on-line via Jetnet within 60 days or these charges will not be covered.)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance (separate calendar year deductible applies to baby)	20% coinsurance for all hospital based services (hospital admission copayment of \$150 does not apply to baby)	20% coinsurance (separate calendar year deductible applies to baby)	40% coinsurance (separate calendar year deductible applies to baby)
Inpatient Physician Services, Surgery, Anesthesia, and Medically Necessary Assistant Surgeon	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Blood Transfusion	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital. No cost if performed in physician's office	20% coinsurance	40% coinsurance
Organ Transplant	20% coinsurance	20% coinsurance	20% coinsurance for inpatient hospital services	20% coinsurance	40% coinsurance
Emergency Ambulance	20% coinsurance	20% coinsurance	No Cost	20% coinsurance	40% coinsurance
Emergency Room (hospital) Visit	20% coinsurance	20% coinsurance	\$75 copayment* Waived if admitted to the hospital	20% coinsurance	40% coinsurance

## 2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
<b>OUT-OF-HOSPITAL CARE</b>					
Convalescent and Skilled Nursing facility, following hospitalization	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	20% coinsurance (max of 60 days per year in-network and out-of-network combined)	40% coinsurance (max of 60 days per year in-network and out-of-network combined)
Home Health Care Visit	20% coinsurance	20% coinsurance	\$20 copayment	20% coinsurance	40% coinsurance
Hospice Care	20% coinsurance	20% coinsurance	20% coinsurance if performed at a hospital; \$20 copayment per day if home care	20% coinsurance	40% coinsurance
<b>OTHER SERVICES</b>					
Tubal Ligation or Vasectomy (reversals are not covered)	20% coinsurance	20% coinsurance	\$20 copay PCP \$30 copay Specialist 20% coinsurance in hospital or freestanding surgical center	20% coinsurance	40% coinsurance
Infertility Treatment	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Radiation Therapy or Chemotherapy	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital	20% coinsurance	40% coinsurance
Kidney Dialysis (if the dialysis continues more than 12 months, participants must apply for Medicare)	20% coinsurance	20% coinsurance	No cost if performed in a physician's office; 20% coinsurance if performed in a hospital or dialysis center	20% coinsurance	40% coinsurance
Supplies, Equipment, and Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	No cost if rented or purchased from Network Provider	20% coinsurance	40% coinsurance
<b>MENTAL HEALTH AND CHEMICAL DEPENDENCY</b>					
Inpatient Mental Health Care	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	20% coinsurance for all hospital based services	20% coinsurance (max of 30 days per year and Lifetime max of 60 days)	40% coinsurance (max of 30 days per year and Lifetime max of 60 days)
Alternative Mental Health Center	50%** (max of 30 days per year)	50%** (max of 30 days per year)	20% coinsurance for all hospital based services	50%** (max of 30 days per year)	50%** (max of 30 days per year)
Outpatient Mental Health Care Visit	50%** (up to max of 60 visits per year)	50%** (up to max of 60 visits per year)	\$30 copayment	50%** (up to max of 60 visits per year)	50%** (up to max of 60 visits per year)
Marriage Counseling	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Detoxification (considered a medical condition)	20% coinsurance	20% coinsurance	20% coinsurance for all hospital based services	20% coinsurance	40% coinsurance

## 2006 American Eagle Medical Plan Comparison Chart

Plan Features	In-Network PPO-Deductible	Out-of-Area Coverage	In-Network PPO-Copay	Minimum Coverage	Out-of-Network PPO-Deductible & PPO-Copay
Chemical Dependency*** Inpatient Rehabilitation	20% coinsurance if approved by EAP (max \$5,000 benefit)	20% coinsurance if approved by EAP (max \$5,000 benefit)	20% coinsurance for all hospital based services if approved by EAP	20% coinsurance if approved by EAP (max \$5,000 benefit)	40% coinsurance if approved by EAP (max \$5,000 benefit)
Chemical Dependency*** Outpatient Rehabilitation	50%** if approved by EAP	50%** if approved by EAP	\$30 copayment* per visit if approved by EAP (max copayment of \$300 per person per year)	50%** if approved by EAP	50%** if approved by EAP
<b>PRESCRIPTION MEDICATIONS</b>					
Retail Pharmacy* (up to a 30 day supply)	<b>Retail Card Program</b> \$10 - Generic 30% (max \$100) - Brand (if no generic available) 50% - Brand (if generic available)	<b>Retail Card Program</b> \$10 - Generic 30% (max \$100) - Brand (if no generic available) 50% - Brand (if generic available)	<b>Retail Card Program</b> \$10 - Generic 30% (max \$100) - Brand (if no generic available) 50% - Brand (if generic available)	<b>Retail Card Program</b> \$10 - Generic 30% (max \$100) - Brand (if no generic available) 50% - Brand (if generic available)	Medco Health will reimburse the amount the drug would have cost at a network pharmacy (less copayment amount)
Mail Service Pharmacy* (up to a 90 day supply)	\$20 - Generic 30% (max of \$250) - Brand 50% - Brand (if generic available)	\$20 - Generic 30% (max of \$250) - Brand 50% - Brand (if generic available)	\$20 - Generic 30% (max of \$250) - Brand 50% - Brand (if generic available)	\$20 - Generic 30% (max of \$250) - Brand 50% - Brand (if generic available)	Not Applicable
Oral Contraceptives (available only thru mail service)	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered However available for purchase at a discounted rate through Mail Service	Not Covered
Over-The-Counter Medication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
<b>OTHER INFORMATION</b>					
CheckFirst (predetermination of benefits via United HealthCare)	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail	Call United HealthCare for a form at 1-800-592-3048, complete, and mail

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

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

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

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